Neutral Citation Number: [2020] EWHC 574 (Fam)

Case No: FD20F00009

IN THE HIGH COURT OF JUSTICE
FAMILY DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 11/03/2020

Before :

MRS JUSTICE LIEVEN

- -

Between :

(1) A HEALTHCARE
(2) B NHS TRUST

Applicants

and

CC
(by his litigation friend, the Official Solicitor)

Respondent

- -
- -

Ms Emma Sutton (instructed by **the in-house legal department for A Healthcare and Capsticks Solicitors LLP for B NHS Trust**) for the **Applicants**
Mr David Lock QC (instructed by **the Official Solicitor**) for the **Respondent**

Hearing dates: **20 February 2020**

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Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

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MRS JUSTICE LIEVEN

Mrs Justice Lieven DBE :

Introduction

1. This application concerns the Respondent, CC (**'CC'**), aged 34. CC has psychiatric diagnoses of psychotic depression and a mixed personality disorder with marked dissocial and dependent traits, he is deaf and communicates via British Sign Language. CC is detained under section 3 of the Mental Health Act 1983 (**'MHA 1983'**) on X Ward which is the medium secure ward for deaf men within A Healthcare (**'A Healthcare'**). The issue in the case is whether CC should be ordered to undergo haemodialysis at times when he does not consent to it.

2. CC was diagnosed with type 1 diabetes mellitus at the age of 15 and he suffers from complex physical health issues caused by his chronically poor compliance with the required diabetic treatment. CC's poor compliance has caused problems with his eyes, but more recently has resulted in renal failure requiring dialysis, and ultimately it is hoped a kidney transplant. It is clear that there is a complex interaction between CC's mental disorder and his physical condition and thus physical health needs.

3. CC's current non-compliance with dialysis treatment is thought by his responsible clinician, Dr H, to be a manifestation or symptom of his mental disorder. CC is described by Dr H as having ***'at best'*** fluctuating capacity to make decisions about dialysis treatment.

4. When CC is physically well, he understands that he needs dialysis and expresses a clear and consistent wish to live, but at times of crisis he will refuse dialysis and admission to Y General Hospital (**'B NHS Trust'**) for such treatment to be provided to him.

5. CC's responsible clinician at A Healthcare and the nephrology team at B NHS Trust (who oversee CC's dialysis care), as joint applicants, seek clarification from the Court that dialysis can be provided to CC under section 63 MHA 1983 as medical treatment within the meaning of section 145(4) MHA 1983.

6. The Applicants were represented before me by Ms Sutton of counsel, and CC through the Official Solicitor by Mr Lock QC. Mr Lock was instructed only shortly before the hearing and, as I explain below, he raised an issue which I considered required further submissions from both parties. I made the order sought under the inherent jurisdiction given the urgency of CC's medical treatment, but reserved judgement so that I could deal with both issues together in a reasoned judgment.

7. I heard evidence, briefly, from Dr H, a consultant psychiatrist, and Dr I, a consultant nephrologist.

The Issues

8. The following issues arise in the case;

    i) Whether CC can be treated under section 63 of the MHA; the renal failure and refusal to accept dialysis being said to be a manifestation of his mental disorder;

    ii) Whether section 63 cannot be relied upon by the Applicants because of section 58 MHA;

iii) Whether in any event CC can be given dialysis pursuant to the Mental Capacity Act 2005 ('MCA 2005') because he does not have capacity to make the relevant decision;

iv) If CC has fluctuating capacity, whether a declaration can still be made under the MCA 2005.

9. Use of section 63 MHA 1983 to authorise dialysis is not straightforward. Dialysis is a treatment for end stage renal failure and this would not normally be treatment to alleviate or prevent a worsening of, or to treat the consequences of, a mental disorder. However, Dr H considers that CC's need for dialysis is a consequence of his mental disorders.

10. A Healthcare and B NHS Trust have brought the matter to Court because Dr H accepts this is not a straightforward case, both because of the issue of whether the dialysis is a treatment to alleviate CC's mental disorder, but also because of his fluctuating capacity. Dr H seeks to ensure that he is acting lawfully and in CC's best interests due to the gravity of the decision.

