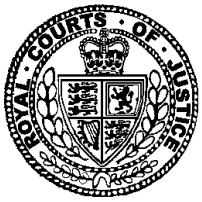

This judgment was delivered in private. The judge has given leave for this version of the judgment to be published on condition that (irrespective of what is contained in the judgment) in any published version of the judgment the anonymity of the children and members of their family must be strictly 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.

Neutral Citation Number: [2021] EWCOP 41

Case No: 13766168

IN THE COURT OF PROTECTION
IN THE MATTER OF THE MENTAL CAPACITY ACT 2005
IN THE MATTER OF TS

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 17/06/2021

Before :

MR JUSTICE PEEL

- -

Between:

CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST [1]

DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST [2]

Applicants

- and -

TS

(by his litigation friend, the Official Solicitor)

Respondent

- -
- -

Miss Emma Sutton (instructed by **Hill Dickinson LLP**) for the **Applicant Trusts**
Miss Sophia Roper (instructed by **Official Solicitor**) for the **Respondent**

Hearing date: 15 June 2021

- -

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.

.....

Mr Justice Peel:

1. This judgment is delivered ex tempore.

2. The applications before me, dated 9 June 2021, have been made by Chesterfield Royal Hospital NHS Foundation Trust and Derbyshire Healthcare NHS Foundation Trust, who jointly seek declarations as to (i) TS's capacity to make decisions regarding the proposed fitting of a pacemaker for his heart block, it being asserted that TS lacks capacity to do so due to a delusional disorder, and (ii) that it is in TS's best interests for a pacemaker to be fitted. Further, the applicants seek a deprivation of liberty order authorising, if and insofar as may be necessary, such minimal restraint and use of force as may be required to carry out the proposed procedure. The first applicant is responsible for providing TS's physical healthcare, and the second applicant is responsible for providing TS's mental health care. Miss Sutton appears on behalf of the applicants and Miss Roper on behalf of the Official Solicitor.

3. It is intended that the procedure be undertaken on 17 June 2021, subject to the decision of this court. That is, therefore, a matter of 2 only days away.

4. TS is 81 years old and lives by himself. His marriage ended in 1998 and he has no children. He has four siblings, but is said not to be in contact with them, and there are no particular friends or family involved in his care. He was initially detained under section 2 of the Mental Health Act 1983 ("MHA") on 20 March 2021, after saying that he had been poisoned by the police. Thereafter he presented as agitated, irritable, and paranoid. Since 13 April 2021 he has been detained under section 3 of the MHA. The unit where TS is currently detained is on the same site as Hospital A, where the proposed procedure to fit the pacemaker would be carried out.

5. On 17 April 2021, TS experienced an episode of chest *pain and had a brief admission to the emergency medical unit.* After some investigation, he was diagnosed with asymptomatic Mobitz type 2 heart block. This arises where there is a problem in the connections to the parts of the heart that beat from the part of the heart that regulates the beat. When there is a wobbly connection, at any time there can suddenly be a problem and the heart's beating can go awry, or stop altogether. The standard medical response to heart block is a pacemaker. On the 21 April 2021, TS agreed to the pacemaker being fitted and the procedure was duly booked to take place on 23 April 2021. He then changed his mind and, since 23 April 2021, has not consented to a pacemaker being fitted. As stated, today the applicants are represented by counsel, as is TS through the Official Solicitor. The position of the Official Solicitor is that the applications are consented to on behalf of TS, although it is right to say that TS himself disagrees with the applications.

6. I pause to comment on the great care and sympathy involved in the preparation of this case. The clinicians have plainly treated and considered TS's case with considerable sensitivity and thoughtfulness. Similarly, I would like to thank the legal team for the applicants and the legal team instructed by the Official Solicitor. The bundle is compact and includes all relevant documents, the position statements of Miss Sutton and Miss Roper are helpful and clear, and the parties have cooperated in terms of producing an agreed transparency order and draft final order for me to consider. In other words, all relevant papers for me to consider were available timeously. I also appreciate and acknowledge the care taken on

behalf of TS, through his advocate and legal team, in putting forward a case with which he disagrees, although he has been made aware of what would be said on his behalf.

