This judgment was delivered in public and the proceedings are subject to the Transparency Order dated 16 November 2023. The anonymity of the first respondent, her family and her treating clinicians must be strictly preserved and nothing must be published that would identify the first respondent or her 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.

Neutral Citation [2023] EWCOP 54

IN THE COURT OF PROTECTION **Case No 13699394**

Royal Courts of Justice
Strand
London WC2A 2LL

17 November 2023

Before

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

Between:

(1) **UNIVERSITY HOSPITALS SOUTHAMPTON NHS FOUNDATION TRUST**

Applicant

AND

(1) Miss T (By her litigation friend, the Official Solicitor)

(2) BT

(3) ST

Respondents

Ms Eloise Power instructed by DAC Beachcroft for the applicant
Ms Jenni Richards KC instructed by the Official Solicitor for the first respondent
Ms Amina Ahmed instructed by BT for the second and third respondents

HEARING DATE: 16 November 2023

APPROVED JUDGMENT

This judgment was handed down remotely at 14.00 on 17.11.23 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

John McKendrick KC:

Introduction

1. Miss T is the much loved member of a close-knit family. She is one of four siblings (three sisters and a brother). She was diagnosed with advanced cervical carcinoma on 12 September 2023. A CT scan undertaken on 11 October 2023 confirmed her tumour was (then) 7.5 cm wide. To treat her cancer she needs two courses of urgent treatment: (1) five weeks of daily external beam radiotherapy and concurrent weekly cisplatin chemotherapy; and (2) high-dose rate brachytherapy delivered over a three day period. The applicant describes this latter treatment as "highly invasive, painful and distressing". Stage 1 cannot be commenced until there is certainty that stage 2 will be provided because of the side effects, and because the risks of stage 1 are not medically justifiable without stage 2 being administered. Her family are in shock and deeply concerned for her.

2. The applicant is the treating acute trust. It issued an application on 13 November 2023 for relief pursuant to the Mental Capacity Act 2005 (hereafter "the 2005 Act") seeking declarations that Miss T lacks capacity to conduct the proceedings and to make a decision to consent to the treatment of her cervical carcinoma and that such treatment is in her best interests. Recognising the distressing nature of the treatment, they ask the court to authorise the ventilation and sedation of Miss T over the three day necessary period for delivery of the brachytherapy. Without the brachytherapy, Miss T's life expectancy would be a matter of months. They wish to begin the stage 1 treatment on Monday 20 November 2023.

3. The first respondent has been joined as a party and the Official Solicitor acts as her litigation friend. She is anonymised in this judgment as Miss T. The second and third respondents are Miss T's brother (who is also her deputy for property and affairs) and one of her sisters. They both support the applicant's case and urgently wish for the

treatment to be provided. Understandably they are concerned about the consequences of any delay.

4. At the outset of the hearing on 16 November 2023, whilst sitting in public, I made a reporting restriction order prohibiting the reporting of the identify of Miss T and her family members. This is necessary to protect her identity and confidential information. I also prohibited the naming of the treating clinicians. There is currently no public interest in reporting this information. The reporting restriction represents the correct balance between Article 8 and 10 ECHR for now.

5. Miss T was born in December 1962. She has a lifelong diagnosis of moderate-severe learning disability. She has never lived independently and needs support. She is surrounded by a happy family with whom she lives. She has a great interest in animals and loves to visit and feed nearby horses. She is very close to her twin sister. BT informs me she operates intellectually at around the five year level. She is described as gentle and eager to agree.

6. After being able to instruct two expert clinicians, the Official Solicitor, on Miss T's behalf, submits, through Ms Richards KC, that she agrees with and supports the applicant's case on capacity and best interests. No party felt it necessary to call evidence and ask questions. I heard the briefest of submissions. Therefore, at the conclusion of the hearing on 16 November 2023, I informed the parties of my decision. Namely, that Miss T lacks capacity in the relevant areas; and, notwithstanding the arduous treatment regime, the proposed treatment is in her best interests. After careful scrutiny, it is also necessary to authorise the ventilation and sedation of Miss T over the 'stage 2' three day period. I briefly set out below my reasons for making the declarations and orders sought.