11. The Applicants brought this matter to court in line with the guidance of Mr Justice Baker in A NHS Trust v A [2013] EWHC 2442 (Fam) at [80] that **'In cases of uncertainty where there is doubt as to whether the treatment falls within section 145 and section 63, the appropriate course is for an application to be made to the court'.**

CC's medical history

12. CC is originally from the Portsmouth area. He has 2 children from previous relationships and despite efforts of his Multi Disciplinary Team, and CC's expressed wishes, he does not have contact with either child. He does however enjoy the benefit of contact with his parents and extended family. His parents support him being given dialysis.

13. CC came to the attention of social services following concerns from his mother regarding the management of his diabetes and self-neglect. He was admitted to Queen Alexandra Hospital in Portsmouth in August 2014 due to complications of diabetes where he was assessed for admission into Bluebell Ward at Springfield Hospital.

Mental health

14. When CC started suffering from a deterioration in his mental health is unknown. The key dates can be summarised as follows:

24 Sep 2014	CC admitted informally to Bluebell Ward, Springfield Hospital, with a diagnosis of depression with psychotic features.
23 Mar 2015	CC detained under section 2 and then section 3 MHA 1983 at Springfield Hospital.
11 May 2015	CC admitted to X Ward, A Healthcare, where he has remained to date.

15. CC is therefore currently detained under section 3 MHA 1983.

16. Dr H characterises the symptoms of CC's mental disorders as follows:

> *'The symptoms of [CC]'s psychotic depression are that he has sustained periods of very low mood which are accompanied by psychotic symptoms including hands signing in free space (which is a Deaf equivalent of hearing voices in a hearing person) and receiving command hallucinations from his dead grandmother. He has also had persecutory beliefs that people are trying to kill him or his family. When he is depressed he very significantly neglects his own wellbeing including by refusing treatment for his physical health problems.*
>
> *The symptoms of [CC]'s personality disorder are that he finds it very difficult to control his emotions, particularly his anger, and his behaviour. This can lead to him becoming very easily agitated and very aggressive or abusive when he is agitated. He has significant difficulties in thinking through his actions and in particular accepting short term discomfort in order to achieve his long term goals. His personality disorder makes it exceptionally difficult for him to make any decision considering information other than the here and now. [CC]'s personality disorder leads to him depending very significantly on others to contain his distress and manage his problems for him. Historically this has been a dependence on his mother to do these things for him, and currently he projects this onto staff working with him as well as his family. [CC]'s personality disorder leads him to refuse treatment of his physical health problems as he is not able to weigh up the short term impact of having treatment that he does not immediately want, against his long term goal of staying alive'.*

17. Dr H further states that:

> *'[CC]'s risk to his own health is very significant. He has incredibly poorly controlled diabetes and is dependent on dialysis to stay alive. He actively undermines attempts to manage both of these conditions and regularly refuses treatment for them. He interferes with dialysis machines while he is undergoing dialysis and has turned off a dialysis machine while it was running which we have been advised could have led to his sudden death.*
>
> *[CC]'s understanding of his diabetes and how to manage it is very limited. Whilst on Bluebell Ward he would snack on sweets which he would conceal from staff resulting in his blood sugars being very variable. His diabetes control has been so poor for so long that he has significant physical sequalae of these including his poor eyesight, renal failure, and severe impairment to his mobility due to him developing an infection in a muscle in his leg which had to debrided …'*

18. CC continues to meet the criteria for detention under section 3 MHA 1983. In particular, Dr H notes that:

> *'The degree of [CC]'s personality disorder is that he is self neglecting to an extreme level currently which places him at imminent risk of death due*

> *to his refusal of dialysis and other lifesaving treatments on a regular basis. He is extremely argumentative and abusive towards staff. He is very impulsive and puts himself at serious risk of harm as a result such as when he has turned off a dialysis machine while he was having active dialysis at the time. He is very skilled at subverting security and does this to get immediate gratification regardless of the longer term harm he does to himself or other'*

Physical Health

19. CC was admitted to A Healthcare on 11 May 2015 and his physical health was a significant problem. His diabetes was unstable with regular instances of significant hypoglycaemia as well as ongoing problems with an infected wound on his head and a UTI. Throughout his admission at A Healthcare CC has complied poorly with the physical healthcare treatment.

20. On 26 March 2019, CC complained of chest pain and was transferred to B NHS Trust where he was found to be anaemic and was given a blood transfusion. He was advised that he was in renal failure and required a kidney transplant. CC commenced renal replacement therapy by haemodialysis on 30 May 2019.

