Neutral Citation Number: [2020] EWCOP 57

Case No: 13645851

**COURT OF PROTECTION**

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 12/11/2020

**Before** :

**MR JUSTICE MOSTYN**

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**Between :**

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|---|---|
| **Livewell Southwest Community Interest Company** | **Applicant** |
| **- and -** | |
| **MD** | |
| **(by his litigation friend, the Official Solicitor)** | **1st Respondent** |
| **- and -** | |
| **University Hospitals Plymouth NHS Trust** | **2nd Respondent** |

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**Mr Ian Brownhill** (instructed by **Enable Law**) for the **Applicant**
**Ms Nageena Khalique QC** (instructed by **Official Solicitor**) for the **1st Respondent**
**Ms Alexis Hearnden** (instructed by **Bevan Brittan LLP**) for the **2nd Respondent**

Hearing date: 6 November 2020

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# Approved Judgment

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MR JUSTICE MOSTYN

This judgment was delivered in public. A reporting restriction order is in force which prevents identification of MD.

**Mr Justice Mostyn:**

1. There was listed before me on 6 November 2020 a final hearing to decide whether MD should have a full dental clearance in his best interests. A full dental clearance means the removal of all teeth. At the conclusion of the hearing I ordered that the application be granted, with reasons to follow. These are my reasons.

2. MD is a young man aged 24.. He has a number of diagnoses: learning disability, paranoid schizophrenia and ADHD. He also has a possible diagnosis of autism. He is voluntarily accommodated in a residential home for men with mental health problems but aspires one day to gain more independence. By all accounts, MD is a very vulnerable man with complex needs. His behaviour can be challenging, and he can become violent and aggressive and destroy property.

3. Unfortunately, MD for a considerable amount of time has suffered from very poor dental health. Ms Khalique QC described the state of his teeth as "absolutely appalling", which was no overstatement. Their condition is not helped by his sweet tooth, which he is unable to see as a contributing factor. MD is unable to accept that new teeth will not grow and replace his lost adult teeth. He is very resistant to practising normal dental hygiene which has resulted inevitably in decaying teeth, missing teeth, retained dental roots, cysts, and infection amongst other problems. This is said to be rapidly deteriorating. As one can imagine, this is a source of great physical pain and discomfort for MD who is now on a diet of soft foods. It should be noted that this soft diet is not exclusively attributable to his dental pain but is also likely a sensory preference consistent with his diagnoses.

4. It is possible that MD has upsetting memories of hospital treatment deriving from an episode when he fell and cut his chin as a child. It may be that he views that experience as analogous to dental treatment. Be that as it may, MD has refused dental intervention. Although he has sometimes booked appointments for treatment, he has also failed to attend, or has refused necessary treatment upon attendance. Some occasional superficial examinations and some x-rays have been permitted by MD but these are the exceptions. Predominantly he tends to be in denial and can turn verbally abusive when he is encouraged to act reasonably and responsibly about his oral and dental hygiene.

5. It is not in dispute that MD lacks capacity both to conduct this litigation and also to make decisions regarding his dental care. I have read the capacity assessments by Dr Daoud and Dr Hopper. I have also read the report of Dr Camden-Smith. It is not suggested that MD will likely regain capacity in the future and although great efforts have been gone to explain the issues to MD, it is not possible to assist him to gain capacity. I am satisfied that MD does lack capacity in both respects within the meaning of section 2 of the Mental Capacity Act 2005.

6. The applicant proposes that MD is not told of the clearance procedure beforehand. This is to avoid MD becoming overly anxious or agitated. The applicant proposes that he be sedated and taken by ambulance to the second respondent, which is the nearest hospital to perform the proposed treatments and investigations. Sedation, it argues, is necessary to avoid MD becoming agitated. The care plan also provides for physical restraint in soft cuffs due to the potential volatility of MD's behaviour. The applicant wishes not to use MD's habitual carers and instead to rely upon alternative security providers. This is to minimise any sense of betrayal or distrust that MD may feel and is to protect the

ongoing therapeutic relationship that he will need to have with his current caregivers. All of MD's teeth would then be removed under general anaesthetic. After recovery, MD would be offered dentures although it is not expected that he would tolerate them. However, the option would always be kept open for him.

