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Case No: COP 14194278

COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 17/01/2024

Before :

THE HONOURABLE MR JUSTICE COBB

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Between :

KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST **SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST**	**Applicants**
- and - **TTN** **(By the Official Solicitor as his litigation friend)**	**Respondent**

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Re TTN (Medical Treatment: Retinal Detachment)

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Sian Davies (instructed by **Bevan Brittan LLP**) for the Applicants
Katie Scott (instructed by the **Official Solicitor**) for the Respondent

Hearing dates: 15 and 17 January 2024

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Approved Judgment

This judgment was delivered orally in public on 17 January 2024.

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THE HONOURABLE MR JUSTICE COBB

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

The Honourable Mr Justice Cobb :

Introduction

1. The application before the court concerns TTN, a 73 year old man, currently an inpatient in hospital for treatment under section 3 of the Mental Health Act 1983. He is under the care of the Second Applicant mental health trust; he currently suffers (and indeed has suffered for some time) from a mental disorder of a nature and/or degree which renders it appropriate for him to receive this level of hospital treatment.

2. In the late-autumn 2023, it became apparent that TTN had suffered significant sight loss, and a probable detached retina, in his right eye. The retinal damage was first formally diagnosed, following examination, on 21 November 2023. Following a failed attempt to work with TTN to achieve further assessment and possible treatment, an application for court authorised intervention was issued by the Applicants on 21 December 2023. Directions were given by Theis J, Vice-President of the Court of Protection, on 9 January 2024 and it was listed before me on 15 January 2024 for further case management, and on 17 January for hearing. This is an application which has been determined within the meaning of Serious Medical Treatment Guidance [2020] EWCOP 2. Time is now of the essence as the Applicants propose that, subject to the court's view, the procedure will be carried out at King's College Hospital on 22 January 2024; King's College Hospital is within the First Applicant acute trust.

3. The orders/declarations sought by the Applicants are:

    i) That TTN lacks litigation capacity; this has never been controversial and the Official Solicitor swiftly accepted an invitation to act, for which I am most grateful;

    ii) That TTN lacks capacity to decide whether to undergo a vitrectomy and associated treatment and aftercare to correct a detached retina in his right eye;

    iii) That it is lawful and in his best interests for TTN to receive care and treatment in line with the proposed treatment plan;

    iv) That it is lawful and in TTN's best interests for sedation and restraint to be used if necessary in line with the detailed transfer plan.

4. For the purposes of determining this application, I have read a collection of witness statements, medical records, and other reports. I received the oral evidence of Dr A, consultant ophthalmic surgeon, on 15 January at the hearing which was actually listed for pre-trial review (Dr A was not going to be available on the date fixed for the final hearing). I also heard from Dr B on issues relating to capacity, and Dr D on issues relating to anaesthesia (who had consulted directly with his colleague, Dr C). I have received detailed oral and written submissions from Ms Davies on behalf of the Applicants, and Ms Scott on behalf of the Respondent.

5. Congruent with my obligation under section 4(4) Mental Capacity Act 2005, I spoke directly with TTN on the morning of the hearing, by video-link to his hospital ward. He was lying on his bed for much of the conversation, though occasionally sat up to address me. This conversation took place in the company of the Official Solicitor's

representative. TTN made clear to me that he did not regard himself as under section 3, he doubted the authority or function of the court to make decisions about the eye surgery, and was resistant to undergoing the procedure at King's College Hospital.

6. I have received updated treatment and transfer plans prepared even during the course of the final hearing.

7. This was a case in which there was never any real doubt about TTN's lack of capacity in the material respects. At the conclusion of the oral evidence the Official Solicitor confirmed her view that it is indeed in TTN's best interests that the proposed retinal surgery takes place.

8. I give this *ex tempore* judgment on the afternoon of the final hearing shortly following the evidence and submissions. It is important that the parties have maximum time to plan for upcoming / planned procedure.

