Neutral Citation Number: [2020] EWCOP 53

Case No: 13670480

IN THE COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 29/10/2020

Before:

THE HONOURABLE MR JUSTICE COBB

- -

Between:

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	**Applicant**
- and -	
TC	**Respondent**
(By her litigation friend, the Official Solicitor) [1]	
AC [2]	
BC [3]	
DC [4]	

- -

Re TC (Urgent Medical Treatment)

- -

Emma Sutton (instructed by **Browne Jacobson LLP**) for the University Hospitals of Leicester NHS Trust
Nageena Khalique QC (instructed by **the Official Solicitor**) on behalf of TC

Hearing date: 29 October 2020

- -

Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

THE HONOURABLE MR JUSTICE COBB

This judgment was delivered in public.
A transparency order has been made.

The Honourable Mr Justice Cobb:

Introduction

1. This is an *ex tempore* judgment delivered at the conclusion of a half-day hearing conducted this morning on the MS Teams platform.

2. The application concerns TC who is 69 years old. She is currently an in-patient at Hospital X, with advanced cancer of the larynx (specifically, a right supraglottic T3 tumour with partial obstruction of breathing and swallowing) which was diagnosed on 7 September 2020. The condition is becoming increasingly life-threatening. Following discussions with her doctor about treatment options, she chose to undergo a course of chemoradiotherapy ('CRT'). She was admitted to X hospital on 6 October 2020 due to the general deterioration of her health and on the following day she was assessed to lack capacity to make decisions regarding treatment.

3. Prior to her hospital admission, TC resided at her home with her husband AC. TC and AC have three adult children. AC and two of the children, BC and DC, are respondents in these proceedings but are not represented.

4. By an application dated 20 October 2020, University of Hospitals Leicester NHS Trust ("the Trust") urgently applied for personal welfare orders under the *Mental Capacity Act 2005* ('*the MCA 2005*') relating to TC's medical treatment. Specifically, the Trust have made the following three applications:

   (i) A declaration that TC lacks capacity to conduct these proceedings and make decisions regarding the proposed medical treatment, and that notwithstanding her lack of capacity, it is lawful and in her best interests for the proposed medical treatment to be provided to her (*s.15(1)(b) and (c) MCA 2005*);
   (ii) An Order that the court consents on behalf of TC to the carrying out of the medical treatment that she requires (*s.16(1)(a) and (2)(a) MCA 2005*);
   (iii) An Order authorising the deprivation of TC's liberty to the extent that the arrangements set out in the treatment plan amount to such (*s.16(1)(a) and (2)(a) and s.4A(3) MCA 2005*).

   Ms Sutton on behalf of the Trust, at the conclusion of the evidence, submitted that the evidence was clear that TC lacks capacity to litigate, and make decisions about her treatment; she further submits that it is in TC's best interests urgently to commence the necessary treatment for her serious condition.

5. The Official Solicitor is acting as TC's litigation friend in this matter. At the conclusion of the evidence, the Official Solicitor (through Ms Khalique QC) has confirmed her view that the evidence tends to indicate that TC lacks capacity to conduct these proceedings and lacks capacity to make decisions about her medical treatment in respect of her throat cancer. As to best interests, the Official Solicitor, having indicated a provisional view to this effect prior to the hearing, confirms that she agrees that it is in TC's best interests to undergo CRT, subject to the recommendations and observations of Dr O'Donovan regarding mental health input, and providing medication to treat her depression and possible agitation and distress at being treated against her will.

6. AC, together with BC and DC have actively participated in the proceedings. They have also spoken with Mr David Edwards of the Official Solicitor's office (I have seen the attendance note) and have submitted their own short statement of evidence in an e-mail sent to the court earlier this week. They also support the treatment for TC. I would like to pay tribute to TC's family who have fully engaged in these proceedings. They have shown great courage and dignity at this very difficult time.

7. For the purposes of determining these issues, I have read a number of reports. These include the witness statements of Ms S, the MacMillan Head and Neck cancer Specialist sister; Ms T, Dietician; Dr P, Consultant ENT / Head and Neck Surgeon; Dr B, Oncologist. I have also read the two reports of the instructed experts, Professor Nutting, Professor of Clinical Oncology, and Dr O'Donovan, Consultant Forensic Psychiatrist. I have (as I say) read the email written by AC, BC and DC outlining the family's position. I heard the oral evidence of Dr P and Dr B, Ms S and Dr O'Donovan. I have read and listened to the written and oral submissions of counsel.