The Evidence

Mr BT

7. Mr BT has provided a helpful witness statement with much background information about his sister. His statement begins with a colourful picture taken from Miss T's

holidays in 2023. She is wearing bright colours, holding up a picture and ever so gently smiling. She looks happy. This is followed by a picture of Miss T and her twin sister. This picture is also from their 2023 holidays. They have just attended a class to make bears. Both are smiling holding the newly made teddy bears. Miss T's bear is bright pink.

8. Mr BT is a lawyer and his wife has a degree in psychology. They are devoted to looking after their sisters. He tells of his shock when they were told this matter must come to court. He sets out that his sisters are known as "the girls". They all live together in a house purchased by their parents in the 1990s. Their parents are now dead. He has exhibited certain earlier psychiatric reports (one relates to property and affairs from 2020 and noted "significant cognitive impairment" when the mini-mental state examination was carried out). His written evidence is that Miss T can read a little "and has no idea even about simple maths". Miss T is a happy person and enjoys a busy social life which includes day centre time, visits to the pub, cinema, boating, garden centres and "her love of playing bingo". He talks of how she loves Christmas and looks forward to it, how she loves "Christmas Dinner". He gives evidence of her love for animals. He supports the applicant's proposed course of treatment. He attended the hearing remotely with his wife and the third respondent.

Dr M

9. The oncological and capacity evidence is provided in a witness statement of Dr M who is a consultant clinical oncologist employed by the applicant. She has been in this role since 2005. She diagnosed Miss T with a locally advanced cervical carcinoma (FIGO state IIIC1 squamous cell carcinoma). She has been involved with Miss T's care since 9 October 2023. She notes that Miss T was diagnosed after a cervical biopsy undertaken on 12 September 2023. She states that thereafter it was important to determine whether her cancer had metastasised. It was agreed, after careful thought, that Miss T would tolerate a CT scan. This was undertaken without sedation on 11 October 2023. The investigations reported a 17mm left external iliac lymph node which is suspicious but no other nodal or metastatic disease. The decision was made that curative and not palliative treatment was required.

10. In terms of capacity, Dr M states:

> "A capacity assessment was undertaken following that meeting which concluded that [Miss T] did not have the capacity to make decisions about treatment for her cancer. Although [Miss T] is able to understand the relevant information to the decision, she is unable to retain the relevant information which impacts upon her ability to use and weigh that information to make a decision."

11. The capacity assessment is exhibited to her witness statement. It notes that Miss T could not recall information given to her after only a few minutes. She could not recall the scan she undertook only a few days prior. It goes on:

> "As [Miss T] cannot retain the information for a period beyond the moment, she is unable to weigh up the risks, pros and cons of the different treatments and therapies available to her. She gives verbal consent to interventions without seeming to understand what they would entail."

12. This inability is attributed to her learning disability and is unlikely to fluctuate.

13. A best interests meeting was convened for 20 October 2023. Miss T was not invited for understandable reasons. Her family were involved. In advance of this meeting, Dr M met with Miss T and a carer on 13 October 2023. Dr M discussed the treatment options. She concluded that Miss T did not have capacity to make a decision to consent to the proposed treatment course for her cervical carcinoma. Thereafter a multi-disciplinary team met to discuss Miss T's treatment options on 20 October 2023. The MDT comprised gynae-oncologists, oncologists, radiologists, pathologists. The MDT confirmed the treatment was:

    a. radical chemo-radiotherapy with five weeks daily external beam radiotherapy and concurrent weekly cisplatin chemotherapy; and
    b. high-dose rate brachytherapy as an in-patient.

14. Dr M explained that there is clinical urgency to the treatment, as the radical chemo-radiotherapy should start within 31 days of the decision to treat. She notes because of the complexity of Miss T's case she has experienced some delay and there cannot be further delay going forward as that could lead to a reduced cure rate. As per guidance from the Royal College of Radiologists and British Gynaecological Society Guidelines the entire stage 1 and stage 2 treatment should be completed within 50 days for maximum effect. This would mean that Miss T would receive the brachytherapy between 2-4 January 2024.