Background

9. TTN is an Iraqi national who has lived in this country for more than 40 years. He has diabetes and a heart condition; he also a history of treatment resistant schizo-affective disorder; he has been established on regular intramuscular injections of antipsychotic medication for many years, since at least 1995. He has been an inpatient in hospital under section 3 MHA 1983 since September 2023. His mental health condition is characterised by:

    i) Paranoid beliefs (typically of individuals attempting to harm or kill him through various means such as poison, deliberate damage to his health, and theft). He most commonly considers these individuals to be part of the intelligence/mafia/similar organisation;

    ii) A belief that he 'receives information' from 'external forces' the identity of whom he cannot disclose, due to top secret status/fear that it would lead to harm to him if he did. He has always indicated that these external individuals (and he, by extension) are related to the secret services in some way;

    iii) Somatic delusions/auditory hallucinations: that this 'information' is received through a form of 'cyberkinetics' that cause certain 'physical motions' which he can interpret;

    iv) Delusions around identification – typically that people are not who they say they are/not qualified in the way they are, and cannot be trusted.

10. For present purposes, it is significant to note that TTN lost all effective sight in his left eye some years ago due to chronic, macula-off, retinal detachment. It is believed that he has no perception of light in that eye, which to the observer (I can confirm) appears cloudy. Due to the severity and duration of the left retinal detachment, it is not treatable. Currently, the vision in his right eye is extremely limited indeed; he can see at best only light/dark and shadows. It follows that complete and irreversible loss of vision in his right eye would have particularly serious consequences for him. He has become effectively virtually blind already, and has become distressed by his loss of sight.

11. TTN has told the Official Solicitor's lawyer that he disputes that he lacks capacity to make the decision about this medical treatment; he denies that he is currently under section 3 Mental Health Act 1983. He has further indicated that he wishes the operation to take place to repair the detached retina; he wishes to be able to regain some sight. However, he opposes the plan for the procedure to take place at the First Applicant's hospital King's College Hospital, "for cultural reasons" and/or because he believes that the hospital has associations with MI5 or MI6.

Capacity

12. The capacity evidence is provided by Dr. B. She is a consultant psychiatrist with responsibility for TTN's care. Her oral evidence, supplementing her written evidence, was given with clarity, and with discernible sympathy and compassion for TTN.

13. The evidence of Dr B is that TTN cannot understand the full consequences of the procedure which is proposed for him. He has fixed delusional beliefs about the surgical team who has been assembled to perform the operation; he has suggested that they are not qualified to undertake the task, and/or they intend to blind him. He has expressed a belief that he would be assassinated after the surgery, and that he would only agree to the proposed surgery if this were communicated to him via 'cyberkinetics'. Dr B is of the view that the strength of TTN's delusional beliefs are such that whilst he understands some elements of the relevant information, he dismisses them as being relevant to him.

14. Dr B reported:

> "TTN has strong delusional and psychotic beliefs which impact his ability to use and weigh the relevant information. TTN said that he would not have surgery under the person who had offered it to him, because he was "not qualified." He based this on the fact that they were "an intern" (he might mean registrar). However, he also said that he was "100% sure" that they would intentionally blind him in both eyes, whilst operating on him, because they were "my enemy," had deliberately come back from France where they had gone in order to harm him, and had received "two thousand million pounds" to do so. He knew this because he had received information from "somebody else from outside" through "cyberkinetics.""

15. Having been advised that TTN had sought to impose conditions as to where the procedure could take place, Dr B told me that TTN has fluctuated in his views about the location for the procedure. Recently, he has been clear with his lawyer (and indeed today personally with me) that he would only have the procedure done at St Thomas' Hospital or at Chelsea and Westminster Hospital in London. Interestingly, he had previously told Dr B that he would *only* be prepared to be treated at King's College Hospital, and would not indeed consider any other hospital. He had previously said that he would be prepared to be treated if the procedure were undertaken by a consultant; when asked how he would check the credentials of the consultant, he said through "cyberkinetics".

16. It is contemplated that he will remain under section 3 Mental Health Act 1983, for at least 3-4 weeks as a minimum, but it may well be a few months. It may be that his current placement is in fact the best available for him.