21. Since May 2019 CC's compliance with dialysis has fluctuated significantly. There has been at least one occasion when he disconnected himself from the dialysis machine and a number of times he has refused to attend dialysis. In order to maintain a reasonably stable state CC needs to have dialysis three times a week for 4 hours on each occasion. In January 2020 his attendance for dialysis fell considerably.

22. Consideration has been given to move CC to peritoneal dialysis (PD). This is an operation that would allow the insertion of a catheter and then CC could have overnight dialysis which would be considerably less burdensome for him. A catheter was inserted on 24 December 2019 but unfortunately the exit site became infected, at least possibly through CC's very poor self-care. On 26 January 2020 CC sustained hyperkaleamic paralysis from very high potassium levels, which was a result of refusal to attend some dialysis sessions. His condition led to loss of ability to use his limbs and a serious risk of death.

23. A second PD catheter was inserted on 12 February 2020 and it is hoped and intended to commence PD dialysis on 9 March 2020. However, it is critical to CC's condition that haemodialysis continues, at an appropriate level, until the PD dialysis can commence otherwise CC will die.

24. CC requires 4 hours of dialysis 3 times a week (total of 12 hours), but despite agreeing to the necessary regime on 4 February 2020 he has since only accepted half the required amount (at best); namely 2 hours of treatment, 3 times a week (total of 6 hours). The likely cause of death if CC continues to refuse the necessary treatment would be hyperkalaemic cardiac arrest. The evidence was that if CC continued with the current sub-optimal level of dialysis he would probably die within 6 weeks.

25. In the past 9 ½ months of dialysis (from 30 May 2019 – 14 February 2020) only 56 of the 122 sessions were for the required 4 hours (46% compliance) and, most concerningly, from 9 November 2019 – 14 February 2020 only 2 of the 49 sessions

were for the required 4 hours (4% compliance). His compliance had improved somewhat in the days before the hearing, but Dr H was keen to stress that little reliance should be placed on this continuing.

26. Less than 4 hours of dialysis is not enough to achieve the toxin removal required in the absence of residual kidney function and this is reflected by the life-threatening episodes of raised potassium levels in CC's bloods which he has suffered. If CC refuses any treatment, the matter is even more urgent and he will die within 9-13 days.

27. The treating clinicians have drawn up a treatment plan to put in place if CC does refuse dialysis. This involves light restraint and, if necessary, sedation. The hope and intention is that this will only need to continue up to early March 2020 when PD can be commenced.

Capacity

28. An assessment regarding CC's capacity to conduct these proceedings was undertaken by Dr H on 18 February 2020 which concluded that he lacked capacity as he was unable to understand or retain the relevant information (section 3(1)(a)-(b) MCA 2005 applied) due to his personality disorder (section 2(1) MCA applied). In his report Dr H said;

> *'[CC] has had many assessments of his capacity to make decisions regarding dialysis. These have been undertaken by many clinicians including myself and his renal consultant [Dr P]. At best [CC] has fluctuating capacity; when he is mentally well and compliant with dialysis he has had capacitous discussions with [Dr P] in which he has been able to understand, retain, and weigh up the relevant information and communicate a decision. When this has happened he has consented to dialysis and engaged in appropriate discussions about future care planning such as his desire to switch to peritoneal dialysis.*
>
> *When [CC] is stressed or physically unwell, particularly if he has gone several days without dialysis he does not have capacity to make decisions about dialysis. When this happens he is unable to understand, retain, or weigh up the relevant information, and at times will refuse to communicate any decision. This includes when he becomes psychotic.*
>
> *In January 2020 [CC] capacitously asked that he be restrained in future if he lacks capacity and is refusing lifesaving treatment as he does not want to die and recognises that when he becomes ill or confused he does not accept treatment that he would accept when capacitous.*
>
> *Following extensive discussions between myself, [Dr P], the [X Ward] MDT, [CC], [CC]'s family, and [CC]'s IMHA, it is my opinion that it is in [CC]'s Best Interests to have dialysis, under restraint/sedation if it is necessary to prevent imminent death and he is refusing dialysis for as long as he is clear and consistent that he does not want to die. If he makes capacitous statements that he wants to die, or lacks capacity but is consistent in stating that he wants to die, his Best Interests need to be re-assessed.*

> *The purpose of ensuring that [CC] has dialysis, even if he is refusing it, is so that his long held desire to stay alive is met, and to enable him to stay alive long enough to receive a renal transplant which will very significantly improve the length and quality of his life'*

29. However, the team at A Healthcare think that CC has fluctuating capacity. Dr H's report said that when CC is stressed or physically unwell, particularly if he has gone several days without dialysis, he loses capacity to make decisions about dialysis (para 2.24). This illustrates the complicated interaction between CC's physical and mental state.