15. Miss T was admitted to hospital for further scans between 29 October and 2 November 2023. This involved MRI scans to determine staging to ensure radiotherapy is properly targeted. It provided further information on the size and location of the tumour.

16. Dr M has drawn up the stage 1 treatment which involves the radical beam radiotherapy. This would involve daily attendance at hospital for the treatment. She will be required to lie on a couch for ten minutes. Dr M, having met her in clinic, is satisfied she can manage this. The treatment is not itself painful. However it does have unpleasant side-effects which Dr M describes:

> "Radiotherapy carries significant short and long term side effects. In the short term the radiotherapy causes tiredness, loose bowels and diarrhoea, urinary frequency and cystitis and risk of both faecal and urinary incontinence. The radiotherapy may also cause nausea and occasional vomiting. These side effects are managed with dietary advice, nutritional supplements at times and supportive medication such as anti-emetics and loperamide.
>
> In the long-term radiotherapy causes a risk of permanent bowel and bladder damage, although during the radiotherapy planning and treatment, we do our best to ensure that this risk is kept to a minimum. Vaginal narrowing and stenosis is also a recognised long term complication. As [Miss T] already experiences urinary and faecal incontinence the risk of this worsening in the long term is significant."

17. The addition of the chemotherapy to the radiotherapy causes further side effects and risks. Cisplatin can cause renal toxicity, peripheral neuropathy and tinnitus. There is also the risk of neutropenic sepsis, which can be life threatening if not detected. As a result Miss T will need careful monitoring. It is proposed that she is placed in a nursing home as her sisters are not in a position to look after her for reasons I need not detail.

18. Dr M goes on to detail the stage 2 treatment, brachytherapy. She says this is an important part of the radical treatment of cervix cancer. At the start of brachytherapy, patients are taken to an operating theatre where applicators are placed into the cervix, uterus and additional interstitial needles to ensure coverage of the tumour, parametrium and vaginal extensions. She describes in some detail the delicate and difficult nature of the treatment, which I set out, as it explains why the applicant has deemed it necessary to seek the court's authorisation for three days of ventilation and sedation. Dr M states:

> "The applicator is inserted in theatre. When the applicator is inserted the ring shape sits at the top of the vagina, just below the cervix with the black tube inserted through the cervix into the canal of the uterus. Additional needles are then inserted into the tissues surrounding the cervix. There will be needles inserted through the ring. If there is still vaginal extension at the time of brachytherapy, the 2nd diagram shows a perineal plate which would be sutured to the skin on the vulva with 6 stitches and then needles pushed through the vulval skin to treat extension down the vagina. The applicator is kept in-situ with gauze vaginal packing and sutured in place. It is understandable that patients find this treatment difficult to tolerate. In all circumstances of treatment, the patient is looked after one to one by a nurse with an epidural and patient-controlled analgesia providing continual analgesia throughout the 2 or 3 days of their admission. In view of the size of [Miss T's] tumour I would anticipate that interstitial needles will be required."

19. Dr M continues in her evidence to explain why the brachytherapy would not likely be tolerated by Miss T. She says:

> "During these procedures, the applicator remains in place for the full duration of the in-patient stay. The usual pathway is for the patient to lie still on their

back and are catheterised. The insertion in theatre is usually done under sedation and with a spinal plus or minus epidural. The patient is also given a patient-controlled analgesia to press and a one-to-one nurse is allocated to care for the patient. If interstitial needles are required, then an epidural is inserted which is kept running for the duration of the inpatient stay. The in-patient team regularly review the patients with epidurals. For patients with capacity, the applicator is removed following the final treatment using a Methoxyflurane inhaler to manage the pain and anxiety.

The brachytherapy treatment pathway is extremely intensive, painful and understandably very difficult for patients to tolerate even when they have full capacity. Post traumatic stress disorder is a recognised sequelae from the treatment. In my opinion, Miss T would not be able to tolerate this treatment whilst awake and I would only attempt the brachytherapy if she were sedated or anaesthetised. For this reason, it is being proposed to undertake this part of the treatment as an inpatient on ITU sedated and ventilated for the whole time during her admission."

