Neutral Citation Number: [2023] EWCOP 35

Case No: 13043376

IN THE COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 15/08/2023

Before:

JOHN MCKENDRICK KC
(Sitting as a Tier 3 Judge of the Court)
SITTING IN PUBLIC

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Between:

(1) BARNET ENFIELD AND HARINGEY MENTAL HEALTH NHS TRUST **(2) NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST**	**Applicant**
- and –	
(1) Mr K (By his litigation friend, the Official Solicitor) **(2) THE LONDON BOROUGH OF ENFIELD** **(3) ROYAL FREE NHS FOUNDATION TRUST**	**Respondent**

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Ms **Arianna Kelly**, instructed by Bevan Brittan for the Applicants and Third Respondent
Mr **Simon Cridland**, instructed by the Official Solicitor for the First Respondent
Ms **Chiara Cordone** instructed by the Local Authority Solicitor for the Second Respondent

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Approved Judgment

This judgment was handed down remotely at 10.30am on 15.08.23 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

This judgment was delivered in public and the proceedings are subject to the Transparency Orders dated 25 July and 15 August 2023. The anonymity of the first respondent and his treating clinicians must be strictly preserved and nothing must be published that would identify the first respondent or his treating clinicians, either directly or indirectly. 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 McKendrick KC:

1. These proceedings concern the health and welfare of the first respondent and in particular focus on the relief necessary to protect him from his resistance to the treatment of his chronic bilateral venous leg ulcers. He is anonymised in this judgment as Mr K. He lacks capacity to conduct these proceedings and the Official Solicitor was invited, and has agreed, to act as his litigation friend.

2. The first and second applicants issued an application on 10 July 2023 for relief pursuant to the Mental Capacity Act 2005 (hereafter "the 2005 Act") seeking orders in respect of Mr K's healthcare. The second respondent is the local authority which owes statutory safeguarding and other duties to him. The third respondent was more latterly joined as a party as its owes obligations to provide Mr K with healthcare, in particular vascular care, cardiology and anaesthesia.

3. After careful case management by Theis J, the Vice President of the Court of Protection, this matter came before me for a hearing by MS Teams at 12.00 on 10 August 2023. It had been the anticipation of the court that the applicants and third respondent would seek section 16, 2005 Act orders that it would be in Mr K's best interests to be conveyed from his care home to hospital in an ambulance for the urgent investigation, assessment and treatment of the, likely, seriously infected ulcers. The vascular evidence had touched upon the potential need for amputation of both legs below the knee.

4. It transpired that as a result of the third respondent's cardiological and anaesthesia evidence, filed and served in compliance with the order of Theis J at 16.00, 9 August 2023, the applicants and third respondent no longer sought declarations to convey Mr K to hospital. The evidence was said to demonstrate a high risk of cardiac arrest, brought about by either or both of the risks of: (i) chemical and physical restraint whilst being conveyed to hospital; (ii) and/or prolonged sedation within hospital. The applicants sought an adjournment and permission to file further evidence.

5. Concerned about the impact of each passing day on Mr K's ulcers and his health generally, directions were made for the applicants and third respondent to file and serve an interim assessment and/or treatment plan by 12.00, 11 August 2023 and the proceedings were listed for a further hearing at 15.00, 11 August 2023. At that hearing, following submissions and consideration of the written evidence, interim declarations were made that there is reason to believe Mr K lacks capacity to make decisions about the treatment of his ulcers and ancillary care (including physical and chemical restraint) and orders were made that it was in his best interests for a clinical team to assess him at the care home, with the use of physical or chemical restraint, if necessary. Set out below are my reasons for making the interim declarations and best interests orders sought.

The Background

6. Mr K was born in 1963. He is 60 years old. I am told his heritage is Nigerian but that little is known about his early life. The papers in the court bundle, understandably, have a heavy focus on his current psychiatric and medical challenges. The papers state that Mr K is said to have been born in Nigeria and travelled to the United Kingdom with his mother and two brothers when he was around eight years old. There is a reference to him having studied economics and as having worked as a mini-cab driver.

7. Much of the history is dominated by charting his mental health challenges. Concerns were raised in 2007 about threatening correspondence sent to the then Prime Minister and the need for a threat assessment to be undertaken. In 2009 it is said Mr K was detained pursuant to section 3 Mental Health Act 1983 (hereafter "the 1983 Act") for a period of five months at a mental health hospital in North London. It appears after his release from liability to be detained he refused to leave the hospital and remained there until 2011. It is then believed he lived outside of the United Kingdom before being returned to the United Kingdom with assistance from the British Consular authorities in Spain, where concerns had arisen because he was attempting to travel to Africa by bus. He was homeless for some time when he returned.

8. In or around July 2014 he was diagnosed with severe ischaemic cardiomyopathy. In April 2016 Mr K was found unconscious and was admitted to hospital. Notes suggest he was diagnosed with 'end stage cardiac failure'. He was offered follow up cardiology appointments but did not attend them. During this admission the second respondent is reported to have terminated the tenancy in respect of his home and he was offered a placement at a supported living placement. He refused to accept this and is said to have forced entry to his previous home and as a result ended up 'on remand' in prison for two months. In 2016 he was detained pursuant to section 2 of the 1983 Act and was prescribed antipsychotic medication. At some stage he was admitted into hospital and it would appear lived in hospital from around 2017 until he was discharged to B Home in 2023.

9. Court of Protection proceedings were issued in 2017 on the application of the second respondent arising out of Mr K's refusal to cease residing at a hospital managed by the first applicant. Orders were sought to convey him to a care home and provide for him to reside there. The application was brought to an end with Mr K remaining in hospital.

10. Further Court of Protection proceedings took place in October 2019, again involving a best interests decision around where Mr K should reside. He resisted a proposed move to a care home. I note it is reported that in those proceedings, in a report dated 30 October 2019, a clinician opined that it would be unsafe to physically or chemically restrain or sedate Mr K in the event of any resistance, "as this may precipitate an episode of heart failure or death."

11. Mr K has been the subject of several capacity assessments. He was assessed as lacking capacity to make decisions about his care and residence in May 2018 by a consultant psychiatrist. In March 2019 he was assessed by a different consultant psychiatrist to lack capacity to make decisions about his residence and his physical health conditions including his cardiomyopathy. His inability to make decisions was said to arise as a result of his delusional beliefs. In May 2019 another psychiatrist concluded his delusional beliefs meant he lacked capacity in respect of making

decisions about his residence. In a section 49, 2005 Act report dated 31 July 2019, the author concluded that on balance Mr K lacked capacity to make decisions about his treatment, care needs and residence, albeit it was noted a thorough assessment was required.

12. A consultant psychiatrist who is said to have been responsible for Mr K's care since October 2020 opined that he had a diagnosis of paranoid personality disorder (and not schizophrenia) and that despite his delusional beliefs was able to make decisions about his physical healthcare and his residence.

13. Eventually further proceedings were brought in the Court of Protection on the application of the first applicant (in these proceedings) to have Mr K discharged from hospital where he was residing and be taken to a care home. The proceedings were deemed to be a section 21A challenge to the second respondent's standard authorisation, granted between 27 May 2019 and 26 May 2020 to authorise Mr K's deprivation of liberty. An order was made by District Judge Ellington to transfer Mr K from the hospital to a care home in December 2019. A recital to an order from January 2020 noted that Mr K resisted the attempts to transfer him, absconded so he could not be transferred and on three occasions had been found in possession of an improvised weapon. In March 2020 the proposed care home stated they would not accept Mr K. The proceedings were ended by order of DJ Ellington on 12 February 2021 as Mr K had capacity.