8. No party is actively opposing the Trust's application, but I am nonetheless conscious of my duty to review the evidence that is before the court before making the orders sought and I do so now.

Background

9. Before her diagnosis, TC is described as being a very outgoing and sociable lady. She enjoyed shopping and until recently she had worked (for many years) at her local Co-op store. AC characterises her as the lady that ran the house and managed the family finances. Her sons say that she has suffered from long-standing anxiety: "she worries about everything, and then she worries about worrying, that is who she is". It appears now, though this has only relatively recently been discovered, that TC had for many years taken anti-depressant medication, only ceasing to do so when her cancer diagnosis was first made.

10. TC first presented to the Trust following a referral from her GP on 13 August 2020. She was placed on the inpatient waiting list by the ENT Surgeon for an urgent panendoscopy and biopsy. A CT scan on 17 August 2020 revealed that she had a large right sided tumour. She first spoke to the Head and Neck cancer specialist nurse, Ms S, on 25 August 2020 as she was awaiting her test results for a potential cancer diagnosis. Ms S has said that TC appeared anxious on the telephone but no more so than any other patient in that situation.

11. It was on the 7 September 2020 that TC was diagnosed with right-sided supraglottic (throat) cancer. Although this was at an advanced stage (stage 3), TC was informed that it was curative with the appropriate treatment. She was offered two options – surgery or chemoradiotherapy (CRT). Significantly, and following discussions, TC made a perfectly capacitous decision to undergo a course of CRT. She was subsequently referred to the oncology team for review and assessment.

12. TC next spoke to Ms S by telephone on 9 September 2020. She presented as confused and her anxiety levels were noted to be higher, but again not unusual given the context of her recent diagnosis. A face to face appointment was arranged to discuss further support.

13. At the clinical appointment on 11 September 2020, Ms S was concerned by TC's increasingly erratic behaviour. TC did not want to engage with advice on her problems with swallowing and was anxious about issues at home, which included issues with heating and hot water, despite her husband explaining that these had been addressed. She was concerned about surgery even when advised that this was not the option she had chosen. She left the meeting abruptly and AC stated that her presentation was completely out of character. A referral was made to the psychology team for support.

14. TC's first appointment with the Consultant Oncologist, Dr B, was on the 16 September 2020. Again, she appeared anxious but was able to have a conversation with Dr B about the proposed treatment. TC confirmed that she did not want surgery. She was considered physically fit for treatment and signed the consent form for chemoradiotherapy after Dr B explained that the treatment was her best chance of a cure. TC became upset after the appointment and was taken to another room by Ms S. AC also reported difficulties with her eating at home.

15. On 22 September 2020, TC attended her planning appointment and no concerns were raised. She was able to discuss the treatment and the side effects. Thereafter, there was a gradual decline in TC's physical and mental health. At the following planning appointment on 25 September 2020, TC was unable to discuss the proposed treatment and behaved irrationally. She missed her next appointment the following week. AC stated that she was too weak to get out of bed and that TC was refusing to eat and drink. He reported that he was unable to have a rational conversation with TC about her treatment.

16. TC was admitted to hospital on 6 October 2020 as a result of a rapid deterioration in her health over the previous weekend. The treating Consultant ENT / Head and Neck Surgeon, Dr P, performed a nasal endoscopy to examine her throat; I was shown this video footage (and the CT scan sequence) this morning. He identified (and indeed we could see) that the tumour was significantly obstructing her airway and there was a risk that the airway could become completely obstructed. Consequently, she was admitted onto the ward for ongoing support and monitoring. TC allowed Dr P to insert a nasogastric tube to help meet her nutrition and hydration needs.

17. On 7 October 2020, TC was assessed by Dr P to lack capacity to make decisions regarding the proposed treatment as a result of her depression and chronic anxiety. It is reported that she had become progressively withdrawn since her hospital admission. She no longer wished to see her family. She refused to engage with the nursing staff on the ward but did comply with medical interventions when asked.