20. Dr M goes to explain the risks of serious internal damage and bleeding should Miss T sit up in her distress. She states that without the brachytherapy the radiotherapy will not be curative. An alternative treatment for patients who cannot have brachytherapy is an 'external beam boost of a further 8-11 fractions'. This, she says, is inferior with a 5-year survival rate at less than 5% and with worse side-effects. Other treatment options have been considered and discounted, such as radical hysterectomy, boost with eternal beam radiotherapy and palliative radiotherapy.

21. The reported 5-year survival treatment for patients with FIGO IIIC 1 cervical cancer treated with chemo-radiotherapy, including brachytherapy, are in the order of 40%, however, this data is based on older radiotherapy and brachytherapy techniques.

Professor Hoskin

22. The applicant and the Official Solicitor jointly instructed Professor Hoskin to report to the court. He is a professor of, and consultant in, clinical oncology. He has produced a

report dated 15 November 2023. He has not met Miss T but carried out a review of the evidence and documents to formulate his opinion. I need only set out one excerpt from his helpful report:

> "The proposal to deliver brachytherapy in four fractions over 3 days following a single operative procedure to insert the applicators reflects standard practice. Once the brachytherapy applicators have been put in place under anaesthetic it is important that they are not displaced by movement of the patient. This requires the patient to remain on bed rest throughout the three days. A urinary catheter is required and constipating medication is given to avoid bowel function during that time which would disturb the geometry of the applicators. Repeated scans before each of the four radiation exposures is imperative to identify any changes in applicator position and to recalculate doses to the bladder and bowel which will also change in size and position over this period. This is challenging for all women who have to undergo this procedure despite the use of regular analgesics and other medications. The proposal to undertake the brachytherapy under anaesthesia and sedation maintained throughout the period of treatment has been carefully considered and anaesthetic opinion given in the statement of Dr [K]. I agree that this approach is in the circumstances the only realistic means of delivering effective and safe brachytherapy given the underlying concerns with the ability of [Miss T] to understand and comply with the requirements for brachytherapy."

23. He concludes by "strongly" supporting the proposed treatment plan for brachytherapy to be given under continuous sedation.

Dr K

24. Dr K is a consultant in anaesthesia and intensive care medicine. He has held this post since 2021. He is employed by the applicant. He first became involved in Miss T's care on 20 October 2023 but he has not met her. He has discussed matters in detail with Dr M and others. He explains that in the light of Dr M's view that Miss T could not tolerate brachytherapy, she would require administration of general anaesthesia, ventilation and

continuous sedation. After MRI and CT scans, and with arterial and central venous lines in place, she would be cared for in the Intensive Care Unit (ICU). As is common with patients in ICU, she would have continuous monitoring of her physiological parameters and her gas exchange. Her sedation will be monitored clinically using the Richmond Agitation Sedation Scale. She will require to be transferred from ICU during the day to attend scans and radiotherapy treatment and transfer will be undertaken by a doctor and transfer technician. The court is reassured that the MRI and CT departments regularly receive patients from ICU who are sedated and ventilated.

25. Once the treatment is completed on day three, she will be woken and removed from the ventilator. She will be discharged to the ward. She may have a period of delirium or agitation.

26. Dr K states:

> "I am not aware of any case where brachytherapy has been performed in our institution with a patient under prolonged sedation as is proposed here. We have, however, electively provided sedation and ventilation on GICU for other patients who lack capacity, for pre-operative optimisation over a period of several days before (semi) elective surgery. We regularly transfer patients within different areas of the hospital for scans and procedures and are very familiar with the processes involved."

27. As for the risks of anaesthesia, generally, but not specifically for three days, he states these are:

    a. damage to lips and minor injuries are common;
    b. an allergic reaction in 1 in 10, 000;
    c. the risk of death is very rare, occurring in 1 in 185, 000;
    d. there are "less common" risks of chest infection, blood clots, heart attacks and strokes.

28. Dr K rightly points out that Miss T has successfully been administered several general anaesthetics, most recently on 1 November 2023. He warns of the risk of secretions

following extubation and the development of pneumonia. There is a risk of her having to go back on the ventilator and there is an increased risk of ventilator associated pneumonia for critical care patients, with an estimated mortality rate of 10 %. He says this is likely to overrepresent the risk to Miss T.