7. In the circumstances, it was agreed that none of the clinicians who provided written evidence should give oral evidence. This was principally due to Dr A (consultant anaesthetist), Dr B (consultant cardiologist) and Dr C (consultant psychiatrist) attending a roundtable meeting last night with counsel who have appeared before me today, and their respective solicitors, to narrow the issues and consider the treatment plan in detail.

8. I spoke to TS on two occasions. First, in the presence of his legal team just after the hearing started, and second, after counsel had given their submissions orally. I have decided to give a reasonably comprehensive judgment because TS is present and because his case deserves nothing less.

9. I turn now to the evidence on the question of capacity. Albeit acknowledging that there is no dispute that TS lacks capacity to make the decision as to whether a pacemaker should be inserted and to have ancillary treatment, that is ultimately a decision for the court. The evidence of the clinicians and, in particular, Dr C (TS's consultant psychiatrist) is as follows.

10. TS has a delusional disorder, and has had paranoid thoughts since at least 2012. He has been known to the community mental health team since 2016. It appears that the disorder deteriorated substantially from 2020 onwards, and was untreated for many years.

11. TS believes that he is, and has been for many years, persecuted by the council, the police, other persons, and now the medical staff who are all (as he believes to be the case) part of a conspiracy against him. In 2015, TS told a judge during a hearing at the local county court regarding his tenancy, that a tunnel had been dug by the police from the police station to underneath his flat so that they could access his property. The papers also record that in 2020 an adult care worker reported that TS was expressing paranoid thoughts to the effect that his neighbours were listening in to his phone calls and following him, and that he had placed foil on his windows to prevent cameras looking in. In hospital, he is reluctant to eat food and take medication unless from a sealed package, so as to reassure himself that it has not been tampered with. He believes that his heart problem has been caused by the torture on him perpetrated by the council and the police who have followed him and poisoned him, and he does not want the pacemaker fitted until they desist from such activities. He understands the nature and the purpose of having a pacemaker, and is able to retain that information, but it is said by the clinicians that he is unable to weigh and balance the risk, as any balance is distorted by his delusional disorder.

12. In what has been accurately described by the applicants as a "Catch 22 situation", unless TS receives antipsychotic medication, the delusional disorder will not improve and he will not be able to regain capacity, but he cannot receive certain types of antipsychotic medication until the pacemaker is fitted due to his heart block. Once the pacemaker is fitted, the benefits could be immediate in terms of receiving medication. There is no guarantee that medication will improve TS's psychosis, but I understand it to be the case that his inter-personal relationships, and quality of life, would improve. Dr C has also said that it would be unlikely that TS would physically seek to attempt to remove the pacemaker once fitted, and that it would be unlikely that TS would resist the procedure. Therefore, it is unlikely that physical restraint would be required, although it cannot be ruled out.

13. Before reaching my conclusions, I turn to the cardiological medical evidence. A heart block presents a serious risk of cardiac problems, including sudden death which could occur at any time. In 2009, TS had a myocardial infarction (a heart attack), and in 2015 he had treatment in the form of angioplasty which is a stent to retore circulation to a narrowed artery in his heart. Without a pacemaker, it is very likely that he will have symptoms including dizziness and fainting, and could die. When this could happen is unpredictable – it could be today, or at any point in the future. The risk of asystole (TS's heart stopping completely) is around 35% per year. Prima facie, TS is at greater risk due to his background of ischaemic heart disease and his psychosis.

14. Dr B (consultant cardiologist) says that the benefits to TS's physical health of having a pacemaker are overwhelming and I quote as follows: "I cannot think of a patient with capacity with a clear indication, who has refused one". He says that there is no less invasive way of treating TS's heart block, there is no other available procedure, and that it is accordingly a choice between either a pacemaker or no treatment at all. The pacemaker, says Dr B, would also allow TS to take medication orally for his paranoid delusions which at present risk worsening the heart block. Dr A and Dr B say that the procedure is straightforward, takes about 1 hour, and could be done under local anaesthetic. General anaesthetic would only be utilised as a last resort.