18. The application by the Trust for personal welfare orders was issued on 20 October 2020. It was made on an urgent basis as it was said that the proposed treatment must commence on 2 November 2020. The Trust's case is, or was, that if the treatment is not started on that date, the pre-treatment steps will have to be repeated which would delay the start of treatment by a further two weeks, escalating the risks associated to TC.

19. A CT scan of the neck and throat performed yesterday afternoon (28 October 2020) cast the application into a marginally different light. The tumour has grown materially. It is now of such a size that if it grows any more, it poses a real and immediate risk to TC's life. The specific concern, as it has most helpfully been explained to me by Dr P, is that

during CRT the tumour may in fact swell (as a result of the treatment), and this could prove fatal. He said this in his oral evidence:

> "I have discussed this with my colleagues, and our view is that we do need to prevent an airway catastrophe, as she will be lying flat in a mask, for 15 mins. It will be difficult to manage this".

20. Accordingly, it is now proposed that the clinical team should attempt an endoscopic resection or debulking of the tumour first; this would require the insertion of a temporary breathing tube. If this procedure (which I emphasise Dr P has described as "necessary") is for any reason unsuccessful, the team have indicated that they would need to move to perform a tracheostomy, which may need to be in place for 3-4 months or more. The CT scan also showed signs of infection but not of a type or degree as to contraindicate the commencement of the treatment.

21. In short, action needs to be taken urgently if there is any chance of preserving TC's life. The ongoing growth of the tumour risks an entire obstruction of TC's airway which could be fatal. Furthermore, if treatment is delayed the cancer may spread to other parts of TC's body which would increase the risk that any treatment might not be curative.

The Law

22. Before turning to the evidence, I identify some core legal principles which underpin my decision:

    (i) A person must be assumed to have capacity unless it is established that he lacks capacity (*s.1(2) MCA 2005*).

    (ii) There is a two-stage test for determining whether a person has capacity.

    (iii) The first is the diagnostic test which is decision specific. It is set out in *s.2(1) MCA 2005* and reads as follows:

    > "A person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain"

    (iv) The second is the functional test set out in *s.3(1)* and reads as follows:

    > "For the purposes of section 2, a person is unable to make a decision for himself if he is unable—
    > (a) to understand the information relevant to the decision,
    > (b) to retain that information,
    > (c) to use or weigh that information as part of the process of making the decision, or

> (d) to communicate his decision (whether by talking, using sign language or any other means)"

(v) The inability to undertake any one of the requirements set out in the above sub-paragraphs will be sufficient for a finding of incapacity provided that the person concerned is unable to satisfy any one of the individual component elements because of an impairment of, or a disturbance in the functioning of, the mind or brain (*RT and LT v A Local Authority [2010] EWHC 1920 (Fam*) at [40]).

(vi) The burden of proof lies on the person asserting a lack of capacity and the standard of proof is the balance of probabilities (*s.2(4) MCA 2005* and *KK v STC and Others [2012] EWHC 2136 (COP)* at [18]).

(vii) If a person is found to lack capacity the court then proceeds to make a best interests decision pursuant to *s.1(5) MCA 2005*, which provides, 'An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests'.

(viii) When determining what is in a person's best interests, consideration must be given to all relevant circumstances, to the person's past and present wishes and feelings, to the beliefs and values that would be likely to influence their decision if they had capacity, and to the other factors that they would be likely to consider if they were able to do so (*s.4(6) MCA 2005*).

(ix) Best interests can be a very broad concept. In *Aintree University Hospitals NHS Foundation Trust v James [2013] UKSC 67* the court stated:

> "[39]The most that can be said, therefore, is that in considering the best interests of this particular patient at this particular time, decision-makers must look at his welfare in the widest sense, not just medical but social and psychological; they must consider the nature of the medical treatment in question, what it involves and its prospects of success; they must consider what the outcome of that treatment for the patient is likely to be; they must try and put themselves in the place of the individual patient and ask what his attitude towards the treatment is or would be likely to be; and they must consult others who are looking after him or are interested in his welfare, in particular for their view of what his attitude would be."

(x) The starting point is the strong presumption that it is in a person's best interests to stay alive, but this is not absolute and there are cases where it will not be in a person's interests to receive life-sustaining treatment (*Aintree University Hospitals NHS Foundation Trust v James [2013] UKSC 67* at [35]).