Dr Bell

29. Very helpfully, the Official Solicitor was able to instruct an expert, Dr Bell, who is a consultant in Intensive Care/Anaesthesia. His report is dated 16 November 2023. He was asked specific questions by the Official Solicitor, I set out some with his answers below:

> *"What do you consider the risk(s) to be to [Miss T] of general anaesthetic and do you agree with Dr K's risk assessment?*
> Response: there are identifiable risks associated with the proposal as set out within the above sections, but these are largely predictable and manageable, and cannot therefore be considered to outweigh the risks of not undertaking the proposed treatment.
> *What do you consider would be the likely consequences for [Miss T's] physical and (in so far as you able to comment on this) her mental health of receiving brachytherapy in the way proposed by the Trust?*
> Response: the most likely adverse consequence of three days' continuing sedation and ventilatory support would be persistent respiratory dysfunction including the development of a lower respiratory tract infection. On the balance of probability, [Miss T] would progressively recover from such a complication with antibiotics and conventional physiotherapy techniques.
> *5. In view of the Trust's concerns regarding [Miss T's] not being able to tolerate brachytherapy, do you have any view as to how sedation, and if necessary, ventilation, could be administered in the least restrictive way?*
> Response: I can see no alternative in this scenario to formal sedation, endotracheal intubation and mechanical ventilatory support for this phase of treatment."

30. He makes proposals to lessen the risks to Miss T but overall he is supportive of the applicant's proposed care plan and concludes:

> "On the basis of the available information, I consider the proposal to conduct brachytherapy under sustained sedation with an associated requirement for intubation and ventilatory support, to be in [Miss T's] best interests."

Nurses AB and SA

31. AB is a clinical nurse specialist in Learning Disability and SA is a Learning Disability and Autism Liaison Advanced Nurse Practitioner (ANP). Both are employed by the applicant. They explain why they consider she lacks capacity to conduct the proceedings and make a decision to consent to the purposed treatment. They state that Miss T will need to be accommodated away from her home during stage 1, given the side effects and if a suitable nursing home is not found, she will be admitted as an inpatient to avoid any delay. They helpfully set out practical and clinical issues with regards to stage 2. They agree Miss T could not tolerate stage 2 without sedation.

Emily Steel

32. Ms Steel, who is a solicitor instructed by the Official Solicitor to meet with Miss T, has provided a helpful attendance note attached to her witness statement. She met Miss T and her sisters on 14 November 2023. Miss T's sister (ST) asked her not to use the word 'cancer' as Miss T is not aware that is her diagnosis and it will likely upset her. When asked about recent trips to see doctors or to hospital, Miss T had no recollection of any of the many recent assessments, scans and hospital visits. When the treatment was explained in outline, Miss T told Ms Steel:

> "*I find the hospitals are a bit dark as they don't have the lights on. The lights in the hospital. It's a bit dark. They do seem dark, they do*".

<u>The Law</u>

33. Sections 1- 4 of the 2005 Act set out the statutory framework in respect of mental capacity and best interests.

34. Serious medical treatment applications are subject to *Practice Guidance (Court of Protection: Serious Medical Treatment)* [2020] EWCOP2 issued by Hayden J in January 2020. It makes clear an application to court may well be required in situations where:

> "Further, in a case involving serious interference with the person's rights under the Convention for the Protection of Human Rights and Fundamental Freedoms or where the proposed procedure or treatment was to be carried out using a degree of force to restrain the person concerned and the restraint might go beyond the parameters set out in sections 5 and 6 of the 2005 Act amounting to a deprivation of the person's liberty, the authority of the court would be required to make that deprivation of liberty lawful."

Capacity

35. MacDonald J set out the relevant capacity principles in the light of the Supreme Court decision in *A Local Authority v JB* [2021] UKSC 52; [2022] AC 1322 in *North Bristol NHS Trust v R* [2023] EWCOP 5. Paragraphs 43 and 46 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."

Best Interests

36. These proceedings concern serious medical treatment. Best interests are determined by sections 1 and 4 of the 2005 Act and by following the dicta of Lady Hale DPSC (as she then was) 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."