14. Proceedings were issued again in the Court of Protection on 15 February 2022. The first applicant sought declarations that Mr K lacked capacity to make decisions about his residence and care. It noted in the application that since the last proceedings Mr K had refused to leave the hospital until very recently but was now sleeping outside the hospital and in its reception area. It sought orders for Mr K to be conveyed to, and reside and be cared for, at a care home.

15. On 15 February 2022, District Judge Eldergill invited the Official Solicitor to act as litigation friend and made a series of case management directions. On 25 May 2022 DJ Eldergill made directions for the instruction of a single joint psychiatrist (Dr Andrew Barker) to report on Mr K's capacity to conduct the proceedings and make decisions about his care and residence. Permission was also given for Dr Cripps, an expert consultant cardiologist, to provide a report on Mr K's prognosis and to report on the "recommendations as to the risks of any form of physical or chemical restraint on Mr K, ……including consideration of any appropriate conveyance plan."

16. At a hearing before DJ Ellington on 13 January 2023 the recitals note that:

> **AND UPON** the court recording:
> i. All parties agree that Mr K lacks capacity to make decisions regarding his capacity regarding residence and care and to conduct proceedings;
> ii. All parties agree that continued residence on the ward is detrimental to Mr K and to other patients
> iii. All parties agree that it is in Mr K's best interests to reside at B House and parties agree receive care there in accordance with the care plan dated 14 January 2022 which will be subject to review six weeks following any move;
> iv. The evidence of Dr Challenor, notwithstanding his agreement that Mr K appears to be in end stage cardiac failure and his consideration of the opinion of Dr RS in 2019 that the use of physical or chemical opinion physical restraint could not be safely managed appears to be:

a. Mr K is in New York Heart Association functional classification (NYHA) (NYHA) stage 3 perhaps even 2, rather than stage 4 on the basis of his involvement in various physical altercations with patients and staff;
b. His prognosis must be reviewed accordingly;
c. His likely life expectancy is estimated at two further years;
d. While any attempt to restrain either physically or chemically will increase the risk of heart failure or arrhythmia, the risk of the same is less than that posed by unchecked and ongoing aggressive physical behaviour;
e. the proposed Plan of Conveyance involving physical and chemical restraint would accordingly, when applied by staff with appropriate expertise, provide less of a risk of adverse cardiovascular events to Mr K than ongoing and uncontrolled aggressive behaviour;"

17. The matter came before Theis J on 6 March 2023. She noted that Mr K had unnecessarily resided at the hospital since 2017. The court noted all parties agreed he lacked capacity to make decisions about his residence, care and to conduct the proceedings. All parties agreed it was in Mr K's best interests to be transferred to reside at B Home. A further recital updated the court in respect of Dr Challenor's cardiac evidence as follows:

The evidence of Dr Challenor, that, on further reflection and discussion with Mr M of Mr K's behaviour in recent years:
a. Mr K is most likely in NYHA class 2 heart failure; class 3 at most, rather than class 4;
b. Mr K's prognosis must be reviewed accordingly;
c. Mr K's likely life expectancy could be between 2 and 5 years;
d. given Mr K is already accustomed to taking oral morphine on demand, the use of oral morphine prior to any attempted move might be effective…
e. while any attempt to restrain either physically or chemically will increase the risk of heart failure or arrhythmia, the risk of the same is less than that posed by unchecked and ongoing aggressive physical behaviour;
f. in the event of cardiac arrest – which might arise in the context of
- planned restraint or in the context of an altercation on the ward - the prospects of resuscitation would be less than 50%;
g. the benefits of a move out of the psychiatric ward outweigh the risks of restraint;
h. the proposed Plan of Conveyance involving physical and chemical restraint would accordingly, when applied by staff with appropriate expertise, provide less of a risk of adverse cardiovascular events to Mr K than ongoing and uncontrolled aggressive behaviour.

18. Theis J declared pursuant to section 15 of the 2005 Act that Mr K lacked capacity to conduct the proceedings and to make decisions about his residence and care. Orders were made pursuant to sections 4, 4A and 16 of the 2005 Act to convey Mr K from the hospital to B Home in March 2023 and thereafter to reside there in his best interests. The matter was transferred from Tier 3 to Tier 1 judiciary, subject to a review hearing which took place post transfer.

19. It is not in evidence before the court, but I was informed Mr K was conveyed from hospital to B Home without difficulty.

20. A standard authorisation was granted by the second respondent to authorise the deprivation of Mr K's liberty at B Home on 20 April 2023. On 22 May 2023 DJ Ellington made directions for further evidence and notes that whilst Mr K had settled and there were some positives, he spent almost all of his time in his room alone,

declined any intervention from professionals and is not attending to his personal hygiene. On 10 July 2023 the recital to DJ Ellington's order notes: "There are significant concerns regarding Mr K's physical health, in particular the state of his leg ulcers which are reported to be in a concerning malodorous state". The second applicant was joined as a party as it was providing some medical input. The third respondent was joined as a party as it was providing some vascular clinical input. DJ Ellington ordered that should an application for serious medical treatment be made, the matter would be transferred to be heard by a Tier 3 judge of the court. Directions for further evidence were made and the s. 21A 2005 Act application was adjourned.

21. On 10 July 2023 the applicants' solicitor issued a form COP 9 application for an order to convey Mr K to hospital and for his ulcers to be treated. The grounds succinctly noted:

> Mr K is subject to a standard authorisation in a care home following five years spent in a mental health facility in which he was not detained but which he refused to leave. He suffers from persistent delusions and paranoia and refuses to engage with professionals. He has a long-standing heart condition which makes any treatment against his will extremely difficult to carry out. Previous orders of the Vice President Theis J have authorised his successful conveyance from hospital to a care home with provision for physical and chemical restraint – neither of which was in fact required. Mr K has longstanding leg ulcers which he has previously treated himself. He refuses to allow staff or other medical professionals to assist him or assess them. Staff at his care home are now concerned, however, that the wounds are foul smelling and may be demonstrative of significant infection: one staff member reports vomiting at the smell and seeing "bone" when dressings were removed. In light of the seriousness of the issues, reallocation to a Tier 3 Judge is considered necessary and appropriate.

22. The proceedings returned to be heard by the Vice President, Theis J who made directions for further evidence and a hearing on 25 July 2023. The hearing was directed to be heard in public with reporting restrictions made to protect Mr K's identity and the names of any treating clinicians and other professionals. Theis J made comprehensive orders for evidence to cover:

    a. a conveyance plan from B Home to the treating hospital;
    b. a care plan upon arrival;
    c. risk assessments from his treating psychiatrist and from those treating the ulcerated leg;
    d. written evidence from a vascular surgeon and in the field of anaesthesia;
    e. a best interests analysis;
    f. evidence to address the issue of deprivation of liberty in hospital.

23. The first applicant sought more time for compliance with these directions because:

> "There have been substantial changes in Mr K's care plan since the previous hearing on 25 July 2023, which have caused a delay in finalising this document. A meeting took place on 28 July 2023 with representatives from North Middlesex University Hospital NHS Trust and Mr K's GP, Dr S. During this meeting there was a discussion about her views regarding Mr K's transfer for assessment. She is of the opinion that Mr K's assessment should be a less restrictive one in the community rather than a restrictive one in hospital. The GP has indicated that before more formally providing this opinion she would like to visit the care home on Wednesday 2 August 2023.

24. The matter returned for a hearing before Theis J on 7 August 2023. The applicants sought an adjournment until the first open date after 16 August 2023. It was recorded that despite the above, the GP, Dr S, agreed to inpatient assessment and treatment after visiting Mr K. Further directions were made for evidence to be filed and the matter was listed for a final hearing of the serious medical treatment application at a remote hearing at 12 pm on 10 August 2023.