30. It is relevant in this regard that Mr Maguire, a solicitor at MJC Law acting on behalf of the Official Solicitor, went to see CC on 19 February 2020 (the day before the hearing). He produced an Attendance Note, which strongly suggested that CC (at that time) had a good understanding of the purpose of dialysis and the reasons for having it. He was asked about what would happen if the dialysis stopped and the Attendance Note says;

> *With some further discussion [CC] was also able to say that if he didn't continue to have dialysis he "... would, not could, would die". I asked him how he felt about that. He said "I don't want to die" and said that he was afraid of dying. I asked him how he thought his family would feel if he got poorly or died. [CC] said that they would be "... very upset ... devastated ... very sad" and that he would not want to cause them that hurt and so, if for that reason only, he would continue having dialysis. "100% it's my intention to carry on having dialysis" he said.*

31. CC was then asked about what would happen if he refused dialysis in the future, and he said;

> *He was reluctant to accept the possibility that he might refuse it but said that "... if I did, I won't but if I did, I would want to be restrained and have it given to me. I've said that before. It's the right thing. I've had discussions about it".*

32. It is also clear from the Attendance Note that CC does not wish to die, and he is not refusing dialysis in order to allow himself to die.

Issue One: The Mental Health Act 1983

33. The arguments on the first issue turn on the interaction between the following sections;

Section 63

> *The consent of a patient shall not be required for any medical treatment given to him for the mental disorder from which he is suffering, not being a form of treatment to which section 57, 58 or 58A above applies, if the treatment is given by or under the direction of the approved clinician in charge of the treatment.*

Section 145(4)

> *(4) Any reference in this Act to medical treatment, in relation to mental disorder, shall be construed as a reference to medical treatment the*

purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations.

Section 58(1)(b) and (3)

(1) This section applies to the following forms of medical treatment for mental disorder—

…

(b) the administration of medicine to a patient by any means (not being a form of treatment specified under paragraph (a) above or section 57 above [or section 58A(1)(b) below]1) at any time during a period for which he is liable to be detained as a patient to whom this Part of this Act applies if three months or more have elapsed since the first occasion in that period when medicine was administered to him by any means for his mental disorder.

…

(3) Subject to section 62 below, a patient shall not be given any form of treatment to which this section applies unless—

(a) he has consented to that treatment and either the [approved clinician in charge of it] or a registered medical practitioner appointed for the purposes of this Part of this Act by the regulatory authority has certified in writing that the patient is capable of understanding its nature, purpose and likely effects and has consented to it; or

(b) a registered medical practitioner appointed as aforesaid (not being the responsible clinician or the approved clinician in charge of the treatment in question) has certified in writing that the patient is not capable of understanding the nature, purpose and likely effects of that treatment or being so capable has not consented to it but that [it is appropriate for the treatment to be given].

Section 62(1)

62.— Urgent treatment.

(1) Sections 57 and 58 above shall not apply to any treatment—

(a) which is immediately necessary to save the patient's life; or

(b) which (not being irreversible) is immediately necessary to prevent a serious deterioration of his condition; or

(c) which (not being irreversible or hazardous) is immediately necessary to alleviate serious suffering by the patient; or

> *(d) which (not being irreversible or hazardous) is immediately necessary and represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to himself or to others.*

34. There are two arguments raised by Mr Lock about whether or not the dialysis can be provided under section 63. The first turns on whether the dialysis is medical treatment, the purpose of which is to alleviate or prevent a worsening of a manifestation of the mental disorder (i.e. the wording of section 145(4)). This issue has been considered in a series of cases and I recently summarised the caselaw in *JK v A Local Health Board* [2019] EWHC 67 (Fam). I will simply set out that summary here;

