Neutral Citation Number: [2020] EWCOP 6

Case No: 13545196

IN THE COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 03/02/2020

Before :

THE HONOURABLE MR JUSTICE HAYDEN
VICE PRESIDENT OF THE COURT OF PROTECTION

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Between :

(1) Sherwood Forest Hospitals NHS Foundation Trust **(2) Nottingham University Hospitals NHS Trust**	**Applicant**
- and -	
H **(by her litigation friend the Official Solicitor)**	**Respondent**

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Ms Sophia Roper (instructed by **Browne Jacobson LLP**) for the **Applicants**
Mr Conrad Hallin (instructed by **Official Solicitor**) for the **Respondent**

Hearing date: 3rd February 2020

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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.

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THE HONOURABLE MR JUSTICE HAYDEN

The judge has given leave for this version of the judgment to be published on condition that (irrespective of what is contained in the judgment) in any published version of the judgment the anonymity of the respondent and members of their family must be strictly preserved. All persons, including representatives of the media, must ensure that this condition is strictly complied with. Failure to do so will be a contempt of court.

Mr Justice Hayden :

1. This morning I had indicated that I would hand down judgment relating to a hearing on 14th January 2020, reported at **[2020] EWCOP 5**. That judgment concerned Mrs H, who is suffering from squamous cell carcinoma ('SCC'), which had manifested itself on her left cheek and which had grown significantly in the period between early December 2019 and mid-January 2020.

2. For reasons set out in that judgment, which do not need to be rehearsed here, Mrs H does not have capacity to make decisions in relation to her medical treatment. Additionally, she suffers from Bipolar Affective Disorder and has, in the past, been admitted to hospitals pursuant to the Mental Health Act 1983. At the time the Trusts sought a declaration as to Mrs H's best interests, she was living at home with her daughter, T, who provides the majority of her care. It is right to say that Mrs H plainly values her own independence, and when her daughter is at work she is able, or has been able to date, to manage, broadly speaking, for herself.

3. In the earlier judgment, I evaluated the range of treatment options. These included the 'no treatment' option, which would inevitably have meant that the SCC would continue to spread and develop into a fungating lesion. Indeed, there was already concern that that had started to happen. Absence of treatment would be fatal. I heard from Mr Pollock, the treating plastic surgeon, who advised that there was a risk of 'distant metastatic disease'. He said in his evidence that, having regard to his own observations on 23rd December, and the growth of the tumour between then and 2nd January as shown on photographs taken by T, the likelihood of lymph node spreading was significant. If untreated, that would probably mean that Mrs H had a life expectancy no greater than nine months, but possibly as little as three months.

4. Radiotherapy was another option. In some circumstances, Mr Pollock told me, it can be as effective as 'surgical excision', but the nature and extent of Mrs H's SCC made that less attractive, not least because it would require a level of compliance that her general functional difficulties would have made an almost insuperable challenge.

5. Thus it was that the third option, surgical excision, was identified as the most propitious. The growth seen on the photographs emanated from an area immediately below the eye but extended very considerably in a balloon shape. Mr Pollock was hopeful that it might not be "attached". He said that, if we were unlucky, surgical excision might not be a viable option, in particular because the reconstructive process to address the wound in the face would require the identification of skin qualitatively strong enough and free from macroscopic tumour to make this effective. I do not need to repeat the details of what this would involve. Again, they are set out in the earlier judgment.

6. Mrs H was not able to conduct the evaluation of treatment options herself, nor was she able to weigh and select the most suitable palliative options, in the worst case scenario.

7. On the date contemplated for surgery, T called the hospital to say that her mother had been awake and agitated for most of the night and that she had been sick. They requested an ambulance be sent. One was dispatched and, when she was brought to the hospital, Mrs H went willingly to the relevant ward. This was very much out of

character, but reflected what I have been told, firstly that she reposed great trust in her surgeon Mr Pollock, and secondly that she had "had enough" and wanted to get the growth "sorted."

8. Initially, Mrs H was unwilling to engage with the nursing staff. However, she was seen by Mr Pollock, who, it would appear, was able to have a soothing effect on her; certainly, after discussing the plan, she became far more placid and agreed to stay and have some basic observations. Though she was offered strong pain relief, she was unprepared to take anything other than paracetamol. Mr Pollock reviewed Mrs H with colleagues, a consultant plastic surgeon and a consultant oncologist. They also had discussions on the telephone with other plastic surgeons and with a second consultant oncologist.