The Evidence

Dr Andrew Barker, jointly instructed expert in old age psychiatry

25. Dr Andrew Barker has produced a report dated 29 September 2022 after assessing Mr K on 26 September 2022. His attempt to interview him was not successful. Dr Barker has previously produced a report about Mr K on 25 May 2017. Dr Barker considered then that Mr K had a persistent delusional disorder and that he lacked capacity to make decisions about his care and treatment. Dr Barker helpfully summarises the wealth of written reports in respect of Mr K's mental health and the various capacity assessments undertaken. He undertook a review of the records and summarised them. He recounted that he met with Mr K and spoke with him in the corridor but Mr K politely declined to be assessed in the absence of a paper version of a court order. He did not accept Dr Barker's offer of seeing the order contained in his laptop. He refused to be assessed.

26. Dr Barker spoke with his key worker. It was noted that on the ward Mr K had dressed his leg wounds himself with supervision. He requested the duty doctor some weeks back because he had seen a maggot in his wound. He was described as very irritable and verbally aggressive.

27. Dr Barker spoke with Mr K's consultant psychiatrist who had been in that role for three months. He thought he was anti-authority but had capacity to decide where to live. He wondered if Dr K "was even prolonging his poor health in order to be considered a legitimate patient".

28. Dr Barker concluded that Mr K suffers from a delusional disorder which underlines his general mistrust of health and social care workers. Mr K has abnormal beliefs most likely as a result of a continuation of a previously long term untreatable delusional disorder though, even if not, as a result of a personality disorder. Dr Barker discounted a hypothesis that Mr K has feigned psychiatric symptoms and manipulating health and care workers to prolong his stay in hospital. After a full history and a careful and balanced analysis Dr Barker arrived at the following conclusions:

    a. It is probable that Mr K continues to suffer from a persistent delusional disorder which affects his ability to use and weigh relevant information on his residence and care even though it may be partially in remission. If this were not to be the case, then in his opinion, Mr K suffers from a severe personality disorder that affects his ability to use and weigh relevant information on his residence and care.
    b. He lacks capacity to conduct the proceedings.
    c. He lacks capacity to make decisions about his residence.
    d. He lacks capacity to make decisions about his care, comprising his health and social care needs.

Dr M, Locum Consultant Psychiatrist

29. More recent psychiatric evidence is attached the minutes of a best interesting meeting held on 13 July 2023. Dr M is a locum consultant psychiatrist. He met with Mr K on 5 and 12 July 2023. He was able to meet him with a tissue viability nurse, Mr K's GP and others. He had previously seen him three times between 19 May and 28 June 2023. Dr M noted the constraints of assessment around Mr K's paranoid personality and his inability to meaningfully engage in discussion. Dr M noted there were bilateral leg ulcers and that Mr K has not allowed any assessment or treatment of them. The last time they had been seen was two weeks previously by the care home manager. Dr M set out his limited discussion with Mr K.

30. His report concludes when responding to the question is Mr K unable to make the decision:

> "Yes. There is impairment of his ability to exercise executive functioning due to the impact of his mental impairment mainly fixation and overvalued ideas have on his ability to make the decision around his care and support for his physical health."

31. Dr M concluded that Mr K can understand the relevant information superficially albeit there was a measure of avoidance. He concluded that he could not retain the information because he could not receive the information and this was due to his paranoid preoccupations and obsessions and that he is unable to engage in any exploratory discussions about his retention and understanding. Dr M concluded that Mr K could not weigh up the information and use it to make a decision. Dr M noted this was also because of his paranoid preoccupations and obsessions. Mr K refused to speak to Dr M about his care because he was suspicious of their motives. He "… lacked the ability to make global decisions about his care needs due to his paranoid thinking and underlying disorder". Dr M was clear that Mr K had a diagnosis of Paranoid Personality Disorder and, on the balance of probability, he concluded that "he lacks the ability to exercise executive functioning due to the impact of his mental impairment and distorted thinking have on his ability to make the decision around his care and support for his physical health."

Dr Challenor, jointly instructed expert cardiologist

32. Dr Challenor produced a report dated 21 November 2022. His main conclusions were:

> In my opinion, physical and chemical restraint as advised in the Terms of Conveyance, are appropriate and present a less material risk to Mr K than ongoing aggressive behaviour when performed by appropriately trained staff.
> On the evidence that is available to me, it is my opinion that Mr K has NYHA grade 3 failure, as a result of a myocardial infarction secondary to ischaemic heart disease. I would assess his life expectancy on the basis of the available data as approximately 2 years.
> My opinion on the use of physical and chemical restraint would not alter irrespective of Mr K's NYHA class. However, my views on prognosis are speculative in the absence of up to date objective and subjective data with regard to Mr K's clinical status. However, it is my understanding that Mr K would not permit cardiovascular physical assessment, routine blood tests or investigations to assess his heart function, which would make recalculation of prognostic investigations function, prognostic data impossible."

33. Dr Challenor was asked further questions, produced an addendum report dated 8 February 2023. He re-calibrated his opinion to conclude that Mr K was in class 2-3 NYHA heart failure. He says:

> "Both chemical and/or physical restraint will have an adverse effect on the cardiovascular system. Physical restraint may result in an increase in pulse rate and blood pressure, or conversely chemical restraint may lead to a fall in blood pressure. All of these might impact adversely on Mr K's cardiological condition. He has very little cardiological reserve on the basis of the evidence that is at present available. When Mr K expresses aggressive behaviour his pulse and/or blood pressure are already likely increased. Further increase in blood pressure would increase the workload on his heart, which would increase the risk of both heart failure and arrhythmia. Equally, chemical restraint may result in a fall in blood pressure which results in less blood flow to the coronary arteries and increases the risk of arrhythmia when the ability of the heart to compensate for a fall in blood pressure, as in Mr K's case, is poor.

Dr S, Locum Consultant In Vascular Surgery

34. Dr S is a locum consultant in vascular surgery in the employ of the third respondent. His witness statement notes he has not met with or assessed Mr K. He offered to meet Mr K on 18 July 2023 at hospital and/or to speak to him on the telephone. Mr K did not agree to either course. It was considered Mr K was unlikely to engage in an assessment at B Home. As a result, Dr S cautiously notes:

> "The information provided below is based on what is currently known about Dr K's physical health condition. It is possible that following investigation and tests (including blood tests), new information will come to light that will drastically change the proposed treatment plan, for example if serious cardiac issues or kidney dysfunction is identified. Subject to that caveat, the information provided below outlines what I envisage to be the likely range of treatment based on the information that is currently available."

35. Dr S notes that sedation may be used to calm Mr K if he is admitted to the hospital for assessment. Restraint may be used, if required. He explains the tissue viability nurses would carry out ultrasounds on the arteries and veins of his legs and change the dressings. Swabs would be taken to identify the bacteria causing the infections. Dr S notes that changing the dressings and a course of antibiotics may be the only course of treatment required. Much depends on whether arterial or venous problems are identified. Further treatment may however be indicated. If there are venous problems, then bedrest elevation and compression bandaging may be required. However, he notes that:

> "If there are other venous problems e.g. varicose veins that require treatment, this would likely be treatable with a very simple ward or office-based procedure that could be carried out at NMUH. Usually these procedures would not be carried out at NMUH as a result of the pathway procedures that are in place, however as an exception to the usual rule, we would provide this treatment at NMUH. This would likely involve injection of an IV drug close to the vein, or a minimal invasive procedure using a catheter to close the vein from the inside."