15. There are, as with any operative procedures, some risks, including the risks of a local anaesthetic and general anaesthetic, but those risks are manageable with interventions. There are some risks associated with the surgery. The mains risks are pneumothorax (collapsed lung) which might require a chest drain, and infection, which would lead to the pacemaker being removed. One or two other potential risks are cited but, in general, these are all relatively moderate and manageable. The mortality rate of the procedure is very low, and Dr B says that he has done thousands of these cases, and thus far, happily, has had no fatality on his watch. Dr A and Dr B tell me that the post-operative recovery is straightforward, and that TS will probably return to his normal bed that same day.

16. I turn to the wishes and feelings of TS. I am grateful to the representative of the firm instructed by the Official Solicitor, Mr Maguire, who has provided a statement of a meeting with TS on 11 June 2021. TS does not object to the procedure per se; the real issue is the timing. He wants the police and the council to be dealt with first. By that he means that they need to stop interfering and persecuting him, and they need to be reported to the Home Office. He objects to the procedure being carried out while he is in hospital, but would agree to the procedure if he is at home. Of course, on the basis of the evidence as set out above, he cannot return home until he is mentally and physically able to do so, and he requires the pacemaker to be fitted for that to take place. He believes that he has no mental health issues and does not need any medical treatment.

17. He refers to a number of instances of police and council inference including allegations of his water being poisoned on 20 March 2021. When asked by Mr Maguire what the medics had found when they analysed the liquid, he said that "they didn't. The police got to them too". He survived, he informed Mr Maguire, only because he had an antidote on him.

18. He also said that the council had unlawfully given a set of keys to a neighbour, described as a drug dealer and a thief who is in cahoots with the council. He also described an incident at a post office in Sheffield, stating that the postmaster had opened registered mail which

he was sending, and another occasion when the police raided his flat while he was undergoing carpel tunnel surgery. TS acknowledges that a pacemaker would have health benefits, but opposes its fitting, saying "what's the point" if the police are still attacking him. I had the pleasure of speaking with TS today, who was very pleasant. I have also read a letter from him in the bundle. He told me about a number of other instances of what he describes as a "persecution". I do not propose to recount them all, but for example, he tells me that he has been physically attacked by the police on at least 10 occasions. I should say that in respect of all accusations levelled at the police, council, medical staff and others, there is no evidence that these incidents have in fact taken place.

19. Turning to the law, this is helpfully agreed between the parties. The application is brought in the Court of Protection under the Mental Capacity Act 2005 ("MCA") and therefore I cannot accede to the orders sought unless they are justified within that Act. I must be satisfied (i) that TS lacks capacity to make the relevant decision, that being the decision as to whether a pacemaker should be inserted, and (ii) if he lacks capacity, that it is in his best interests to have a pacemaker fitted.

20. I have had regard to sections 1-3 of the MCA which are particularly relevant to the question of capacity. I must be satisfied that the "diagnostic" test is met, namely that TS has an impairment of, or a disturbance in the functioning of the mind or brain, and that the "functional" test is met, namely that as a result of the said impairment he is unable to make a decision in relation to the matter in issue.

21. I record with gratitude a summary of the law on capacity as set out by Mr Justice MacDonald in **An NHS Foundation Trust v AB and CD [2019] EWCOP 45** at paragraph 26 as follows:

"Within this statutory context, a number of cardinal principles can be identified to which the court must have regard when deciding, on the balance of probabilities, whether a person lacks capacity in respect of the relevant decision or decisions, in this case capacity to make decisions in respect of contraception, for the purposes of the 2005 Act (see PH v A Local Authority [2011] EWHC 1704 (COP) at [16]):

i) A person must be assumed to have capacity unless it is established that they lack capacity (Mental Capacity Act 2005 s 1(2)). The burden of proof lies on the person asserting a lack of capacity and the standard of proof is the balance of probabilities (Mental Capacity Act 2005 s 2(4) and see KK v STC and Others [2012] EWHC 2136 (COP) at [18]).