9. It was absolutely clear to me, in his evidence and indeed watching him in court, that Mr Pollock was prepared to go to any lengths possible to do all that medically could be achieved for his patient.

10. The tumour has grown at what all regard to be an astonishing rate since 23rd December 2019. The growth since the photograph on 2nd January 2020 has been catastrophic and, I am told, its appearance is now changing daily.

11. Over the weekend, attached to an email to which I shall return, T sent me a photograph, taken in the last few days, which shows a very considerably enlarged tumour mass to that which I was shown in photographs even as recently as 14th January. It is incredibly distressing to see. All agree that it is causing Mrs H enormous discomfort. It is much thicker and more protuberant than was hitherto the case.

12. When Mr Pollock began his investigations, he sadly concluded that, because it had become so much thicker and was now fixed to the underlying bone, the tumour was inoperable. In coming to that conclusion, he took care to evaluate the options, however limited they might be, with the range of colleagues to whom I have referred.

13. Any attempt to try to remove the growth surgically is to be regarded, he concluded, as futile. In the photograph I saw this morning, it is impossible to see the eye on the side of the face where the tumour exists. When Mr Pollock investigated it was not quite that close, but it was close enough for him to conclude, as he had foreshadowed in his evidence, that removal of the growth would require removal of the eye. It is fixed to the maxillary (upper jaw) bone. Inevitably, removal of the tumour would require removal of that bone as well, and whilst there is a technical possibility of being able to undertake it, that would not in any way enhance the prospect of a cure. The morbidity of that operation is 'colossal' and not a single clinician was able to consider that option as justifiable.

14. The oncologists provided further assistance as to other potential options for treatment. In particular, they identified Electro-Chemo Therapy ('ECT'). That had not been contemplated as a possibility when the options were presented to me, but, largely due to the size of the tumour now and the clinical realities of Mrs H's situation, they recommended it as a viable option to take place, under general anaesthetic, on the following Monday, followed by six sessions of palliative radiotherapy over three weeks if Mrs H is able to comply.

15. When I heard from her on 14th January, T seemed to be able to contemplate the urgency of the situation and the reality of the challenges her mother faces. I have the strong impression, as does the Official Solicitor, that the devastating news delivered by Mr Pollock has caused her to draw back from some of the realities. It is understandable. I suspect it is shock: she is upset, she is angry, and some of that anger focuses itself at the doctors treating her mother.

16. ECT is a one off palliative treatment, given under general anaesthetic, where a chemotherapy agent is insinuated into the patient's bloodstream whilst an electrical pulse is delivered into the tumour mass by way of injection. It follows that a certain thickness of the tumour is required for that to be a viable option. The process changes the complexion of the outer layer of the cells of the tumour in order to permit the tumour to absorb the chemotherapy agent, the objective of which is to enter and kill the tumour cells.

17. In consequence of that unique and easily explained objective, lower doses of chemotherapy are required because they are able to be absorbed more efficiently. In essence, the process renders the tumour more sensitive to the treatment, targets it more powerfully and enables it to be administered by way of a single treatment.

18. When he had seen the photographs, and indeed examined the growth earlier, Mr Pollock did not consider that the tumour was thick enough for ECT to be an option. I suspect this is simply because it was not. However, by the time he saw Mrs H for surgery, the tumour was far more extensive and thus made the treatment viable.

19. The oncology perspective is that where this technique is used, it has the impact of reducing the tumour and significantly stemming the bleeding.

20. Secondary to this, as Ms Roper has helpfully outlined today, a course of radiotherapy becomes an option. That treatment, as contemplated in earlier evidence, requires to be delivered in fractions. It is not possible to say now how many doses could effectively be delivered, she tells me, but they would be spaced out over a period of weeks. Once the impact of the ECT has been evaluated, it will be easier to determine the extent of the radiotherapy with greater accuracy.

21. There are, of course, continuing challenges presented by Mrs H's behaviour. For radiotherapy to be administered there would have to be a proper level of cooperation, both in the process of pre-treatment assessment and in the process of treatment itself, which requires her to lie very still on a bed in order that an appropriate mask may be fitted which is specific to her face. Having seen the photographs, I do not underestimate the challenge involved even at that stage of the process.