36. If severe problems are identified (e.g. arterial issues) then this would involve admission to one of two hospitals for surgery. This would be for:

> "This could be for an angioplasty (after a course on antibiotics and wound care) or, if his leg is unsalvageable, he could require a leg amputation, to be carried out at Hospital, for which he would be an inpatient for several weeks. In my view, the chances of this occurring are very small. From a vascular perspective, I do not believe there would be any other reason for Mr K to be transferred elsewhere from the Hospital.
>
> If Mr K requires a skin graft for his leg ulcers, he would need to be under the care of plastic surgeons and I am not aware if this is something that can be offered to him at the Hospital. Skin grafts are not a medical emergency and are not urgent from a clinical perspective. Generally, this is a planned procedure and a patient could be discharged and then re-admitted at a later date for any skin graft to be carried out, however in Mr K's case, it is likely that this could be expedited. "

Prof M, Consultant Vascular Surgeon

37. Prof M is a consultant vascular surgeon in the employ of the third respondent. She qualified in 1987. She has not met or assessed Mr K. She has read and agreed with Mr S's evidence, which is summarised above. She notes her opinion is based on the "limited information" currently available. She states: "*Efforts to carry out an assessment of Mr K's leg ulcers in the community have been unsuccessful to date and so it is not possible to provide a definitive answer to the question of what treatment may be required, however the information provided below reflects what I believe to be the most likely courses of action*."

38. She notes the first line of treatment would be the initial assessment, which would need to be carried out under sedation if Mr K is resistant. Then wound management would be required with antibiotics to fight any infection. "*Debridement can range from wiping down the wound with a swab and using special dressings, to a 'sharp debridement' which involves cutting away the non-viable areas. Debridement is not generally painful although it can produce a 'tugging sensation' which can be uncomfortable. If Mr K is compliant then that his can be done at the bedside. If Mr K is not cooperating, then this would require profound sedation or general anaesthetic.*"

39. She notes that in many cases this is all that would be required and that it is not known whether Mr K has an infection.

40. Once the ulcers have been cleaned and if there is an infection and it is treated and is under control (which would be measured by blood tests, wound inspection and vital signs) the next step would be to consider how the ulcers will heal which will be dependent upon whether the ulcers are caused by venous or arterial issues. If there are arterial issues, i.e. the blood supply is restricted, then the ulcers may not heal. This can be ascertained by an ultrasound scan or a CT angioplasty. If there are venous issues this would be identified by duplex scan, and if issues are identified then this would be treated by way of percutaneous procedures by ablating the veins. This would improve the 'environment' in which the ulcer is able to heal. In Mr K's case, it could take weeks in hospital for the infection to subside before beginning such treatment. Patients would ordinarily be sent home, but Mr K probably would not be. It is also noted Mr K has critically impaired circulation to his foot and therefore an arterial procedure may need to be carried out more quickly. She notes depending upon his cooperation he may require some degree of sedation throughout this period.

41. She notes at the more severe end, amputation of the leg may be required. She writes:

> "This would be a possibility if during our initial assessment it appears that Mr K is dying as a result of his infection and there is no time to treat the infection. In that case, an amputation would be performed within hours of the assessment. Amputation may also be considered at a later stage if efforts to treat any infection or to optimize his circulation are unsuccessful."

42. She notes the risks as follows:

> "There are risks and benefits associated with all of the treatment options outlined. The risks include:
>
> 1. Adverse reaction or allergy to any treatment, such as antibiotics.
> 2. There is a chance that Mr K's heart failure may be causing or contributing to his swollen legs (and it may be necessary to seek a cardiology opinion on this).
> 3. Failure to improve his ulcers, requiring amputation
> 4. Complications of any intervention undertaken
> 5. Psychological trauma to both Mr K and staff associated with enforced treatment or restraint
> 6. Physical trauma to both Mr K and staff as a result of restraint
> 7. Trauma to other hospital patients."

43. She notes that Mr K was admitted to a hospital in 2021 for treatment for his right leg ulcers. She notes the pros and cons of admission to three different possible hospitals. She notes first line wound management may take weeks. Normally a patient would be discharged the same day after surgical interventions. Amputation, if required, would require inpatient rehabilitation and the whole process can take months.

Dr W, Consultant Anaesthetist

44. Dr W is a consultant anaesthetist and has been a doctor since 1997. She is employed by the third respondent. She notes that she has not met or assessed Dr K. She provides evidence in respect of the anaesthesia risks to convey Mr K to hospital and the risks post admission. In the preparation of her evidence she discussed the matters with Professor R, who is a consultant interventional cardiologist with the third respondent.

45. She notes that careful consideration would have to be given to the type of sedative to be provided to Mr K given his heart condition. She notes he has been prescribed oral and PRN lorazepam previously. It is noted this could be provided again but may present risks with his cardiac function.

46. Dr W states:

> "In my view, having consulted with Prof R, attempting to transfer Mr K to hospital using physical restraint and/or sedation is likely to be risky, with little guarantee of a safe transfer in light of his heart condition (known severe left ventricular failure). Any physical restraint is likely to be detrimental from a cardiac point of view."

47. She further states:

> "Whilst it may be feasible to get Mr K to the hospital with lorazepam and aripiprazole (if he tolerates them given the issues mentioned in paragraph 7) we would then need continuing sedation to carry out the investigations, assessment and potential treatment. The anaesthetic agents that we would use to sedate for a protracted period, would have a detrimental impact on the

cardiovascular system. This is made worse by the length of time sedation is needed. Should Mr K experience a decrease in his blood pressure or pending cardiovascular collapse we would initiate inotropic/ vasopressor support to maintain blood pressure and the cardiovascular system. This may not reverse the cardiovascular collapse and is very difficult to withdraw at the end of the assessment period. A decision would need to be made that we withdraw with an end-of-life plan should this occur. "

48. If Mr K were to be admitted to hospital and if he is non-compliant with initial assessments/investigations such that he requires sedation, then anaesthetics may be administered by way of intravenous access but having not seen Mr K it is not clear how easy such access would be. She states that even light sedation could lead to cardiovascular collapse which would result in admission to ICU and end of life care. She states that if patients are resistant and combative, then deeper sedation would be required which may require inotropic support and intensive care admission. She says this is often futile for patients with severe cardiac disease and would necessitate end of life care. Whilst she has experience of anaesthetizing patients with cardiac failure, they are not normally as severe as Mr K.

49. She considered that alternative management strategies such as regional anaesthesia or local anaesthesia "would not be tolerated by Mr K due to non-compliance". She states that: "With a patient such as Mr K with end stage heart failure, there is a high probability that we would take the view that administering anaesthetics is too risky. We would explore other options of management with a multi- professional team – this would include conservative management if intervention was considered to be more detrimental to the patient's health. Consequently, any surgical intervention which would require anaesthetics to be administered may not be an option in Mr K's case, thereby limiting the types of treatment that he could receive in hospital."

50. It is important to set out Dr W and Prof R's recommendation to the court in full (emphasis added):

> "Profr R and I are are (sic) <u>both of the view that there may be merit in attempting to carry out the assessment in the care home, with use of limited psychiatric administered sedation and/or restraint, if necessary, if this were a possibility</u>. This would have to take account the aforementioned risks to his physiological state as mentioned in previous reports but could be a one-off sedation for a short period of time to enable the dressing to be removed and a healthcare professional to view the ulcers. This could be managed using agents he has previously received when transferred to the care home. I have not seen any statements commenting on the depth of sedation achieved with these agents – this may not be sufficient to cover any pain experienced when removing the dressing and hence a risk assessment would need to be made to ensure the health care workers are kept safe. The rationale for this is to enable a suitably qualified healthcare professional to view the ulcers which we believe have not been seen for many months or at all by someone able to assess them. This may help us plan the future direction of care. <u>We do not currently consider there to be a safe way of managing Mr K even if we can manage a transfer to the hospital door, the ongoing care once in the hospital is extremely difficult and high risk. For the reasons set out, neither general nor loca/ regional anaesthesia would be an option for Mr K and so treatment would necessarily be limited to conservative management</u>, i.e. dressing his legs, as he is unlikely to be compliant with IV antibiotics, and would therefore require sedation for intravenous access and antibiotics to be administered, possibly for some weeks, which we would not be prepared to do. The only

available treatment option would therefore be conservative management" (sic).