37. 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."

38. Ms Power also relies on the decision of Hayden J in *Norfolk and Norwich University Hospitals NHS Foundation Trust and others v Jordan Tooke and others* [2023] EWCOP 45. She relies in particular on these paragraphs from the judgment:

> "Dr V, in that final paragraph, recognises that the alternative to the undoubted challenges identified, is to put in place a palliative plan, involving certain death but one which would be "predictable and controlled". Dr V and others have referred to the sedation proposal as "chemical restraint". That is, I think, accurate. But in the context of what is being contemplated here, I find it an emotive term which does not, to my mind, really do justice to the skill and subtlety of what the general anaesthetists can provide" (para 26).
>
> "There can be no doubt that the sedation plan carries significant and troubling risks. Some of those risks involve potentially very serious consequences. But the calibration of risk really requires confrontation with the alternatives" (para 33).

39. Any decision of this court, as a public authority, must not violate any rights set out in Schedule 1 to the Human Rights Act 1998.The best interests test should accommodate an assessment of the patient's rights.

The Parties' Submissions

40. All four parties submitted that Miss T lacks capacity to make the relevant decision and that it was in her best interests to receive the applicant's proposed treatment, including the necessary ventilation and sedation for the three day period of brachytherapy.

Analysis

41. Ms Power's position statement references *Re P* [2021] EWCOP 27; [2021] 4 WLR 69 and *Re Q* [2022] EWCOP 6; [2022] COPLR 315. She submits that Miss T lacks capacity to conduct these proceedings. The Official Solicitor did not contest this issue and nor did the family. I make the declaration necessary and rely on the written evidence of Dr M and the specialist nurses, as summarised above.

42. The matter for the purposes of section 2 (1) of the 2005 Act is whether or not to consent to the stage 1 and 2 treatment (including the ventilation and sedation) to treat her cervical carcinoma. It is not necessary to spell out each item of the section 2005 Act relevant information for the purposes of accepting the applicant's case that, on the balance of probabilities, Miss T lacks capacity to make this decision. Anyone consenting to the stage 1 and stage 2 treatment proposed would need to understand: i. in broad terms what the treatment is and what it involves; ii. that there are benefits to that treatment; iii. that there are risks and there are likely unpleasant side-effects; iv that the alternative is likely no treatment, palliation and death in a matter of months. Additionally the 'matter' for the purposes of Miss T would also require an understanding of the need for sedation and ventilation in ICU for three days and the reasons for this and the risks of it.

43. Miss T leads a full and active life, surrounded by her family and others. She has a moderate to severe lifelong learning difficulty. It is clear, looking at the longitudinal evidence provided by the family, that the cognitive and working memory difficulties

she faces are not temporary or likely to fluctuate. The 2013 mini-mental statement examination demonstrates her limited cognitive function. The many notes of recent meetings amply evidence her very significant difficulty remembering and recalling even very recent advice or events.

44. I remind myself that the assessment of capacity is time and issue specific. I am in no doubt, in November 2023, that Miss T is unable to make a decision whether to consent to the stage 1 and 2 treatments now and over the next two months. I have no doubt she is also unable to make a decision to consent to the ventilation and sedation. Her cognitive profile means that she cannot retain and understand all the relevant pieces of the information, even in broad outline, to be able to weigh up and use this information. I accept Dr M's capacity assessment evidence set out above, supported as it is by two highly experienced learning disability nurses. Moreover, their assessment is entirely at one with the family's view and the second respondent's written evidence. Miss T cannot understand and weigh the relevant information and therefore she is unable to make a decision. That inability is, in my judgement, caused by her cognitive challenges brought about by her unique learning profile, which is an impairment and/or a disturbance of the mind or brain. Therefore it is clear she lacks capacity in respect of the matter for the purposes of section 2 of the 2005 Act and I will make a declaration to that effect. I am satisfied in arriving at this conclusion that both all practicable steps have been taken to assist her to obtain the ability to make the decision, and furthermore, that within the timescales necessary she will be unable to be in a position to make a capacitous decision. In particular I see no basis for thinking that over the course of the treatment, and before 2 January 2024, there is any likelihood of steps being taken to assist her to be able to consent to the ventilation and sedation. This is not realistic and should not be attempted given further explanation of her cancer and the difficult nature of the treatment is likely to be anxiety causing.