> *45.In B v Croydon Health Authority [1995] 1 ALL ER 683 it was held by the Court of Appeal that the feeding by nasogastric tube of a patient who was suffering from borderline personality disorder was treatment which fell within the scope of section 63 MHA 1983 because such treatment was aimed at treating a symptom of the disorder which was a compulsion to self harm. Therefore, the basic proposition that force feeding can be treatment within the meaning of s.63 is established, and not in issue.*
>
> *46.In R v Collins ex p ISB [2000] Lloyd's Rep. Med. 355 , Mr Justice Maurice Kay was considering an application for judicial review by Ian Brady, challenging a decision by the clinicians at Ashworth Hospital to force feed him. Mr Brady had been diagnosed as having a psychopathic disorder and had decided to refuse food in part as a protest against events in Ashworth. The Judge's conclusion is at [44];*
>
> *'On any view, and to a high degree of probability, section 63 was triggered because what arose was the need for medical treatment for the mental disorder from which the Applicant was and is suffering. The hunger strike is a manifestation or symptom of the personality disorder. The fact (if such it be) that a person without mental disorder could reach the same decision on a rational basis in similar circumstances does not avail the Applicant because he reached and persists in his decision because of his personality disorder'.*
>
> *47.A similar issue arose before Baker J in A NHS Trust v Dr A [2014] Fam 161 . In that case the patient had been diagnosed as suffering from a delusional disorder and was refusing to eat, at least in part in protest about being placed in immigration detention. He was found under the MCA not to have capacity and had been detained under s.3 of the MHA . The Judge found, when considering the MCA , that it was in A's best interests to force feed him, but there was a significant problem in determining by what power the Court could so order. The Judge considered s.63 but found that its terms were not met. He said at [79] that he;*
>
> *'found the views articulated by the treating clinicians, and in particular Dr. WJ, persuasive. She does not consider that the administration of artificial nutrition and hydration to Dr. A. in the circumstances of this case to be a medical treatment for his mental disorder, but rather for a physical disorder that arises from his decision to refuse food. That*

> *decision is, of course, flawed in part because his mental disorder deprives him of the capacity to use and weigh information relevant to the decision. The physical disorder is thus in part a consequence of his mental disorder, but, in my judgement, it is not obviously either a manifestation or a symptom of the mental disorder. This case is thus distinguishable from both the Croydon case and Brady'.*
>
> *48.The Judge went on to hold that A could not be force fed under the MCA , even though he did not have capacity, because the MHA had primacy over the MCA when a person is detained in hospital under the hospital treatment regime. Baker J however, went on to find that the Health Board could be authorised to force feed A pursuant to the inherent jurisdiction, because there was a lacuna in the statutory schemes, between the MCA and MHA on the facts of the case, and Dr A was a vulnerable person.*
>
> *49.In Nottinghamshire Healthcare NHS Trust v RC [2014] EWCOP 1317 Mostyn J observed at paragraph 24 that the extent to which a condition is within the ambit of section 63 read with section 145 can be difficult to ascertain:*
>
> *"The cases have drawn a distinction between a condition which is, on the one hand, a consequence of the disorder, and, on other hand, a condition which is a symptom or manifestation of it. The former is not within section 63 , the latter is. I confess to finding the distinction intellectually challenging. At all events a wide (but not always consistent) interpretation has been given to section 145(4) . Thus the decision to force-feed Ian Brady was held to be within section 63 . His hunger strike, ostensibly in protest at the decision to move him to another ward, was held to be a manifestation or symptom of his very profound personality disorder (he was additionally found to be incapacitated): see Ex parte Brady [2000] Lloyd's Rep Med 355 . In B v Croydon Health Authority [1995] Fam 133 the court declared that it was lawful to force-feed a patient who would otherwise die from self-starvation which was the result of her borderline personality disorder. By contrast in A NHS Trust v Dr A [2014] 2 WLR 607 a hunger strike by a detained Iranian doctor protesting about the impoundment of his passport was held to be not a manifestation or symptom of his mental disorder. In Tameside and Glossop Acute Services v CH [1996] 1 FLR 762 it was held that section 63 could be used to restrain a patient to enforce a Caesarean section upon her; while in St George's Healthcare NHS Trust v S the opposite conclusion was reached."*

35. Mr Lock argues that the treatment proposed, dialysis, is not treatment for a manifestation of CC's mental disorder. Ms Sutton on the basis of the caselaw set out above and Dr H's evidence, argues that the dialysis is treatment to alleviate one of the manifestations of CC's mental disorder.