Ms Emma Varley

51. Ms Varley is a solicitor. She was instructed by the Official Solicitor to meet with Mr K and obtain his views. She visited him at B Home on 17 July 2023. The B Home staff told her that Mr K had been difficult and was "bullying" but he was now quieter. The staff member said that Mr K does not like A Hospital. Mr K said to the staff member he was a prisoner at B Home. Ms Varley tried to engage with Mr K but he was resistant to accepting that he had a solicitor. He was very focused on the fact the B Home staff had opened a letter addressed to him without his consent. Mr Varley records the following:

> "Mr K spoke to EV and stated: "I have asked for a letter of engagement three times, and I still don't have it." EV explained that she had brought a letter of engagement the last time she had come to visit him. In response, Mr K stated: "That was not a letter of engagement", before closing his eyes and resting his head on .."

<u>The Hearings</u>

52. The first hearing took place by MS Teams. The applicants and third respondent were represented by Ms Kelly, counsel; the first respondent by Mr Cridland, counsel and the second respondent by Ms Cordone, counsel. In the light of the evidence of Dr W, the applicants and third respondent no longer pursued their application for an order that it was in Mr K's best interests to be conveyed to hospital for assessment and treatment. They sought a further hearing and permission to file further evidence. The Official Solicitor sought permission to instruct two experts. The applicants opposed that. No interim relief was sought by the parties.

53. Mr Cridland crystalised the difficulty facing Mr K, and the court, in his position statement, which stated:

> "The Official Solicitor is very concerned for Mr K:
> (1) It appears highly likely that Mr K's leg ulcers are infected, and that they have been so for some time.
> (2) The evidence the ulcers are associated with a repugnant smell sufficient to induce Mr R to vomit, that Mr K screams in pain and has not changed his dressings for 3 weeks, and that the bone is exposed, potentially suggests the infection is serious.
> (3) Given (1) and (2), it appears likely that Mr K will require, as a minimum, admission for treatment by way of intravenous antibiotics. Moreover, that there is a risk of osteomyelitis developing, if it has not already done so, and systemic infection.
> (4) There is a risk of an underlying vascular complication associated with Mr K's leg ulcers.
> (5) Mr K's congestive heart failure operates to complicate matters and increase the risk to him of serious complications.
> (6) Transfer to hospital for assessment and treatment is likely for Mr K to result in:
>
> > (i) A need for some restraint – chemical and potentially physical.
> > (ii) Significant distress.
> > (iii) Deterioration in his mental health particularly in respect of his distrust and apparent paranoid beliefs concerning healthcare agencies.

(7) Dr W's evidence appears to indicate that transfer and treatment in hospital under sedation or indeed GA, will be associated with such high risk to Mr K that it will not be clinically indicated or appropriate.
(8) What if any treatment can be provided in the community and how is currently unclear."

54. I made directions on 10 August 2023 that the applicants and third respondent must file and serve by 12.00 11 August 2023 an interim treatment/assessment care plan for the court's consideration. Very helpfully this was provided and the clinical team supported it and sought an order the court authorise and approve it on Mr K's behalf. I shall return to the care plan in more detail below. The Official Solicitor was able to consider it carefully on Mr K's behalf and shortly before the hearing at 15.00 on 11 August, Mr Cridland was able to file and serve a position statement which set out the Official Solicitor's agreement that a care plan authorising the applicants' and third respondent's clinicians to carry out an assessment and investigation of Mr K's chronic bilateral venous leg ulcers, at B home, with chemical and physical restraint, if necessary, was in Mr K's best interests.

The Law

55. Sections 1-4 of the 2005 Act set out the statutory framework and need not be repeated. I set out the terms of section 48 as the matter I am concerned with directly engages it:

> **"48 Interim orders and directions**
> The court may, pending the determination of an application to it in relation to a person ("P"), make an order or give directions in respect of any matter if–
> (a) there is reason to believe that P lacks capacity in relation to the matter,
> (b) the matter is one to which its powers under this Act extend, and
> (c) it is in P's best interests to make the order, or give the directions, without delay."

Capacity

56. MacDonald J has clearly set out the relevant capacity principles in the light of the Supreme Court decision in *A Local Authority v JB* [2021] UKSC52; [2022] AC 1322 in the case of *North Bristol NHS Trust v R* [2023] EWCOP 5. I have particular regard to paragraphs 43 and 46, which state:

> "The foregoing authorities now fall to be read in light of the judgment of the Supreme Court in *A Local Authority v JB* [2022] AC 1322. The Supreme Court held that in order to determine whether a person lacks capacity in relation to "a matter" for the purposes of s. 2(1) of the Mental Capacity Act 2005, the court must first identify the correct formulation of "the matter" in respect of which it is required to evaluate whether P is unable to make a decision. Once the correct formulation of "the matter" has been arrived at, it is then that the court moves to identify the "information relevant to the decision" under section 3(1) of the 2005 Act. That latter task falls, as recognised by Cobb J in *Re DD*, to be undertaken on the specific facts of the case. Once the information relevant to the decision has been identified, the question for the court is whether P is unable to make a decision in relation to the matter and, if so, whether that inability is because of an impairment of, or a disturbance, in the functioning of the mind or brain.
> …
> In *A Local Authority v JB* at [65], the Supreme Court described s.2(1) as the core determinative provision within the statutory scheme for the assessment of

whether P lacks capacity. The remaining provisions of ss 2 and 3, including the specific decision making elements within the decision making process described by s.3(1), were characterised as statutory descriptions and explanations in support of the core provision in s.2(1), which requires any inability to make a decision in relation to the matter to be because of an impairment of, or a disturbance in the functioning of, the mind or brain. Within this context, the Supreme Court noted that s.2(1) constitutes the single test for capacity, albeit that the test falls to be interpreted by applying the more detailed provisions around it in ss 2 and 3 of the Act. Again, once the matter has been formulated and the information relevant to the decision identified, the question for the court is whether P is unable to make a decision in relation to the matter and, if so, whether that inability is *because of* an impairment of, or a disturbance, in the functioning of the mind or brain."

57. Section 48 of the 2005 Act has most recently been considered in the cases of: (i) *Local Authority v LD* [2023] EWHC 1258 (Fam) (Mostyn J) and (ii) *DP v London Borough of Hillingdon* [2020] EWCOP 45 (Hayden J). I take from these authorities that the language of section 48 needs no gloss and that the court need not be satisfied, on the evidence available to it, that the person lacks capacity on the balance of probabilities, but rather a lower test is applied. Belief is different from proof. Section 48 requires: '*reason to believe that P lacks capacity.*' Section 2 requires: '*whether a person lacks capacity within the meaning of this Act must be decided on the balance of probabilities'*. That being said in a case of this nature, where medical treatment is being considered which the patient does not consent to, the court must be satisfied there is evidence to provide a proper basis to reasonably believe the patient lacks capacity in respect of the medical decision.

Best Interests

58. These proceedings concern serious medical treatment. Best interests are determined by sections 1 and 4 and by following the dicta of Lady Hale DPSC in *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67; [2014] A.C. 591. At paragraphs 18 and 22 the role of the court and its proper focus pursuant to the 2005 Act is identified:

> "Its [the court's] role is to decide whether a particular treatment is in the best interests of a patient who is incapable of making the decision for himself.
> …
> 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."