22. Without her full cooperation, which strikes me as being unlikely because it requires to be so complete, a level of sedation would be required to keep her still enough for the process. This, in particular, would require protection of the airways. In reality, as Ms Roper explained, this would effectively be a general anaesthetic on each occasion.

23. Because T has, in my view, retreated psychologically from some of the harsh realities of her mother's circumstances, and because it is necessary that she confront them in order effectively to assist her mother, I stress that this entire process is to shrink the tumour: cosmetically, to make it less unsightly; practically, in order that she may, for

example, be able to use her dentures to eat more comfortably; and, more widely, because it would reduce the profoundly malodorous smell from the cancer.

24. The email that I received from T this morning reflected intense distress in every paragraph. She told me that she was suffering tremendous stress and anxiety. She felt that, because her mother lacked capacity, Mrs H had been "downgraded to palliative care", when, in her view, a capacitous individual would have been afforded greater options.

25. This is simply not the case. For the reasons that I have sought to set out at some length, it strikes me that every conceivable option has been considered in what it is a profoundly difficult clinical scenario.

26. T was concerned that her mother had been discharged before the situation had been fully discussed with her. She records in her email that Mrs H had been returned home at 11pm on Tuesday evening in a taxi with two nurses. I am clear that T had been determined to resist this, and indeed that she took some measures to try and thwart it, but she was unsuccessful.

27. On the Thursday, T called out a local doctor to check her mother's eye and, she told me, *"*to make him aware of the situation." The following day, that is to say fewer than three days from discharge, Mrs H fell on the floor at home, breaking her right humerus. She is now back in hospital. She is, T tells me, broadly passive, managing to eat a little, losing weight, but nonetheless sleeping well.

28. T is very concerned that her mother is presently in circumstances which compromise her dignity, in particular because of the smell from the cancer, which she describes as "awful". In order to spare the other patients on the ward, Mrs H has been placed in a private room. The nurses are vigilant to close the door to that room in order to protect the patients from the smell, which is described by all as "malodourous". Her room is regularly sprayed to reduce the smell.

29. The tumour is described by T, essentially accurately, as "constantly weeping." It drips onto clothes, and the photograph shows a pile of tissues reflecting Mrs H's attempts to attend to it. T feels that she is not "kept in the loop", that she is not told what is going on. She believes that her mother is not receiving the best treatment options available for her cancer. She is also, she acknowledges, struggling to manage the situation herself.

30. There may be some basis for T's complaint that she has not been kept fully informed, but there is also a good deal of evidence that points to her being reluctant to confront the realities of Mrs H's situation. I emphasise that this is not in any way a criticism; it simply reflects T's own distress and shock.

31. Very shortly, there is to be a multi-disciplinary team meeting with representatives concerned with every aspect of Mrs H's care, including her diet, community health services and the representatives of the various Trusts. She does not need to be in hospital at the moment. It is possible that she may be at enhanced risk of infection while she remains there. Historically, it has to be said, the hospital is the last place that Mrs H would wish to be.

32. Following this meeting, there is to be a second meeting, this time with oncologists, to look at the options, including the possibility of immunotherapy. This was contra-indicated at the time of the earlier hearing, but in view of Mrs H's recent compliance, it is an option may now be revisited.

33. Mrs H has strong religious beliefs. My firm view is that she would have wished, were she capacitous, to explore all the options that may be available to her. She values life, manifestly, as a gift from God. The evidence points to her wishing to preserve that gift for as long as she can, notwithstanding that it may prolong the pain and discomfort that she is presently experiencing. On this point T tells me that she (T) has not been given sufficient information to "confront the new reality of the situation".

34. T is to be invited not only to the multi-disciplinary team meeting, but also to the oncology meeting, so she may be informed properly about the options and helped to confront them.

35. When these meetings have been undertaken, the Trusts are to put together a care plan which will best meet Mrs H's needs for the remainder of her life, however long or short that may be. When they have done so, this court will review it and evaluate whether it meets Mrs H's best interests (see **Aintree University Hospitals NHS Foundation Trust v. James [2013] UKSC 67; Re D [2012] EWHC 885 (COP); Salford Royal Foundation Trust v. Mrs P [2017] EWCOP 23**). I have listed the case for review of the care plan for two reasons: firstly, because in my view the history of this case requires that it is monitored; and secondly, because T has requested that I overview the plan.

36. When the Trusts indicate that a plan has been finalised, the case will be given a listing as a priority.