(xi) The views of anyone engaged in caring for the person or interested in their welfare must be taken into account (*s.4(7) MCA 2005*).

The Evidence

Capacity

23. A capacity assessment was undertaken by Dr P on 7 October 2020. In his Assessment Capacity Report, he states that TC is showing symptoms of depression and chronic anxiety which has impaired her decision-making ability. He specified the following:

> "This impairment of mind is sufficient such that she is unable to make a decision to proceed with a treatment option - chemo-radiation. She understands she has a throat cancer which can be treated at this stage. She retains the information and has declined surgery after the risks were explained to her and her husband. She also does not want chemo-radiation although the cancer team have expressed this treatment option is in her best interests. She understands that having no treatment would result in cancer progression with eventual obstruction of breathing and death. She is however unable to make a decision to proceed with treatment despite all reassurances from the cancer team."

24. Dr P was of the view that TC is unable to use or weigh the relevant information due to her anxiety. Dr P specified that she had been assessed at intervals since her admission:

> "The impairment of mind has been demonstrated repeatedly over the last 2 weeks in hospital. The cancer team have had multiple discussions with her about the need to proceed to treatment for her throat cancer… She is however unable to make a decision to proceed despite acknowledging that no treatment will end her life. Her mood and self-care have deteriorated, and she is unable to engage with the required decision. She agreed to some aspects of care like insertion of a feeding tube but struggles with the decision on complex treatment for the throat cancer itself. The team have painstakingly explained in detail the treatment options and involved her family."

25. He advises that TC is not likely to regain capacity in the short term as her lack of capacity is unlikely to be temporary. He also advises that it is unlikely that TC will be able to make a capacitous decision within the relevant timescales:

> "Sadly, the decision is urgent as the throat cancer is already partially obstructing both her airway and swallowing. This cancer is likely to progress and lead to death by blocking her breathing altogether if nothing is done in the next few weeks."

26. This view is also supported by Ms S who reports that there have been issues with TC's medication which has impacted upon her mental health:

> "There has been recent non-compliance with TC's medication of citalopram for anxiety. This has impacted TC's deterioration in her mental health. We will continue to encourage compliance with citalopram to improve TC's anxiety, however this would not be enough to regain capacity in the next few weeks before treatment is required to start."

27. In oral evidence, both confirmed these views.

Treatment

28. The three following treatment options for TC are outlined by Dr P in his statement:

   (i) Option 1. A total laryngectomy (the surgical removal of TC's voicebox) and bilateral neck dissections (surgical removal of lymph nodes in both sides of her neck), which would be carried out by the ENT surgical team. Depending on the histology following surgery, she might still require radiotherapy.

   (ii) Option 2. Chemoradiotherapy, carried out by the Macmillan nurses and radiotherapy team, overseen by the Oncology team.

   (iii) Option 3. Palliative treatment.

29. Both options 1 and 2 offer a 60% chance of being curative:

> "By "curative", I mean that TC would have a 60% chance of overall survival for 5 years after treatment. 5 years is the standard time period for post-treatment follow up by the ENT and/or Oncology teams. At the end of that period, the patient's odds of longer-term survival are significantly improved as the chance of the cancer returning is much less by that point."

30. Dr P is of the opinion that TC would have a very good chance of living a long life if the cancer did not return within the 5-year period:

> "It is therefore the case that, provided the tumour did not return within the 5-year timeframe, TC would have a very good chance of living a long and healthy life."

31. Dr B, in his written statement of evidence, told me:

> "Chemoradiotherapy treatment is generally considered a better treatment option than surgery for patients such as TC, whose cancer is of a nature and stage where this

> offers an equally good chance of curing the condition as surgery, whilst preserving the larynx.
>
> His proposal involved
>
> "… 30 doses of radiotherapy, ideally over a 6-week period. In addition to radiotherapy, a weekly chemotherapy infusion would be administered by the Macmillan cancer specialist nursing team."
>
> He made the important point that:
>
> "Treatment remains effective, provided all necessary doses are delivered within an 8-week period. If the course of treatment is not completed within that time, the likelihood of it successfully treating the condition reduces fairly rapidly and significantly, with each additional week that passes resulting in a reduction in success rate of approximately 10% and increasing the risk of the tumour becoming resistant to treatment"