45. It is therefore necessary to consider with clarity the available options before the court to assess the merits and demerits of each.

46. In *N (Appellant) v A CCG and others* [2017] UKSC 22: Lady Black JSC held (with the agreement of the other members of the court): "So how is the court's duty to decide what is in the best interests of P to be reconciled with the fact that the court only has

power to take a decision that P himself could have taken? It has no greater power to oblige others to do what is best than P would have himself. This must mean that, just like P, the court can only choose between the 'available options'"

47. There are no effective alternative cancer treatments available. Surgery has been ruled out by the applicant. It is also important to recall that brachytherapy without sedation and ventilation is not an option before this court, as the applicant is not prepared to offer that. The court therefore is faced with two choices: (i) the stage 1 and stage 2 lengthy and difficult treatment regime of chemoradiotherapy and brachytherapy with the three days of ventilation and sedation; or (ii) palliation.

48. I remind myself that with palliation Miss T would have months but not years to live. She is only sixty. The best interests analysis must appropriately acknowledge the gravity of the decision which could have life limiting consequences for her. Ms Power rightly relies on excerpts of relevant case law. She refers to: "*The starting point is a strong presumption that it is in a person's best interests to stay alive, but this is not an absolute, and there are cases where it will not be in a person's interests to receive life-sustaining treatment" (Aintree v James* [2013] UKSC 67, para 35).

49. She also references Baker J's (as he then was) wise formulation in *W v M* [2011] EWHC 2443 (Fam) at paragraph 220: *"The principle of the right to life can be simply stated but of the most profound importance. It needs no further elucidation. It carries very great weight in any balancing exercise.'*

50. On the facts, this case is different to the stark issues in *Aintree* and *W v M.* The term life sustaining has to be understood in a different way. But it is important for the court to orientate itself to confront the reality behind the term 'palliative treatment'.

51. It is important to emphasise that treatment for radiotherapy and chemotherapy and lengthy or complex cancer treatments are quite routine (although never easy). Such courses of treatment will regularly be given to many incapacitous patients up and down the country without any involvement of the court. This was made clear by Lady Black in *An NHS Trust v Y* [2018] UKSC 46. (Reference should also be made to the Practice Guidance quoted above.) This case has come before the court because of the need for ventilation and sedation. In my judgement it is right that the applicant has sought court

authorisation. I appreciate this was a shock to the family members and has added to their anxiety.

52. It is necessary for the court to consider stage 1 and stage 2 with the ventilation and sedation. The applicant, as I have noted, will not offer stage 2 without ventilation and sedation and will not offer stage 1 without stage 2 (with ventilation and sedation). Therefore the court is being asked to authorise the full package of treatment, even though in most normal circumstances as long as the test in *Y supra* would be met, routine chemotherapy and radiotherapy would not require authorisation and there are compelling reasons why that is the case, not least to avoid delay with time sensitive treatments.

53. I accept the medical evidence that there are considerable side effects of the stage 1 treatment. These are sufficiently serious that Miss T will need to move out of her home between 20 November 2023 and around Christmas time. I take into account this move, especially at a time of potential ill-health brought about by the side-effects, will have an emotional impact on her. I understand her family will be able to visit her almost daily. I very much hope they can provide the re-assurance she needs that she will be home in time for Christmas. I also accept the medical evidence of Dr M in respect of the risks of the stage 1 treatment and in particular the life threatening risk of neutropenic sepsis. Miss T will need careful observation from professionals.

54. I also accept the risks of the anaesthesia set out by Dr K and agreed by Dr Bell. General anaesthesia is routinely offered and is safe, but as the summary of the evidence above notes there are risks. I am comforted by the fact Miss T has very recently safely managed general anaesthesia. However, I do not discount the fact that this Trust's medical team have not provided the brachytherapy treatment in circumstances where the patient is sedated and ventilated. Each move from ICU to the radiotherapy site comes with small risks. Great care will be needed. I also factor in the risks of delusion and the risks of pneumonia from the prolonged ventilation.