59. At paragraph 39, Lady Hale encapsulated the best interests test and held:

> "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 to the treatment is or would be likely to be; and they must consult others who are looking after him or interested in his welfare, in particular for their view of what his attitude would be."

60. At paragraph 45, Lady Hale described the correct approach to the court's assessment of the patient's wishes and feelings, within the context of the statutory factors identified in section 4 of the 2005 Act:

> "Finally, insofar as Sir Alan Ward and Arden LJ were suggesting that the test of the patient's wishes and feelings was an objective one, what the reasonable patient would think, again I respectfully disagree. The purpose of the best interests test is to consider matters from the patient's point of view. That is not to say that his wishes must prevail, any more than those of a fully capable patient must prevail. We cannot always have what we want. Nor will it always be possible to ascertain what an incapable patient's wishes are. Even if it is possible to determine what his views were in the past, they might well have changed in the light of the stresses and strains of his current predicament. In this case, the highest it could be put was, as counsel had agreed, that "It was likely that Mr James would want treatment up to the point where it became hopeless". But insofar as it is possible to ascertain the patient's wishes and feelings, his beliefs and values or the things which were important to him, it is those which should be taken into account because they are a component in making the choice which is right for him as an individual human being."

61. Any decision of this court, as a public authority, must not violate any rights set out in the schedule 1 to the Human Rights Act 1998 and in particular Articles 2, 3, 5 and 8. The best interests test should accommodate an assessment of the patient's rights.

Analysis

62. Mr K faces a dilemma. On the one hand, he needs an urgent assessment of, and treatment for, his chronic bilateral venous leg ulcers. Without this, the evidence suggests, an infection may become sufficiently serious that amputation of both legs below the knee will be indicated. He remains resistant to professional assessment of his ulcers at B Home. He remains resistant to being returned to hospital for investigations and treatment. As far back as 26 June 2023 serious concerns were raised in respect of the urgent necessity of treatment of the ulcers. A member of staff noted they could see bone appear in the wound. After a short period of time in Mr Ks' room, the manager of B Home rushed out to vomit, over-powered by the smell of the wounds. Urgent safeguarding concerns were raised at round table meeting in June 2023.

63. Mr R, the Manager at B Home has provided an alarming level of detail of concern. He states that in his opinion Mr K's wounds are severely infected and malodorous. He says "the ankle bone is visible and seriously infects skin is hanging down his leg". He thinks the wounds have not been dressed since 17 July 2023. He states that Mr K screams in pain, mainly at night. Notwithstanding this, Mr K refused assistance from B Home staff and from tissue viability nurses and will "never allow anybody to touch his leg and will retaliate with force if someone tries…". Paramedics have been called in May and June but Mr K refused to engage.

64. On the other hand, as a result of his documented cardiac problems, the evidence from the cardiologists and experts in anaesthesia suggests, for now at least, that the use of chemical and physical restraint poses significant risks to Mr K if conveyed to hospital

against his will. Further, should he remain resistant to treatment when in hospital and therefore require longer term sedation, the risks of prolonged chemical sedation are significant.

65. Even if he were to be conveyed to hospital and underwent the necessary investigations set out above in the vascular evidence, there is a reasonable likelihood that any procedure which involves a general anaesthetic would be contrary to his best interests because of the risks it poses to his cardiac ill-health and in any event may not be an option and clinicians may not provide it.

66. This is the stark background that confronts the court. Mr K is in a parlous state.

Capacity

67. I note the long history of capacity assessments of Mr K's capacity in respect of his residence and care. Dr Barker's report provides a wealth of information about Mr K's mind and brain and the extent to which it impaired or disturbed. Dr Barker's opinion in September 2022 was that Mr K had a persistent delusional disorder or if he was wrong about that a personality disorder. Dr M, follow his assessment in July 2023, concluded Mr K has paranoid personality disorder. I am in no doubt that there is reason to believe that Mr K has an impairment of, or a disturbance in the functioning of, the mind or brain. This is based on the evidence summarised above. It is not necessary for me to identify, certainly for the purposes of meeting the section 48 2005 test, the exact nature of the impairment or what is the correct diagnosis in August 2023 (see *North Bristol NHS Trust v R*).

68. No party sought to persuade the court that Mr K has capacity to make decisions in respect of the treatment of his chronic bilateral venous leg ulcers. I am satisfied applying the statutory principles set out in section 3 of the 2005 Act that there is reason to believe that Mr K is unable to make decisions about the treatment options. I accept the written evidence of Dr M following his recent assessment that Mr K is unable to weigh the relevant information in respect of the treatment for his ulcers. This is largely because of his paranoid preoccupations and obsessions. Mr K is reported to be screaming at night in pain, yet will not permit a tissue viability nurse to assess his malodorous wounds. All the evidence points to there being reasons to believe he cannot make a decision for the purposes of section 3. His ability to understand and weigh the necessary relevant information has been undermined by his irrational preoccupations and his distrust of professionals. The 'matter' before him is the urgent investigation, assessment and treatment of his ulcers. The relevant information plainly includes the facts that: i. his wounds are in a very poor state; ii. his ulcers have not been assessed for weeks; iii. there is a high risk the wounds are infected; iv. there is a need for urgent assessment and treatment; v. without this he is at risk of severe infections which may compromise his venous and arterial systems and may lead to the necessity of amputation (if that is even possible given his cardiac presentation). There may well be other relevant information, I have not been addressed on this, given the urgency of the situation. Considering the 'matter', the likely relevant information and all the information about Mr K's recent responses over the last two months, I am entirely satisfied there is reason to believe he lacks capacity to make the relevant decision. The decision includes ancillary treatment matters related to the immediate need to assess and investigate his chronic bilateral venous leg ulcers. There is reason to believe that the inability to make the decision is caused by impairment of, or a disturbance in the functioning of, the mind or brain, which is evidenced by both Dr Barker and Dr M, albeit their diagnoses are slightly different.

69. I will make an interim declaration that: "Pursuant to section 48 of the 2005 Act there is reason to believe that the first respondent lacks capacity to make decisions about the medical treatment of his chronic bilateral venous leg ulcers and all necessary ancillary treatment to permit the assessment, investigation and assessment."

70. The court accordingly has jurisdiction to consider where Mr K's best interests lie.

Best Interests

71. There are, at least, four options:

    a. await further evidence (**1**);
    b. provide for an order to permit urgent investigation, assessment and interim treatment at B Home (**2**);
    c. convey him to hospital (**3**);
    d. persuade Mr K to attend hospital (**4**).

72. The urgency of Mr K's situation was made clear in June. The application was made in July. There cannot be any delay going forward. The court is conscious of its duties to Mr K as a public body and the intolerable situation he faces, apparently screaming in pain with his untreated wounds. Option 1 is not in his best interests. Whilst it is tempting to delay the assessment of the different risks by obtaining further evidence, that evidence will be of limited value in the absence of clinicians meeting and assessing Mr K.

73. On the basis of the cardiac and anaesthesia evidence, the risks to Mr K of urgent conveyance to hospital, at this stage, are too high. I note, of course, that Mr K was conveyed from hospital to B Home in late March 2023 without incident. However, in the interim and until further, clearer evidence emerges, I am persuaded, and indeed no party sought to persuade me otherwise, that now is not the time for conveyance to hospital for assessment with the use of chemical and physical restraint. That being said, that is a finely balanced assessment, given that it is likely, on the evidence of the vascular surgeons, that some form of inpatient investigations will be needed, for scans etc to assess the damage to Mr K's venous and arterial system and to assess whether or not his wounds are capable of healing. Option three is not *currently* in his best interests, but I anticipate that the evidence which emerges from the assessment to take place this week (see below) and the evidence from the two experts instructed by the Official Solicitor, will result in the court confronting the acutely difficult dilemma of balancing the risks to Mr K's physical and psychological health of non-admission to hospital and therefore limited treatment at B Home for his chronic bilateral venous leg ulcers, against the cardiac risks of chemical and physical restraint in, or being conveyed, to hospital. This will be a difficult balancing act and will require clear, expert evidence to assist the court to undertake the balancing exercise in Mr K's best interests.