36. In my view this is a clear case of the treatment proposed, the dialysis, treating a manifestation of the mental disorder, namely personality disorder. The need for dialysis stems from CC's self-neglect, including in regard to diet, which has led in whole or in part to his kidney failure. The reason his diabetes has resulted in kidney failure is to a

large extent because of that self-neglect, which is itself a consequence of his mental disorder. Mr Lock argued that the primary cause of the condition which required the treatment must be the mental disorder. As with any mental disorder or mental illness and its link to physical ill-health, causation and the link between the mental and physical condition is intensely complex and not really amenable to a primary cause analysis. However, it seems to me clear that the physical condition CC is now in, by which dialysis is critical to keep him alive, is properly described as a manifestation of his mental disorder. There is a very real prospect that if he was not mentally ill he would self care in a way that would have not led to the need for dialysis. Further, that CC is refusing dialysis is very obviously a manifestation of his mental disorder. When he is mentally well he agrees to dialysis. His situation is therefore highly analogous with that of the force feeding cases.

37. Mr Lock argues that for section 63 to apply, the primary purpose of the treatment must be to treat the mental disorder. He takes this from section 145(4) which refers to the "purpose" being to treat the disorder. However, I do not think that one can take from the words of section 145(4) a need to analyse a hierarchy of potential purposes of the treatment or causative links. It is in my view sufficient that a purpose of the proposed treatment is to alleviate a manifestation of the mental disorder. There is no suggestion in any of the caselaw that I have referred to above that the Court (or a clinician) has to go through the type of exercise Mr Lock proposes. It is therefore sufficient that the renal failure is a manifestation of the mental disorder.

38. However, this then brings one to the second argument on the power under section 63. Mr Lock argues that section 63 excludes treatment that falls within section 58. Section 58 covers the administration of medicine and it is accepted that the provision of any form of sedation would be medicine within section 58, even though Mr Lock agrees that the dialysis itself would not fall within the definition. The other conditions within section 58(1) are met.

39. He then goes on to argue that this means that under section 58(3) either the patient must consent to the medical treatment or the clinician must follow the procedure under section 58(3)(b) and (4), which includes the requirement to consult two other persons, one of whom is known as the second opinion doctor (SOAD).

40. Mr Lock relies on R (B) v S [2006] 1 WLR 810 where at [46] Lord Phillips said;

> *The MHA makes lawful further interference with Article 8 rights in permitting treatment without consent. As Baroness Hale pointed out in B v Ashworth, until 1983 the legislation dealt expressly only with the right to detain for treatment, taking it for granted that it would be lawful compulsorily to treat those detained. Part IV of the MHA now deals expressly with the power compulsorily to treat where that is the object of the detention. A distinction is drawn between the most invasive treatment, which can only be administered with the capacitated consent of the patient (section 57), medical treatment for mental disorder, which requires capacitated consent or the opinions of two medical officers that the treatment should be given having regard to the likelihood that it will alleviate or prevent a deterioration of the patient's condition (section 58) and other medical treatment for the patient's mental condition, which can be administered without consent (section 63).*

41. Mr Lock therefore argues that section 63 is inapplicable in this case, and the correct route for the Trust to go down is section 58 and the SOAD.

42. The whole issue of section 58 only came up just before the hearing, and I therefore gave both parties permission to file additional submissions in writing on the point. Ms Sutton in her written submissions argues that section 58 has no relevance in a case such as this. She points out that by section 62, section 58 is expressly excluded from cases where the treatment is immediately necessary to save life or to prevent serious deterioration of the patient's condition. She says that the evidence shows beyond any doubt that the treatment is urgently needed and meets the section 62 threshold.

43. Further she argues that Mr Lock accepts that the dialysis itself does not fall within section 58 because it does not involve the giving of medicine. To the degree that Mr Lock is relying on the sedative (midazolam) as being medicine that is not being used to treat the mental disorder but rather to facilitate the treatment plan. The Trust would be in an unworkable situation by which part of the proposed treatment plan (the dialysis), would go by way of section 63 and another part (the sedation) would be under section 58. I note that this would also be the case with force feeding cases, which is the subject matter of much of the caselaw, because the feeding itself would not fall under section 58 but any sedation given would. It will often if not always be the case that any force feeding treatment plan will include the prospect of sedation. Therefore, Ms Sutton argues that in practice, section 63 would become largely if not wholly unworkable.