ii) Determination of capacity under Part I of the Mental Capacity Act 2005 is always 'decision specific' having regard to the clear structure provided by sections 1 to 3 of the Act (see PC v City of York Council [2014] 2 WLR 1 at [35]). Thus capacity is required to be assessed in relation to the specific decision at the time the decision needs to be made and not to a person's capacity to make decisions generally. The requirement is to consider the question of capacity in relation to the particular transaction (its nature and complexity) in respect of which the decisions as to capacity fall to be made (see Masterman-Lister v Brutton & Co [2003] 1 WLR 1511 at [27]).

iii) A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success (Mental Capacity Act 2005 s 1(3)).

iv) A person is not to be treated as unable to make a decision merely because he or she makes a decision that is unwise (Mental Capacity Act 2005 s 1(4) and see Heart of England NHS Foundation Trust v JB [2014] EWHC 342 (COP) at [7]).

v) The outcome of the decision made is not relevant to the question of whether the person taking the decision has capacity for the purposes of the Mental Capacity Act 2005 (see R v Cooper [2009] 1 WLR 1786 at [13] and York City Council v C [2014] 2 WLR 1 at [53] and [54]).

vi) 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 (the so called 'diagnostic test'). It does not matter whether the impairment or disturbance in the functioning of the mind or brain is permanent or temporary (Mental Capacity Act 2005 s 2(2)). The question for the court is not whether the person's ability to take the decision is impaired by the impairment of, or disturbance in the functioning of, the mind or brain but rather whether the person is rendered unable to make the decision by reason thereof (see Re SB (A Patient: Capacity to Consent to Termination) [2013] EWHC 1417 (COP) at [38]).

vii) A person is "unable to make a decision for himself" if he is unable (a) to understand the information relevant to 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 (the so called 'functional test'). In PCT v P, AH and The Local Authority [2009] COPLR Con Vol 956 at [35] Hedley J described the ability to use and weigh information as "the capacity actually to engage in the decision-making process itself and to be able to see the various parts of the argument and to relate one to another". An inability to undertake any one of these four aspects of the decision-making process will be sufficient for a finding of incapacity provided the inability is because of an impairment of, or a disturbance in the functioning of, the mind or brain (see RT and LT v A Local Authority [2010] EWHC 1920 (Fam) at [40]). The information relevant to the decision includes information about the reasonably foreseeable consequences of deciding one way or another (Mental Capacity Act 2005 s 3(4)(a)).

viii) For a person to be found to lack capacity there must be a causal connection between the 'functional test', being unable to make a decision by reason of one or more of the functional elements set out in s 3(1) of the Act, and the 'diagnostic test', 'impairment of, or a disturbance in the functioning of, the mind or brain' required by s 2(1) of the Act (see York City Council v C [2014] 2 WLR 1 at [58] and [59]).

ix) Whilst the evidence of psychiatrists is likely to be determinative of the issue of whether there is an impairment of the mind for the purposes of s 2(1), the decision as to capacity is a judgment for the court to make (see Re SB [2013] EWHC 1417 (COP))"

22. As for best interests, section 4 of the MCA reads as follows:

4 Best interests

(1) In determining for the purposes of this Act what is in a person's best interests, the person making the determination must not make it merely on the basis of—

(a) the person's age or appearance, or

(b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about what might be in his best interests.