7. MD's family members have been consulted and they are in support of the application.

8. I have read the witness statements of:

   i) Dr Hopper, specialist in special care dentistry;

   ii) Ms Sacker, nursing assistant;

   iii) Dr Porter, consultant anaesthetist;

   iv) Mr Simon Heywood, specialist in oral surgery;

   v) Ms James, specialist in special care dentistry; and

   vi) Ms Lamble, deputy unit manager and registered mental health nurse;

   upon whom the applicant relies in support of the application.

9. The Official Solicitor properly sought her own evidence on behalf of MD. In particular Dr Miller, specialist in special care dentistry, was instructed and I have read her report. I have also read the psychiatric report of Dr Camden-Smith, specialist in learning disability psychiatry.

10. All of the medical evidence above speaks with one voice that the procedure is necessary from a clinical perspective: it is no exaggeration to state plainly that without intervention MD is at risk of infection, sepsis and death. The psychiatric evidence also recommends the procedure as being in MD's best interests.

11. I now turn to the law. There was no dispute amongst the advocates as to the applicable principles.

12. Section 4 of the Mental Capacity Act 2005 provides, so far as is material to this case:

> "**4 Best interests**
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> (1) In determining for the purposes of this Act what is in a person's best interests, the person making the determination must not make it merely on the basis of -
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> (a) the person's age or appearance, or
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> (b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about what might be in his best interests.

> (2) The person making the determination must consider all the relevant circumstances and, in particular, take the following steps.
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> (3) He must consider -
>
> (a) whether it is likely that the person will at some time have capacity in relation to the matter in question, and
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> (b) if it appears likely that he will, when that is likely to be.
>
> (4) He must, so far as reasonably practicable, permit and encourage the person to participate, or to improve his ability to participate, as fully as possible in any act done for him and any decision affecting him.
>
> …
>
> (6) He must consider, so far as is reasonably ascertainable -
>
> (a) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity),
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> (b) the beliefs and values that would be likely to influence his decision if he had capacity, and
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> (c) the other factors that he would be likely to consider if he were able to do so.
>
> (7) He must take into account, if it is practicable and appropriate to consult them, the views of –
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> …
>
> (b) anyone engaged in caring for the person or interested in his welfare,
>
> …
>
> as to what would be in the person's best interests and, in particular, as to the matters mentioned in subsection (6). …"

13. When assessing best interests, I have to form an evaluative judgment where first and foremost I consider matters from the point of view of the protected party: *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67 at [45]. Welfare must be assessed in the widest sense, not merely medically but socially and psychologically also: ibid at [39].

14. Although there was consensus between all parties that it is in MD's best interests to undergo a full dental clearance, the court is the ultimate decision maker and must be independently satisfied on the evidence that such an invasive and permanent procedure

would be so. I am fully satisfied that the procedure would indeed be in MD's best interests. I am fully satisfied that if such the procedure were not carried out, there would be an unacceptably grave risk to MD's health and life. This is not a decision I have taken lightly, but the risks attendant upon inaction are simply too serious to ignore.

15. I am told that whilst proceedings have been afoot MD has voluntarily attended A&E on three occasions because of an acute crisis in his dental health. Ms. Lamble, whose oral evidence I heard, said that MD was in severe pain; was observed to have facial swelling; and was reported (by MD) as having internal swelling. MD did not want to be in pain and was compliant in taking the antibiotics prescribed to him.

16. At other times it is believed that he has invented ailments in order to obtain pain medication. Ms. Lamble told me frankly that on each occasion MD consistently stated that he did not consent to the removal of any of his teeth. It was her belief that what blocked him from providing consent was the pain he apprehended from such a procedure. This belief is vindicated by the discussions that Dr Camden-Smith has had with MD. In those discussions, MD has not indicated that his refusal is motivated by a wish to keep his teeth because of, for example, the wish to maintain bodily integrity or to sustain self-image. Of course, such a wish is to be expected and I do not take MD to be indifferent to such considerations. But what is clear from the discussions is that MD is predominantly motivated by the desire to avoid pain.

17. The difficulty for MD is that without intervention he will continue to experience severe recurring pain and infection. The short-term pain and discomfort of intervention will save him a lifetime of agony. It is precisely this sort of balancing analysis that MD is not able to undertake. However, if MD were to have a brief window of capacity, I am sure that he would consent to intervention as a necessary measure to avoid pain. I am specifically required by section 4(6)(b) Mental Capacity Act 2005 to ask myself this somewhat unreal, hypothetical question.