74. Option three engages the section 4, 2005 Act statutory factors. I very much take into account Mr K's wishes and feelings and his resistance to any form of assessment or treatment of his ulcers. However, his refusal to have them treated is endangering his physical and psychological health in a manner the court cannot permit, given the interim declaration on his capacity. I also acknowledge there are risks to both his physical health and his psychological health of the assessment. There are cardiac risks posed by even the limited use of chemical and/or physical restraint that may be necessary to permit the assessment of his ulcers at B Home. I weigh them in the balance. I also weigh up the reported concerns of the manager at B home who is concerned about the impact of Mr K of the assessment taking place in Mr K's home,

his room at B Home. But weighing these matters, the balance comes down in favour of authorising the use of chemical and physical restraint to permit the assessment and investigation of the chronic bilateral venous leg ulcers. Continuing to permit them to go un-treated is not a humane option. They are plainly painful and whether or not there is already an infection (it is likely there is), untreated they will further compromise Mr K's physical and psychological health and result in further harm to him. Dr W and Prof R support assessment with limited chemical or physical restraint at B Home. Dr W will be present at B Home to oversee Mr K's response.

75. The care plan put before the court on 11 August was the result of the overnight hard work of the clinical team. They are much under pressure anyway, but particularly so as a result of the junior doctors' strike. I was told a 'critical incident' had been declared at the third respondent's hospital and that all senior staff were being redeployed to cover the gaps in treatment and care brought about by the strike. The clinical team trying to treat Mr K are operating in the most demanding of circumstances and have the court's admiration and gratitude.

76. The care plan has had the input of Mr S (consultant vascular surgeon); Dr W (consultant anaesthetist), Dr M (consultant psychiatrist), a senior team manager at the Mental Health Trust and 'Patient Transport UK'. The plan was shared with the second respondent and the manager at B Home. It states:

> "The aim of this care plan is to ensure that a vascular surgeon is able to undertake an assessment of Mr K's leg ulcers in the care home environment and that any interventions required to accomplish this are applied safely and in as least distressing manner as possible."

77. The plan is for a vascular team, supported by others to attend B home on 16 August 2023. The plan provides for chemical restraint as follows:

> Dr M will prescribe sedative medication and a Registered Mental Health Nurse (X X) will be on site on the day to administer this if required.
>
> The sedative prescribed will be lorazepam and the dosage will be 1-2 mg IM max 4 mg in 24 hours including oral. Lorazepam 1-2 mg PO max 4 mg in 24 hours including intramuscular.
> If there is continued behavioural dyscontrol, agitation and aggression then further treatment as below can be considered.
> Aripiprazole 10 mg oral. max 20 mg in 24 hours. Aripiprazole 9.75 mg IM once daily.

78. Physical restraint is also provided for:

> Appropriately trained restraint team from Patient Transport UK will be in attendance to facilitate the assessment.
>
> A four-person team will be available to perform any restraint required and will ensure the safety of Mr K and others in the room.
>
> Any restraint will be performed with each member of the team responsible for the restraint of an individual limb (2 arms, 2 legs)
>
> Restraint will only be engaged if required following dynamic risk assessment and only if necessary. Even during restraint, the patient will be made aware that compliance with treatment will de-escalate the restraint and the team will

actively look to de-escalate and/or release any restraint at the earliest safe opportunity.
Patient Transport's protocols ensure that restraint holds do not cause damage to muscle or bone at any point and no prone techniques, asphyxiation or flexion holds are used at any point.

The primary focus of any restraint is patient care and the safety of all parties.

Restraint will escalate in accordance with the patient's requirements. Initially verbal techniques will be employed to try to achieve compliance with treatment. If this is unsuccessful light holds may be applied. If this needs to be escalated the holds can be increased to allow for full immobilisation of limbs for a small period of time. These methods will be de-escalated at the first safe opportunity in all cases.

79. Mr S and Dr W will attend and lead the assessment. This will provide for a high level of expertise in vascular surgery and anaesthesia on the day. Mr S will examine the wound and re-dress them. He will take medical pictures to share with colleagues and for him to further consider in a less difficult environment. Dr W plans to take bloods for "*(FBC, U&E, CRP and BNP).*"

80. I note that: "Dr W will have responsibility for monitoring the safety of the restraints applied (both chemical and physical) and will be the ultimate decision-maker as to whether or not any additional restraint is appropriate, in light of the risks to Mr K associated with this."

81. To underline the risks to Mr K, the plan notes that should Mr K collapse an ambulance will be called, albeit I note there will be many skilled professionals onsite.

82. The Official Solicitor supports this plan and makes the following observations:

(1) The presence of the four-person restraint team from Patient Transport UK, if present in the room whilst the assessment is taking place, carries with it a risk of increasing any distress and anxiety suffered by Mr K. The Official Solicitor would invite consideration be given to provision for the team to remain outside the room, but ready to come in if called.
(2) Following on from (1), the Official Solicitor is concerned the number of people present should be kept to the minimum reasonably necessary. It appears that there could be as many as 8 people present….
(3) Under paragraph 3 of "to ensure that Mr K is able to undergo assessment" (pp 3 of the care plan), the Official Solicitor would question whether it is sensible for Mr K to be informed in advance of the professionals attending and to be given a copy of the court order, as this seems likely to add to Mr K's anxiety and distress in advance of the assessment commencing.
(4) Paragraph (6), the Official Solicitor would invite consideration be given as to whether it would be preferable for Mr R, who appears to have a good relationship with Mr K, to explain the proposed assessment to Mr K and to invite his agreement. If, as seems very likely, Mr K declines assessment, as he has to-date when other professionals such as GPs, TVNs, or paramedics have attended, there could then perhaps be an attempt to administer oral Lorazepam covertly. As currently drafted it appears likely, should Mr K refuse the assessment when invited by Mr S to consent, that IM sedation will thereafter need to be administered under some physical restraint.
(5) The Official Solicitor would invite revision of the plan to set out the detail as to how the dressings are to be removed, given they are thought not to have been

changed since mid-July, and Professor M felt in such circumstances they would likely require soaking in order to remove them; along with what facilities are likely to be required from BH in that respect.

(6) The Official Solicitor is unclear whether Mr K will need for pain relief when removing the dressing, but if the same may be required would invite provision be made for the same."

83. These observations all have force and I anticipate minor revisions to the applicants' and third respondent's proposed care plan are made before I approve the plan and attach it to an order providing for the court's consent.

84. Mr K should be provided with a paper copy of the order and the care plan. The order will be sealed. The order will be accompanied with a short letter from me asking him to consent to the assessment because the court is very concerned for him. It will emphasise the court has authority to do so and ask for him to cooperate. The letter and order shall be provided to Mr K in a sealed envelope a little before the assessment. I am told by the parties, and I have read in the notes, that Mr K can be very respectful of authority. He refused to be assessed by Dr Barker because he did not have a paper copy of the order. He was concerned about Ms Varley's letter of engagement and concerned that his correspondence had been opened by B Home staff. I think it likely an envelope with a short letter and order will have marginal impact on Mr K, but if there is a possibility, even a remote one, that this would reduce the risks to him of the assessment, then it should be attempted.

85. I therefore make a best interest order pursuant to sections 48 of the 2005 Act that the assessment and treatment care plan is in Mr K's best interests and authorise the use of chemical and physical restraint, if necessary as a last resort. Although the deprivation of Mr K's liberty is authorised by way of an earlier standard authorisation, pursuant to sections 4A and 16 I authorise any residual deprivation of his liberty occasioned by the assessment.