32. The treatment options have now been rendered more complicated by the fact that the tumour is assessed to have grown materially since the last scan, and important preparatory work needs to be done to ensure that during any CRT, TC maintains effective airway. As I indicated above, the plan is to attempt to debulk the tumour in one of three ways: a micro-debrider (which Dr P described as a type of lawnmower which will shave the tumour), laser treatment (which is less likely to be effective because this provides a more targeted or focused attack on the tumour), and/or thirdly a treatment which vaporises the tumour. If any of these procedures fail, then a tracheostomy would need to be put in place. It is acknowledged by all the treating doctors and the family that this would not be what TC would want but the doctors are clear that 'needs must'.

33. This preliminary operative procedure will delay the start of CRT by 2-3 weeks. This is, again, not what one would have hoped for, but 'we are where we are'. It is better, opined Dr B in his oral evidence, to ensure the integrity of the airway before the CRT begins, than to have to interrupt it. If CRT is interrupted for any period of time, it loses its efficacy, and the treatment would have to revert to palliative care only.

34. There is an understandable concern about whether TC will co-operate with all or any of these treatments. There is a real risk that she will not. She has indicated that she was opposed to surgery; she is terrified of losing the ability to speak; this is a temporary consequence of the tracheostomy should that be necessary, although after a period there is the possibility of introducing a fenestrated tube which may allow some vocal function. There are also risks associated with leaving a tube in place which she may well want to try and remove, and the repeated submission to daily CRT is likely to be challenging to her. On the other hand, (a) low level dosage of lorazepam on the ward this week has had a beneficial effect on her anxiety levels; a single larger daily dose prior to the treatment would be indicated, (b) she has forged a good and trusting relationship with Ms S, who appears to understand her well, and who has been able to contain TC's anxiety levels for the procedures undertaken thus far, (c) it is Ms S's view that while TC may vocalise her

opposition to various interventions, she is unlikely to be aggressive or physically resistant, (d) she will have the benefit of psychological interventions, and last but by no means least, (e) she has the unconditional support of her husband and sons whose care for, and interest in her, is evident, and which as she begins her recovery, she will I am sure increasingly come to appreciate.

Second opinion: cancer treatment

35. At a case management hearing on Tuesday of this week (27 October 2020), I gave permission to the Official Solicitor to obtain a second opinion from Professor Nutting, he is a well-known Professor of Clinical Oncology and Clinical Director of the Head and Neck Unit at the Royal Marsden Hospital, London. Professor Nutting reviewed the papers (he has not examined TC) and provided his report within a matter of only a few hours of this hearing. He reports the diagnosis of laryngeal cancer, and opines as follows as to her prognosis:

> "If no treatment is given then the immediate risks (within days or weeks) are that the tumour will grow further and obstruct the larynx such that TC will have increased difficulty breathing, and may be unable to breathe at all."
>
> Later in the report he added:
>
> "If she were to accept chemotherapy and radiation as proposed by her consultant oncologist and agreed by the multidisciplinary team (MDT), then the long-term cure rate is in the region of 60-70%"

Professor Nutting is of the view that total laryngectomy and bilateral neck dissection would achieve a similar prospect of success. He counsels strongly against any delay in treatment. He adds:

> "In my clinical experience of over 20 years of treating laryngeal cancer, chemoradiotherapy is the treatment of choice for the vast majority (>90%) of patients in this particular situation".

36. He observes that both laryngectomy and chemo-radiation are major treatments with side effects and risks, but he confirms that in his experience over 90% of patients in this specific situation opt for chemoradiotherapy. If only palliative chemotherapy were to be offered (accompanied by tracheostomy), the anticipated survival would be 6-12 months. If all treatment were refused, the survival rate would be a matter of a few weeks only. There are risks and complications (acute and long term) associated with the procedure, which he outlines in his report: he refers to acute mucositis (pain in the mucous membranes of the mouth and throat) within the high-dose region. He comments that where significant volumes of salivary tissue are irradiated to high dose, long-term xerostomia is a risk, and this in itself predisposes to dental caries.