18. There are downsides associated with the proposed procedure. Not only are there the risks inherent in any operation such as the effect of general anaesthetic, but there is also the fact that MD's facial appearance may be altered, and his speech may be impacted. Also, it will limit the diet that MD can consume. However, I note that MD's normal diet is the same as for a person without teeth and therefore this would only have a limited impact on him.

19. I have stated above that what is in MD's best interests is informed not just by his physical health but also by his psychological and social health. This issue has rightly been raised on MD's behalf and a psychiatric report by Dr Camden-Smith was obtained. Dr Camden-Smith is clear that there is a risk that MD may feel betrayed by his care givers with whom he has built up a very trusting relationship. This is all the more so because of the covert nature of the plan. This risks the progress he has made and could trigger the re-emergence of paranoia and violence.

20. The disadvantages identified above need to be balanced against the grave risk to health and life if MD's dental health is allowed to deteriorate without intervention. The reality is that MD will continue to suffer pain and infections. Ms. Lamble was clear that if an infection were to lead to sepsis, she would not expect MD to survive: he is morbidly obese and not in good physical health. The stakes therefore could not be higher. Unfortunately, MD is not able to appreciate what sepsis is or what the risks of sepsis

are. I am nonetheless sure, if granted that brief window of lucidity, that he would want to avoid this outcome.

21. Plainly, there is a risk that a short-term consequence of the procedure is to downcast MD and to cause him to feel angry and betrayed. Ms Lamble told me in her oral evidence MD's carers are specialist in managing patients who have become withdrawn and isolated. She told me that due consideration has been given as to what to do should MD become mistrustful of them. Further, minimising the use of his caregivers in transporting him to the hospital should reduce his association of them with the intervention. In the future it is likely that MD will move from his current accommodation and therefore will be able to build fresh therapeutic relationships with new carers. At his present placement he has the best chance of being suitably treated should his mental health deteriorate compared to in a more independent setting.

22. For completeness I have considered whether a partial dental clearance would be in the best interests of MD. It is not a course of action urged upon me by any of the parties, but I am mindful that a full clearance in a drastic measure. Would an attempt to salvage any healthy teeth be a proportionate and less intrusive means of securing MD's best interests? I do not think so. The evidence all suggests that were a partial removal undertaken now the parties would find themselves back in court in a few years' time. The problem is that MD is unable to comply with elementary dental hygiene measures and is strongly resistant to any suggestion that he should do so. Any remaining teeth will soon enough decay and start to cause MD further pain. No doubt a similar application would have to be made, and, in all likelihood, an order made for MD to undergo the exact same procedure. I intend to save MD the further pain of decaying teeth and infection and the further pain of a second procedure.

23. There remains the issue of the covert nature of the plan and the authorisation to use chemical and physical restraint. On MD's behalf these elements of the plan have been probed. MD has said that he would resist going to hospital and would become physically resistant. As stated above MD has a history of violence, aggression and not cooperating. MD is a large adult male and if such circumstances were to arise, he would pose a risk to himself and to those around him. The report of Dr Camden-Smith is clear that there is no realistic alternative to covertly administered sedation.

24. I therefore conclude that it is in MD's best interests for the procedure to be undertaken covertly and that the use of chemical and physical restraint is in his best interests, if so required.

25. It follows from the above that I also approve of the amendment to the care plan to make provision of treatment in the event of a deterioration between now and the planned dated of the operation. The operation was originally provisionally scheduled for October 2020 but because of this litigation has been re-scheduled for January 2021. That is still some time away and there is a real risk that MD will experience another crisis between now and then. As stated above, there have already been three admissions to A&E during the currency of these proceedings.

26. For the reasons set out above I am entirely satisfied that it is in the best interests of MD to undergo a full dental clearance under the care plan as approved by the court. It is important that MD knows that the upmost scrutiny has been exercised in coming to this decision and the gist of this judgment should be explained to him so that he may

understand why this course of action has been taken. I hope that he can set aside any feelings of betrayal and understand that his caregivers sought this outcome, and the court acceded to it, because it was manifestly in his best interests.

27. That is my judgment.

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