44. Finally, she argues that Mr Lock's argument is contrary to binding authority. In B v Croydon Health Authority [1995] 1 All ER 863 the Court of Appeal was dealing with an argument about whether force feeding, via a nasal gastric tube, was treatment within section 63. The Court of Appeal found that it was treatment that fell within section 145 and therefore section 63. Ms Sutton relies on two passages in particular. Hoffman LJ at p.138E-G;

> *This is a powerful submission. But I have come to the conclusion that it is too atomistic. It requires every individual element of the treatment being given to the patient to be directed to his mental condition. But in my view this test applies only to the treatment as a whole. Section 145(1) gives a wide definition to the term "medical treatment." It includes "nursing, and also includes care, habilitation and rehabilitation under medical supervision." So a range of acts ancillary to the core treatment fall within the definition. I accept that by virtue of section 3(2)(b) a patient with a psychopathic disorder cannot be detained unless the proposed treatment, taken as a whole, is "likely to alleviate or prevent a deterioration of his condition." In my view, contrary to the submission of Mr. Francis, "condition" in this paragraph means the mental disorder on grounds of which the application for his admission and detention has been made. It follows that if there was no proposed treatment for Ms. B.'s psychopathic disorder, section 63 could not have been invoked to justify feeding her by nasogastric tube. Indeed, it would not be lawful to detain her at all.*

And Neil LJ, who agreed with Hoffman LJ added;

> *I am satisfied that the words in section 63 of the Mental Health Act 1983 "any medical treatment given to him for the mental disorder from which*

> *he is suffering" include treatment given to alleviate the symptoms of the disorder as well as treatment to remedy its underlying cause. In the first place it seems to me that it would often be difficult in practice for those treating a patient to draw a clear distinction between procedures or parts of procedures which were designed to treat the disorder itself and those procedures or parts which were designed to treat its symptoms and sequelae. In my view the medical treatment has to be looked at as a whole, and this approach is reinforced by the wide definition of "medical treatment" in section 145(1) as including "nursing" and also "care, habilitation and rehabilitation under medical supervision."*
>
> *In the second place I too find support for this construction of "medical treatment" in section 63 in the provisions relating to urgent treatment in section 62. Section 57 of the Act of 1983, which is concerned primarily with medical treatment which involves surgery on brain tissue, contains detailed provisions for the steps which have to be taken before such treatment can be administered. Similarly section 58 which is concerned with other specified forms of treatment and with the administration of medicine where the medicine has been administered for a period in excess of three months, contains provisions for the steps to be taken before the treatment is given or continued as the case may be. It is against this background that one turns to section 62 which provides:*
>
> *"(1) Sections 57 and 58 above shall not apply to any treatment - (a) which is immediately necessary to save the patient's life; or . . . (c) which (not being irreversible or hazardous) is immediately necessary to alleviate serious suffering by the patient; or (d) which (not being irreversible or hazardous) is immediately necessary and represents the minimum of interference necessary to prevent the patient from behaving violently or being a danger to himself or to others."*
>
> *It seems to me to be clear that section 62 contemplates treatment which is designed to deal with the symptoms of the disorder rather than the disorder itself. It follows therefore that as section 62 excepts urgent treatment from the regimes imposed by sections 57 and 58 medical treatment in those sections includes treatment of symptoms as well as of causes".*

45. I raised with Mr Lock that if he was correct it would appear that a number of the previous decisions on section 63 must have been wrongly decided, because they would have involved, to a greater or lesser degree, the giving of medication. These cases include A NHS Trust v A [2013] EWHC 2442 (COP) where Baker J was considering the force feeding of an asylum seeker who was detained under section 3 MHA 1983. In that case, the Official Solicitor had submitted at [73] that *Croydon, Brady, and Tameside* (previous cases on the use of section 63) *'taken together are authority for the proposition that the necessary feeding and associated measures in this case can be taken under the MHA'*. The associated measures must have included sedation as needed. Mr Lock argued that the issue of section 58 was not addressed in those cases, and that it is not clear the degree to which the treatment in question would have required medication. It may be that in some of these cases the question of the use of section 58 rather than section 63 was not raised, but it is apparent from the passage of Neil LJ in

B which I have set out above, that this was a live issue in that case and the Court of Appeal found that section 63 did apply.