17. Under the Mental Capacity Act 2005 there are certain core and immutable principles which the court must consider when presented with an application of this kind. They include, notably:

    i) A person is assumed to have capacity unless it is established that he lacks capacity;

    ii) A person is not to be treated as unable to make a decision unless all practicable steps have been taken to help him to do so without success; (pausing here, Dr B's view is that there is no prospect of TTN being able to make the decision himself in the near future: she records that medication titration could take several months, potentially 12 months for full effect, and the recommended treatment (clozapine) is only available orally and requires blood testing at regular intervals, both of which are contra-indicated by TTN's presentation and wishes);

    iii) A person is not to be treated as unable to make a decision merely because he makes an unwise decision;

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

    v) A person will be treated as unable to make a decision for himself if he is unable to understand the information relevant to the decision, unable to retain that information, unable to use or weigh that information as part of the process of making the decision, or unable to communicate his decision.

18. As I earlier mentioned, there is no dispute between the parties that TTN lacks capacity to participate in these proceedings, and to make decisions about his medical treatment. He was able to understand some of the information relevant to the decision as to whether or not to have a vitrectomy, but also had a strong belief in false (delusional) information around the surgery which causes Dr B to assess that on balance he cannot understand the relevant information. It is the expert view (essentially unchallenged) that TTN cannot use or weigh the relevant information because his strong delusional beliefs about the characteristics of the hospital, and the qualifications of the surgical team, and their malign intentions towards him, prevent him from doing so.

19. I turn to the question of best interests.

Assessment and anaesthesia

20. It is now proposed under the 'Transfer and Treatment Plans' that TTN will initially be moved to another ward within the mental health trust (physically closer to King's College Hospital) before moving the short distance to King's College Hospital for the surgery. It is not envisaged that he will rail against this initial move, as he knows the

ward, and has been there before. Dr B will be there to receive him. This part of the transfer does not look controversial.

21. Dr D told me that TTN would then be sedated (using Ketamine) at hospital in order to convey him to King's College Hospital; he would be conscious, but a 'deeper end' of sedation is contemplated. The anaesthetist told me that TTN would be told that this was his usual intramuscular injection (the administration of this would therefore be covert) and he would be likely to co-operate; Dr B considers that TTN should in fact be told the truth if he specifically asks about the nature of the injection (but she believes that he will not ask). If he is told about the Ketamine, he will be advised that this is to make him drowsy (again Dr B believes that TTN is unlikely to challenge this). Ketamine is a rapid onset sedation, although while sedated he will maintain his own airway function. Sedation carries a small risk of allergy or anaphylactic reaction but this is not clinically significant.

22. It is likely that once at King's College Hospital, TTN will need to be placed under general anaesthetic for the purposes of examining the eye to assess its current condition; in a co-operative patient who is capable of responding to instruction, this assessment would generally be done with the patient sitting in a chair using the slit lamp procedure and without any form of anaesthesia at all. While this would indeed be preferable, it is not possible in TTN's case.

23. It is proposed that, if the retinal re-attachment surgery is to be attempted (as hoped), he will remain under general anaesthetic while the surgery is performed.

24. Following the procedure under general anaesthetic, it is proposed that a level of sedation will be maintained so as to return TTN to the mental health ward without incident where he can be safely handed over to his mental health team.

The procedure: vitrectomy and post-operative care

25. Dr A gave clear, concise and extremely valuable evidence. He himself had consulted with another senior colleague in order to obtain a second opinion; the views he expressed were supported by this senior colleague. He was asked about the aetiology of the detached retina, but was not able to explain its cause. He observed that a patient who has suffered one detached retina (as TTN has done in his left eye) is statistically more likely to suffer a second. He did not consider that the detached retina was linked to TTN's diabetes. It is a relatively rare condition.

26. Dr A explained that a detached retina is usually a medical emergency, and the longer the retina is detached from the supporting tissue the harder it is to re-attach it, and the worse the prognosis. He accepted that the prognosis for successful treatment of the right eye is already "poor" given the chronic nature of the presentation; he said:

> "TTN has a poor prognosis with or without surgery, but on balance I believe his chance of vision gain is better with surgery than without. Further delay will probably adversely affect the outcome, but as there has been delay already we are no longer in a situation where emergency care is needed as much of the damage has already occurred".