(2) The person making the determination must consider all the relevant circumstances and, in particular, take the following steps.
(3) He must consider—
(a) whether it is likely that the person will at some time have capacity in relation to the matter in question, and
(b) if it appears likely that he will, when that is likely to be.
(4) He must, so far as reasonably practicable, permit and encourage the person to participate, or to improve his ability to participate, as fully as possible in any act done for him and any decision affecting him.
(5) Where the determination relates to life-sustaining treatment he must not, in considering whether the treatment is in the best interests of the person concerned, be motivated by a desire to bring about his death.
(6) He must consider, so far as is reasonably ascertainable—
(a) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity),
(b) the beliefs and values that would be likely to influence his decision if he had capacity, and
(c) the other factors that he would be likely to consider if he were able to do so.
(7) He must take into account, if it is practicable and appropriate to consult them, the views of—
(a) anyone named by the person as someone to be consulted on the matter in question or on matters of that kind,
(b) anyone engaged in caring for the person or interested in his welfare,
(c) any donee of a lasting power of attorney granted by the person, and
(d) any deputy appointed for the person by the court,
as to what would be in the person's best interests and, in particular, as to the matters mentioned in subsection (6).
(8) The duties imposed by subsections (1) to (7) also apply in relation to the exercise of any powers which—
(a) are exercisable under a lasting power of attorney, or
(b) are exercisable by a person under this Act where he reasonably believes that another person lacks capacity.
(9) In the case of an act done, or a decision made, by a person other than the court, there is sufficient compliance with this section if (having complied with the requirements of subsections (1) to (7)) he reasonably believes that what he does or decides is in the best interests of the person concerned.
(10) "Life-sustaining treatment" means treatment which in the view of a person providing health care for the person concerned is necessary to sustain life.
(11) "Relevant circumstances" are those—
(a) of which the person making the determination is aware, and
(b) which it would be reasonable to regard as relevant.

23. I make it plain that I have the above fully in mind. Of course, where a person has capacity, they are entitled to the protection of the European Convention on Human Rights. Those rights apply just as much to someone who lacks capacity as to someone who does not lack capacity.

24. The courts have emphasised time and again in a variety of different contexts, that best interests is a very broad context. The classic formulation is contained in **Aintree v James [2013] UKSC 6** and I propose to quote two paragraphs of Baroness Hale:

"22. Hence the focus is on whether it is in the patient's best interests to give the treatment, rather than on whether it is in his best interests to withhold or withdraw it. If the treatment is not in his best interests, the court will not be able to give its consent on his behalf and it will follow that it will be lawful to withhold or withdraw it. Indeed, it will follow that it will not be lawful to give it. It also follows that (provided of course that they have acted reasonably and without negligence) the clinical team will not be in breach of any duty towards the patient if they withhold or withdraw it.

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"

25. In **Re A (A Child) [2016] EWCA Civ 759,** albeit in the context of a child, the Court of Appeal at paragraph 33 recorded with approval the analysis of Mrs Justice Parker that: *"Best interest considerations cannot be mathematically weighed and include all considerations, which include (non-exhaustively), medical, emotional, sensory (pleasure, pain and suffering) and instinctive (the human instinct to survive) considerations"* and that *"There is considerable weight or a strong presumption for the prolongation of life but it is not absolute"*.

26. As is apparent from these dicta, the starting point is the strong presumption that it is in a person's best interests to stay alive, but that is not absolute (**Aintree v James [2013] UKSC 6**, at paragraph 35). The fact that a party lacks capacity does not mean that his or her wishes and feelings do not require consideration. As set out **in SS v London Borough of Richmond upon Thames [2021] EWCOP 31**, wishes and feelings are, and remain integral to, the autonomy of the patient to which this court is bound to protect.

27. The weight to be attributed to those wishes and feelings will differ in each case, and relevant circumstance will include:

    a) the degree of P's incapacity, for the nearer to the borderline the more weight must in principle be attached to P's wishes and feelings;
    b) the strength and consistency of the views being expressed by P;
    c) the possible impact on P of knowledge that their wishes and feelings are not being given effect to;
    d) the extent to which P's wishes and feelings are, or are not, rational, sensible, responsible, and pragmatically capable of sensible implementation in the particular circumstances; and
    e) crucially, the extent to which P's wishes and feelings, if given effect to, can properly be accommodated within the court's overall assessment of what is in her best interests; (**Re M, ITW v Z [2009] EWHC 2525(COP),** Munby J (as he then was) at paragraph 35).

28. I do not need to go any further into the law which is set out fully in the legal note prepared by Miss Sutton and Miss Roper, and which I adopt.

29. Having rehearsed the evidence, and the law, I now step back and consider all matters in the round as part of my analysis and decision-making process.