55. All of those difficulties must, however, be seen in the context of the at least 40 % of survival at five years, if the stage 1 and stage 2 treatment is given. Section 4 of the 2005 Act requires all of the statutory factors to be considered. As is well known the best interests assessment is much wider than the medical evidence, the risks, benefits and

disbenefits. The court's aim is to arrive at the right decision, from the options, for the person the subject of the proceedings.

56. Miss T's wishes in respect of the treatment are far from clear. She readily agrees to what is suggested to her. However, she does not know she has cancer. As I came into court yesterday, Ms Richards helpfully sent me a note asking me not to mention the 'cancer' word as Miss T was briefly on the remote hearing link. Miss T has very little understanding of her diagnosis and the prognosis options.

57. As Baker J sets out (above) the continuation of life needs no elucidation. Certainly no justification. Miss T is, however, a person with a zest for life. Whether it is a question of her feelings or her values, she is a family person. She believes in spending time with her sisters and her brother. She loves the happy family time when they all share Christmas. She evidently enjoys her holidays with her family and they enjoy fun activities together. She is fortunate to live a life in a private home surrounded by her family. She has not known institutional care. Her parents wisely arranged financial, practical and housing matters with the assistance of her brother and her sister. Her family deal with her finances. Their evidence is clear that Miss T is desirous of this life. They wisely note, given her cognitive profile, that they have not troubled her with questions such as 'would she want to live?' I understand their evidence to be that they need not ask that question, as the answer is obvious, that she does. That is hinted at in the photographs I have seen and the rich description of family life set out in the written evidence. This is a close, committed and caring family. Family life is a value that Miss T cherishes. She feels it every day.

58. Therefore, applying section 4 (6) factors, I apply significant weight to the richness of family life as a value and a feeling that Miss T will want to continue and to enjoy. Her life has much value. Miss T is very close to one of her sisters and she has been unwell. Her brother is concerned for the health of Miss T's sister, if palliation were the treatment route for Miss T. In the context of this close family, I place weight on the section 4 (6) (c) factor: namely that Miss T would likely want to protect her twin sister from the anxiety and upset of her own early death.

59. I take into account the other section 4 factors and in particular the views of the second and third respondents. They are in favour of stage 1 and 2 and keen for it to start on

Monday. I take into account the unanimous clinical and expert evidence that the stage 1 and stage 2 treatment with sedation and ventilation is in Miss T's best interests. I have not lost sight of the fact that it is a considerable step for the state to authorise a patient to be rendered unconscious for three days to submit to an otherwise invasive, intimate and distressing treatment. In legal terms this is a profound interference in Miss T's Article 8 ECHR right to respect both in terms of her bodily integrity, her dignity and her psychological wellbeing. I have deliberately set out in detail, in the summary of the evidence above, the nature of brachytherapy. It is important to understand the unpleasant, invasive nature of that treatment, which can lead to PTSD, to fully understand the necessity of sedation for Miss T.

60. Considering all the section 4 factors and factoring in the Article 8 balancing act within the best interest analysis, I have little doubt that it is in Miss T's best interests to undergo stage 1 and stage 2 treatment for her cervical cancer including the three days of ventilation and sedation. The interference in her Article 8 rights is necessary and proportionate for the reasons I have endeavoured to explain above in the best interests analysis. Life has significant value. Miss T's rich life, enhanced by her family, is a thing of great value. Notwithstanding the risks and the difficult invasive treatment, stages 1 and 2 are plainly in her best interests, over a palliative pathway. I will make an order to that effect.

61. I am also asked to consider questions of deprivation of liberty. It seems to me there is a question over whether Miss T would be deprived of her liberty when sedated. It is not necessary to resolve that question, given the urgency with which this judgment must be handed down. Any deprivation of liberty occasioned by the care home or inpatient hospital stay can be covered by standard or urgent authorisation of deprivation of liberty as provided for the 2005 Act.

62. I thank the clinical team who have confronted the dilemma which Miss T faces with dedication and professionalism. I thank all solicitors and counsel for their assistance. I end by wishing Miss T and her family well in the weeks and months ahead.