It may not indeed be possible even to attempt to re-attach the retina, but he will only know this when he has access to it.

27. Dr A explained the procedure, which will involve an element of laser surgery in an attempt to re-attach the retina, and then the insertion of a silicon oil bubble into the eye, which has the effect of pushing and retaining the retina back into place.

28. Ordinarily this procedure would be done with the patient awake and alert, and the affected area simply under local anaesthetic. However, given TTN's particular presentation, and his likely lack of co-operation it is reasonably considered (rightly in my judgment) that this would not work. Accordingly it is proposed to undertake the examination and the procedure under general anaesthetic. It is envisaged that this may take in the region of one hour.

29. Dr A described the optimal post-operative regime. This would involve a degree of posturing for a period of hours (by which the patient sits or lies with the head tilted in a position which ensures that the silicon oil presses against the retina); regular steroid and antibiotic eyedrops up to four times per day for a number of days or weeks, to speed along the recovery and minimise infection. It is reasonable to assume that there would need to be post-operative checkups. The crucial period is the first month post-operatively. If the retina does not detach again in this period the overall prognosis is reasonable.

30. Dr A explained that the procedure will not leave TTN with a painful eye; it may be mildly uncomfortable for a few days, but nothing that cannot be perfectly properly addressed with eye drops (if TTN will take them) and/or paracetamol.

31. Dr A explained that it would probably (not invariably) be appropriate at the right time (measured in months, not less than three, though up to twelve months or more) to replace the silicon oil with another form of synthetic vitreous gel. This further procedure was not explained in any detail, but would be likely to involve further general anaesthesia.

32. Dr B was of the view that TTN would be unlikely to engage with post-operative care given his mental state. The nursing staff will do their best over the first 24 hours to enable him to co-operate with the treatment plan. Dr B is of the view that they should avoid restraint in the post-operative period, as this may compromise the surgical treatment itself. Dr B was clear that the nursing staff would resist having to handle TTN at all.

33. Dr A was of the view that if TTN was non-compliant with any of the post-operative procedures, this would not be likely to have such a drastic adverse effect on the prospects of success as to render the entire process futile. He spoke of the risks of infection (endophthalmitis) which, if it were to affect the eye at all, is most likely to occur during the procedure itself (and hence is out of TTN's control); he referenced the risk of high or low eye pressure, which may have an impact on the functioning of the eye. Dr A proposed that he could inject some steroid into the eye (or region around the eye) at the time of the operation in order to maximise the speed and extent of the recovery.

34. Dr A averred that there was 70-80% chance that TTN would go completely blind if nothing were done to cure the right eye retinal issues now. He felt that the prospects of success of the operation was somewhere between 40-60%. The operation would be regarded as a success if the level of vision improved to any extent.

35. In terms of the benefits, Dr A felt that – if the operation succeeds – TTN would experience *some* benefits by way of vision improvement. Some of those benefits may be experienced straight away; images would probably appear brighter, even if blurred. He told me that the silicon oil can distort focus, but that this can be corrected with glasses. The recovery would have several phases, with each new phase bringing more benefits than the last. Dr A said that the best outcome would be that TTN would be left with "poor or at best moderate vision", but overall this was better than no vision at all. Dr B told me that she thought that improved vision would have a beneficial effect on TTN's mental state.

36. In making a best interests decision in relation to treatment, again I apply the following immutable statutory rules:

    i) I must take into account all relevant circumstances;

    ii) I make no assumptions about what might be in his best interests simply on the basis of his condition;

    iii) I must consider whether, and if so when, TTN would be likely to regain capacity.

    iv) I must consider TTN's past and present wishes and feelings, and such factors as he would be likely to consider if he were able to do so;

    v) I must take into account in so far as I can the views of his brother as someone who is "interested in his welfare".

Conclusion

37. The evidence is clear that TTN lacks capacity to make the decision about the retinal surgery. I am satisfied that he is unable to understand, or use or weigh the information relevant to the decision. Those functions are fundamentally undermined by his irrational paranoid beliefs about the hospital and about those who have been lined up to perform the surgery.