Second opinion: mental state

37. A mental state examination was performed by Dr. O'Donovan, consultant forensic psychiatrist, on 27 October 2020. She prepared a detailed and thorough report yesterday which I received shortly before 9am this morning. Her conclusions can be summarised thus:

> "TC has a diagnosis of Severe Depression. Given the relatively acute onset of her symptoms, the evidence suggests that with treatment with antidepressants, her mental state could significantly improve. Given the severity of her depressive episode her current antidepressant is unlikely to be of benefit. Therefore, she would need to undergo cross-titration with an alternative antidepressant such as Venlafaxine or Lofepramine. However, it is unlikely that any improvement will be observed for at least 6 weeks".
>
> "TC has demonstrated that she is able to understand and retain information in regard to her diagnosis and the treatment interventions available. She is also able to communicate her decision. However, as a result of her depressive illness, she is experiencing symptoms of hopelessness and does not consider that she has a future. As is typical in severe depression she is experiencing catastrophic thinking. As a result, she is unable to weigh up the information she has been given in order to make a capacitous decision. <u>It is therefore my view that TC lacks capacity to make decisions about her medical treatment.</u>
>
> On the issue of capacity to conduct these proceedings:
>
> "Due to her limited motivation and sense of hopelessness, TC would be unable to identify an appropriate representative and weigh up the necessary information to provide instruction. Therefore, it is my view that as a consequence of her mental disorder TC is unable to weigh up the necessary information to conduct these proceedings and thus lacks capacity to do this".

The views of TC

38. It is to be noted, of importance, that TC provided her signed written consent to this treatment on 16 September 2020 (I have seen the signed consent form), this was given when, it is accepted, she was capacitous. She has subsequently refused this (and the alternative treatment option of surgery). Hence this application.

39. Last Sunday morning, 25 October 2020, Mr Maguire, solicitor agent for the Official Solicitor visited TC. He was able to speak with her; she was able to identify correctly the

possible alternative treatments. He asked her why she was now reluctant to have the treatment and he recorded her answer as follows:

> "When it was offered, and I picked the chemo option I asked how long it would take. I can't remember exactly what they said but however long it was I thought it was too long. There is no point in it" she said. I put it to [TC] that the doctors still think that there is real value in the treatment and the prospects of success are better than not. There was a long pause before she responded. "I don't think so" she said. I asked her what would happen if she had no treatment at all. Again, there was a long pause before she responded, "I'll just die"."

40. TC disputed the capacity evidence of Dr P indicating in a tone which suggested a degree of indifference "I feel I can make the decision. He obviously feels I can't. That is his opinion. I just have a sense that I can make it and that the decision should be mine".

41. She was advised that her family felt that she should have the treatment, and was asked whether she would accept the treatment if the Judge thought that was what was right for her.

> "If a Judge said that it had to happen then it would have to happen".

And with that, the meeting effectively ended.

The views of the family/Respondents

42. AC, and TC's adult sons DC and BC, provided their views to the Official Solicitor's representative on 23 October 2020 and have subsequently provided their views in an e-mail sent on Tuesday afternoon.

43. They said, last Friday, that "all the family, everyone who knows her, her friends, the neighbours agree that she should be treated". [BC] says: "the nurses have said it's treatable; it's curable – so we all think, let's cure it then".

44. BC told the Official Solicitor's representative: "she most certainly doesn't want to die. She has a perfectly happy life – she is not long into retirement; this has hit her, and she's gone downhill, her anxiety has gone through the roof. She knows the consequences' she wanted to have the treatment".

45. In an e-mail sent following the case management hearing on Tuesday 27th October 2020, they say this (I repeat it in full to give full justice to their important views):

> "We are all of the opinion including the wider family i.e. TC's brothers, sisters and grandchildren, the best course of action is to start the treatment asap. To ensure the treatment is successful and prolong TC's life, as she always had an active, happy, and outgoing look on life.

> We all love and miss TC, and all have her best interests at heart.
> We feel TC's anxiety went thought the roof when she was diagnosed and became very depressed and her whole demeanour changed instantly and her ability to function rationally rapidly plummeted. Soon after we discovered she had stopped taking her anxiety medication, which we feel has blurred her ability to make rational decisions.
> At the beginning she was all for having the radio chemotherapy as she was adamant she didn't want invasive surgery, and quite willing to sign and agree to the treatment.
> We please urge that this matter is concluded asap, so the treatment can start as planned for on Monday the 2nd November".