30. All of the clinicians are of the view that TS lacks capacity to make this particular decision. That is also the view of the Official Solicitor, and I agree. TS does not believe that he has any mental health problems which means that he cannot weigh and balance the decision to have a pacemaker, in particular the physical benefits, and that he would be able to receive antipsychotic medication. His ability to weigh up the advantages and disadvantages is distorted by a paranoid belief that the authorities are persecuting him. That generates a resistance to the pacemaker and an inability to decide that he should have it until such time as the persecution ends, which is potentially an indefinite timescale. The conditions he lays down are incapable of being fulfilled. The antipsychotic medication might enable him to regain capacity, or mitigate some of the delusional disorder, but that cannot be demonstrated until the pacemaker is fitted. Furthermore, I am satisfied that TS lacks capacity to conduct these proceedings. Due to his paranoia, he would be unable to give instructions, and use and weigh any advice given regarding the issues in this case.

31. Turning to best interests, I bear in mind the following points, which are of particular significance in my judgment:

    (1) TS's wishes and feelings are not based on an objection to surgery in principle, but a delusional belief that he would agree to a pacemaker after the persecution ended. His wishes are not rational, sensible, responsible, and pragmatically capable of sensible implementation in the particular circumstances. His views therefore cannot carry predominant weight.

    (2) Absent the fitting of the pacemaker, TS is likely to experience harmful symptoms, and there is a probability of premature death in circumstances where there is a strong presumption in favour of prolonging life. That presumption has not been displaced by anything that I have read or heard. The benefits to his physical health would be immediate and substantial.

    (3) This is a standard procedure which carries a low risk. The risk of fatality is low, and this is a conventional procedure to address a heart block. There are no significant risks that I can see, or putting it another way, there are very substantial benefits which outweigh the minor medical risks identified.

    (4) There is a possibility of a risk to TS's mental health if the procedure is carried out, as it will be, against his will. I am conscious that this has been carefully considered by the Official Solicitor. He may view the procedure as part of the conspiracy, and therefore part of an ongoing process. On the other hand, the benefits significantly outweigh the risks, and it also seems to me, that future treatment with antipsychotic medication would at least ameliorate the consequences.

    (5) In general terms for his age, he is in reasonably good health.

(6) The fitting of a pacemaker might enable improvement to his psychosis by reason of antipsychotic medication being given, which, at the very least, will improve the quality of his life.

(7) In the past, and significantly, at a time when he was capacitous, there has been no opposition by TS for a heart procedure in 2016 (angioplasty), and an operation for carpal tunnel syndrome, again in 2016, both of which were under local anaesthetic. It seems to me that if TS was capacitous now, it is likely that he would consent to the procedure without any real demur.

(8) At present, he experiences a much reduced quality of life. He is placed on a unit where he does not wish to be. He is surrounded by those who he considers are engaged in a conspiracy against him. He complained to me about the hospital food. Until a pacemaker is fitted, he is at risk of significant heart problems. His psychosis cannot be treated. If, by contrast, the pacemaker is fitted, then there is every possibility he will be able to go home, work will commence on his delusional disorder and his quality of life will swiftly improve.

32. For all of those reasons, it seems to me that this is a clear-cut case where TS's best interests are served by the applications being granted. I have considered the circumstances which might justify the need for sedative medication being administered, incrementally, potentially increasing to physical restraint and general anaesthetic if there is opposition to the procedure. It seems to me that this has been looked at very carefully by the applicants in this case, and the suggested amendments made by the Official Solicitor to the treatment plan are cautious and sensible. It may be that none of this will in fact be required, but in my judgment, it is appropriate to authorise the deprivation of liberty in the manner sought by the applicants.

33. I will therefore grant the applications, make the declarations sought, including in respect of the deprivation of liberty, and I shall approve the treatment plan. That concludes this judgment.

34. On 17 June I was informed by solicitors for the applicants that the pacemaker had been duly fitted that morning in accordance with my authorisation. TS went willingly to theatre, with no sedation or restraint required. The procedure was carried out under local anaesthetic. The indications are that the procedure went smoothly, and it was intended that treatment by antipsychotic medication would begin the next day