38. But what about his best interests? In order to make this decision it is necessary for me to consider the benefits and the risks. The benefits are fairly obvious. If the operation is successful, then TTN will have restored to him some level of vision even if it is limited to a perception of light/dark. Even if that is the limit of the success, this would be a material benefit to him in my judgment and would give him at least some better awareness of night/day. It was Dr A's view (in cross-examination from Ms Scott) that "we should not underestimate the potential for improvement in his quality of life… even if not good vision". Without the operation he is assuredly condemned to go blind.

39. Dr B thinks that if the operation were to be successful he would be likely to become brighter in mood if he regains some vision. He values independence which he has currently lost. It could reduce the depressive phases of his condition.

40. That said, the operation carries with it risks. They can be identified as follows:

    i) Dr A and his supporting surgeons fail to re-attach the right eye retina either because it has been detached for too long, or the process is clinically too complex;

    ii) Once attached, the retina re-detaches;

    iii) There is a risk of infection transferred during the operation itself (not so materially in the post-operative phase), though this is a relatively small risk;

    iv) The risks associated with general anaesthesia for a man of TTN's age (the risk is no greater for TTN than any other similar 73 year old male);

    v) TTN may suffer high or low ocular pressure following the procedure which is not then detected. This can cause further complications including glaucoma and/or loss of vision.

    Significantly, there is limited if any risk to TTN's existing vision *per se*; frankly, there is a considerable risk that TTN will go completely blind without intervention. TTN has extremely limited vision now, and it is only going to get worse. It was pretty clear to me that this is a once-and-for-all final attempt to afford him some vision for the balance of his life.

41. Dr A was clear that the decision to proceed with surgery is "not … straightforward". Indeed, if it were the case that TTN had better or good vision in his left eye, Dr A explained that he would not in fact consider let alone recommend the retinal repair of the right eye. But this is effectively the last chance to save some level of vision for TTN, and therefore in the view of Dr A it is a risk worth taking.

42. TTN's own views on the issues before me are complex, but consistently he has said that he wishes to have improved sight. He knows that he needs an operation to restore his sight. He has sought to impose conditions in relation to treatment (in particular the location of the procedure) and choice of consultant (to be achieved through cyberkinetics), but these are the product of his delusional belief system. I take as TTN's constant position that he wishes to be more independent, and his poor vision is inhibiting this. I further note that TTN's brother is keen for TTN to have the operation and is believed to be supportive of the application.

43. Implicit in the plan for TTN is that he will, in different ways, need to be deprived of his liberty. There is reason to believe that he will be resistant to being conveyed to hospital for the purposes of the procedure; he needs to be sedated. It is not envisaged that he will need to be physically restrained. I have reviewed the 'Treatment and Transfer Plans', and am satisfied that the ground is well covered in those documents. I agree with Ms Scott in her submission that the physical and chemical restraint that will inevitably be required to get TTN to King's College Hospital and keep him there, is required for the purpose of facilitating the safe performance of the ophthalmic surgery and is not 'treatment for mental disorder in a hospital' as provided for in paragraph 4 of Schedule 1A. Therefore specific provision needs to be made for this in this order and /or associated plan.

44. There is a marginal dispute about what TTN should be told and when. There is some concern on the part of the Applicants that TTN should not be told until after the procedure about the outcome of this hearing. The Official Solicitor is concerned about this and feels that TTN should (if he asks) be told the truth. The Official Solicitor is somewhat less concerned that TTN is to be misled about the administration of sedation medication given that with sedation he is less likely to need restraint and this becomes therefore the least restrictive option. I am of the view that the Applicants should avoid as far as possible actively misleading TTN, but where it is necessary to do so in order to achieve this outcome in the least restrictive way, then this in my judgment can be permitted. For the avoidance of doubt, I am of the view that TTN should be told after the event (at the latest) that the procedure has been authorised by the court.

45. In all the circumstances I very much hope that the procedure is successful and that some level of right-eye vision is restored to TTN; I am convinced that TTN is in extremely capable hands given the involvement of Dr A and Dr D, and for as long as he remains under the mental health supervision of Dr B.

[END]