86. Any interference with Mr K's right to respect for a private life and wider Article 8 ECHR rights are in my judgement entirely necessary and proportionate to protect him.

A Hospital

87. Lastly, I note Mr K has appeared to speak very positively of A Hospital. It shall remain anonymous. I have asked for an urgent update about the willingness of the managers and/or clinical team at this Hospital, which falls under a different NHS Trust to admit and treat Mr K. He has said it is a very good hospital. It may be that the care plan above is unnecessary if Mr K is willing to be admitted to A Hospital. I made orders at the last hearing providing permission to disclose information from these proceedings to the Trust which operates A Hospital. I asked that they understand the court is inviting them to assist in this difficult matter.

88. I also invited the manager of B Home to discuss with Mr K his willingness to be admitted to A Hospital. I hope these conversations have taken place.

89. The applicants and third respondent must have a response from the Trust which manages A Hospital before they implement the care plan that I have approved above. If it be the case that A Hospital will admit Mr K to assess and treat him and if he is willing to be admitted, then that should be the urgent resolution to this matter.

Conclusion

90. I declare pursuant to sections 48 of the 2005 Act there is reason to believe the first respondent lacks capacity to make decisions about the medical treatment of his chronic bilateral venous leg ulcers and in respect of necessary ancillary treatment to permit the assessment, investigation and assessment of them.

91. I order pursuant to section 48 of the 2005 Act that the assessment and treatment care plan, duly amended to take into account the Official Solicitor's observations, is in Mr K's best interests and authorise the use of chemical and physical restraint to be applied as a last resort, in accordance with the care plan. A limited deprivation of liberty order is also made pursuant to section 4Aa and 16 of the 2005 Act.

92. There will be a further hearing at 14.00 on 18 August 2023 to determine the way forward in Mr K's best interests in the light of the assessment and the further expert evidence.

93. I thank all solicitors and counsel for their considerable assistance and ask that they draft an order to give effect to the decisions contained in this judgment.

Postscript

94. I provided a draft embargoed judgment to the parties' legal representatives in the normal way. Very properly, Mr Cridland suggested I should reconsider making section 48 declarations in the light of the guidance given by Hayden J in *DP v London Borough of Hillingdon* supra and in particular what was said at paragraph 40, which states:

> "All Counsel agree that an application made pursuant to Section 21A does not permit the making of an interim declaration pursuant to Section 48. Indeed, they submit that Section 48 itself does not permit the making of interim declarations, notwithstanding that this is almost universally the practice. As set out at para 29, above Section 48 provides for the making of an order or for the giving of directions. It does not provide for the making of a declaration. Thus, the Court's finding that there is reason to believe that P lacks capacity ought, strictly, not to be phrased in declaratory terms. Ms Butler-Cole also argues that, as the COPR 2017 describe an interim declaration as an "interim remedy", there can be no interim remedy in a Section 21A MCA application. As P is deprived, lawfully, of his liberty under a standard authorisation, the only remedy, it is argued, must be termination or variation of the standard authorisation."

95. I am not concerned with the court's powers pursuant to section 21A of the 2005 Act. If possible, it appears to me the court should make an interim declaration in respect of Mr K's capacity in respect of the matter identified in the judgment.

96. Section 47 of the 2005 states (emphasis added):

> **47 General powers and effect of orders etc.**
> (1)The court has in connection with its jurisdiction the same powers, rights, privileges and authority as the High Court.
> (2)Section 204 of the Law of Property Act 1925 (c. 20) (orders of High Court conclusive in favour of purchasers) applies in relation to orders and directions of the court as it applies to orders of the High Court.
> (3)Office copies of orders made, directions given or other instruments issued by the court and sealed with its official seal are admissible in all legal proceedings as evidence of the originals without any further proof.

97. Section 19 of the Senior Courts Act 1981 (hereafter "the 1981 Act") states *inter alia*:

> **19.— General jurisdiction of High Court.**
> (1) The High Court shall be a superior court of record.
> (2) Subject to the provisions of this Act, there shall be exercisable by the High Court—
> (a) all such jurisdiction (whether civil or criminal) as is conferred on it by this or any other Act; and
> (b) all such other jurisdiction (whether civil or criminal) as was exercisable by it immediately before the commencement of this Act (including jurisdiction conferred on a judge of the High Court by any statutory provision).

98. Section 19 provides the High Court with the power to make declarations, see the recent decision of Mr Ashley Greenbank, sitting as a Deputy High Court judge in *Radia v Jhaveri* [2021] EWHC 2098 (Ch). I note, of course, that section 15 of the 2005 Act provides a jurisdiction in respect of the making of declarations, but I do not read this to have oustered the basis of the jurisdiction to make declarations or interim declarations as provided for in section 19 of the 1981 Act (when read with Part 25 of the Civil Procedure Rules) when read with section 47 of the 2005 Act. It is desirable that through section 47 the Court of Protection has a wide range of powers to act both to protect and empower P, as is necessary. Such an interpretation of the 2005 Act is consistent with the language and purposes of the Act. This seems to be consistent with the approach to the 2005 Act taken by Baker LJ (with the agreement of Phillips and Nugee LJJ) in *Re G (Court of Protection: Injunction)* [2022] EWCA Civ 1312; [2023] Fam 107 at paragraphs 48-50.

99. Like Part 25 of the Civil Procedure Rules, the Court of Protection Rules also provides for interim remedies, see Rule 10.10 (emphasis added):

> **Orders for interim remedies**
> **10.10.**—(1) The court may grant the following interim remedies—
> (a)an interim injunction;
> (b)an interim declaration; or
> (c)any other interim order it considers appropriate.
> (2) Unless the court orders otherwise, a person on whom an application form is served under Part 9, or who is given notice of such an application, may not apply for an interim remedy before filing an acknowledgment of service or notification in accordance with Part 9.
> (3) This rule does not limit any other power of the court to grant interim relief.

100. Having regard to COP Rule 10.10 (1) (b) and applying the terms of section 48 (1) and section 47 (1), the Court of Protection has the power to make an interim declaration in respect of capacity. The fact that the terms of sections 15 and 48 do not provide for interim declarations does not limit the court's wider powers, as provided for in section 47.

101. I am fortified in reaching this conclusion by considering that an interim declaration could be made in respect of a vulnerable adult pursuant to the High Court's inherent jurisdiction, see Munby J (as he then was) in *Re SA* [2005] EWHC 2942 (Fam); [2006] 1 FLR 867 at paragraph 80. It would be surprising if Parliament when legislating for the 2005 Act would have chosen to remove the power to make interim declarations in respect of incapacity.

102. It is also desirable that the Court retains the power to make interim declarations in respect of capacity. A determination that there is reason to believe P lacks capacity in relation to the matter, is an important steps which establishes the court has jurisdiction to make best interests orders in respect of P, if additionally the section 48 (c) test of 'without delay' is met. The declaration should be precisely worded to make clear the matters in respect of which the court has jurisdiction. A finding is a less precise basis upon which to exercise the court's jurisdiction.

103. Therefore I add to the paragraph 90 above in the judgment, that I am making a section 48 order and an interim declaration pursuant to section 47 of the 2005 Act and COP Rule 10.10. (1) (b).

104. I have not heard argument on this narrow matter, as there is a pressing need to hand down judgment and approve the orders to permit the assessment at B Home to take place tomorrow, so if I am wrong in respect of this analysis, I also apply the learning of paragraph 40 of *DP v London Borough of Hillingdon* and make a finding in the same terms as the interim declaration. Through either route, as there can be no further delay, the best interests orders above are made for Mr K, who needs the Court's protection.