Conclusion

46. This is a distressing and worrying case. TC is very poorly indeed. It is plain from all that I have heard that she urgently needs treatment.

47. First, I should indicate that I am entirely satisfied on all that I have read that TC lacks capacity to conduct these proceedings, and lacks capacity to make a decision about this medical treatment. I accept the evidence of Dr P which is buttressed comprehensively by the report of Dr O'Donovan and consistent with the factual evidence of Mr Maguire, that she is unable to use or weigh the evidence relevant to this decision.

48. In relation to her best interests, the starting point is a strong presumption that it is TC's best interests to stay alive (*Aintree v James* [2013] §35 applied). Without the proposed treatment, TC will surely die. And soon. Thus, let me make clear now that I am entirely satisfied that it is in TC's best interests that she should undergo the treatment proposed by the trust. As Dr B said in his evidence in chief this morning: "We are dealing with a challenging task, and we are dealing with limited options. … Soon we will have no option but to act".

49. I am satisfied that the treatment proposed is the least restrictive and/or least interventionist, and therefore the closest to what I find TC's wishes are or would be, even though it is not exactly what she had consented to when she was capacitous, and there are risks that she will be resistant to it. The treatment plan is also supported by her husband and sons. While there are risks to the CRT treatment, including sore skin, sore throat, difficulty swallowing, taste changes, voice changes and fatigue, skin discolouration and/or ulceration and mucositis, these side effects are generally usually temporary, and typically resolve in 6-8 weeks.

50. The treatment is likely to commence with the attempted endoscopic resection (debulking), failing which the clinicians will revert to a tracheostomy. I am satisfied that the clinicians recognise the need to adopt the least interventionist process first. Once safe to proceed, it is in TC's best interests that she should undergo the course of CRT. This course of treatment enjoys reasonable prospects of success, no worse than any other

course of treatment proposed, and would stand the greatest chance of her retaining her ability to use her voice in the future, which is TC's greatest concerns. I am of course concerned about the delay in starting the CRT particularly as Dr B had earlier said:

> "The impact of a delay in commencing treatment is significant. Treatment would generally commence within 3 weeks of the pre-treatment steps having been completed. It should therefore start by 30.10.2020 at the latest".

51. But I am equally satisfied that it is in TC's best interests to secure her airway before the CRT begins. To leave it to chance carries in my view unacceptable risks to her health and indeed to her life; again, to quote Dr B: "It may affect her survivability. But we don't have a choice."

52. I am also concerned about the fact, as Dr B told us, in soberingly stark terms, "this CRT cycle is challenging and I believe that if she is not co-operative it is also impossible to deliver it. Anything less than 6 weeks, with interruptions of more than 2 weeks, will not be curative anymore".

53. The steps taken to mitigate the impact on TC which I have outlined above, most significant among them being the attentive and sensitive care which I find she receives from Ms S, will be as effective as any to reduce the levels of anxiety and promote a successful outcome.

54. All of this treatment will have a serious effect on TC's profound depression. As Dr O'Donovan was able to point out, even if it were not for the cancer, TC's mental health state would probably justify inpatient treatment just now. I am pleased to note and approve the fact that the report of Dr O'Donovan has already been disclosed to the liaison psychiatric team, who will continue to provide psychiatric treatment and support to TC and consider the recommendations made by Dr O'Donovan.

55. For the avoidance of doubt the order will contain a declaration and order to the effect that it is lawful and in TC's best interests to be treated by way of chemoradiotherapy and to undergo endoscopic resection and/or a tracheostomy, in accordance with the treatment plan.

56. I wish to conclude first by expressing my considerable gratitude to the lawyers for bringing this case to the court so efficiently. For the treating clinicians and nurses, Dr P, Dr B, and Ms S in particular, for their obvious sensitive and attentive care of TC. I wish to thank Professor Nutting and Dr O'Donovan for preparing their clear and thorough court reports so quickly within the very tight timeframe imposed by the court. I wish to thank AC, BC and DC for their participation in this difficult legal process; I am conscious how painful all of this is for them, and how desperately worried they are for TC, their much loved wife and mother.

57. Finally, I wish to express my personal good wishes to TC for successful treatment and a good recovery.

58. That is my judgment.