46. In my view, on this second issue under the MHA 1983 Mr Lock's arguments are wrong and section 63 is the appropriate course. There is no doubt that in this case, as in most if not all the previous authorities, the treatment being proposed under section 63 is urgent, and in all those cases life-saving. The proposed dialysis for CC is plainly extremely urgent, and without it he will undoubtedly die. In those circumstances in my view the case plainly falls within section 62(1)(a) (b) and (c) and as such section 58 is excluded. In particular, in urgent treatment cases such as this, treatment is immediately necessary to save CC's life, to prevent a serious deterioration of his condition and to alleviate serious suffering.

47. I also accept on the facts that Mr Lock's analysis would make section 63 largely, if not wholly redundant, because in most if not all cases where section 63 is relied upon, the treatment will involve some use of medication, often sedation. It makes no sense of the statute for sedation to be dealt with under one statutory route and other forms of treatment to be dealt with by a wholly different one.

48. I do accept Mr Lock's point that considerable care needs to be taken in the use of section 63 if it is not to become a way of treating detained mental patients, with or without capacity, without their consent. However, the safeguard that is in place is the requirement set out by Baker J in NHS Trust v A at [80] that in cases of uncertainty, the appropriate course is to apply to the Court.

Issue Two: Mental Capacity Act 2005

49. The alternative basis upon which A Healthcare and B NHS Trust put their case is that CC has fluctuating capacity to consent to dialysis and the Court should make a contingent declaration pursuant to section 15(1)(c) MCA 2005 that it is lawful to treat CC in accordance with the proposed dialysis treatment plan in the event that he lacks capacity to make the relevant decision.

50. I have no doubt on the evidence that CC does have fluctuating capacity. Mr Maguire's statement and Attendance Note indicates strongly that when Mr Maguire saw CC on 19 February 2020 he understood the benefits of dialysis and understood the consequences of not having it, i.e. that he would die. He could understand and process the information and the Attendance Note points clearly to CC having capacity on that day.

51. However, the evidence both from Dr H and Dr I points equally clearly to a conclusion that when CC is agitated or upset and starts to refuse dialysis, his mental state becomes very poor, and when he refuses dialysis, he does not have capacity. I emphasise that this is not a case of CC simply making a poor decision with which the Court and the health professionals do not agree. Mr Maguire's Attendance Note and Dr H's evidence are both clear, that when well CC does not wish to die and wishes to have dialysis. His change of position is a function of his mental state worsening, and that in turn is a function at least in part of him refusing dialysis. I therefore find that when CC refuses dialysis he does lack capacity.

52. It is not possible or practical for A Healthcare and / or B NHS Trust to come to Court at each point when CC has lost capacity to seek a declaration that giving him dialysis,

and if necessary restraining him, is lawful. His mental state appears to fluctuate sufficiently rapidly for this not to be practicable. It is also the case that depending on the amount of dialysis he has had in the previous period, any delay could be extremely detrimental, if not fatal to him.

53. In those circumstances A Healthcare and B NHS Trust ask that I make a contingent declaration. The Applicants rely on the recent decision of Hayden J in GSTT and SLAM v R [2020] EWCOP 4. In that case Hayden J was dealing with woman who was 39 weeks pregnant, and at the time of the hearing had capacity in relation to her obstetric care. She was adamant that she did not want a caesarean section. However, she suffered from bipolar disorder and was detained under section 3 MHA 1983. With considerable reluctance Hayden J made a declaration under section 15 MCA 2005 that if the woman lost capacity it was lawful for the Trust to deliver her obstetric care even if it did not accord with her clearly stated, and at the point of the application, capacitous wishes.

54. Hayden J was very careful to explain that he was only making this type of contingent declaration because of the particular facts of the case, see [57]. In particular, he pointed out that women did quite frequently change their view on what obstetric interventions they wished for once labour began. But because the woman here would not have that opportunity, because she was likely to lose capacity, the judge needed to ensure that her range of obstetric options were not closed down when she went into labour. It was in those circumstances that he was prepared to make the contingent declaration under section 15 MCA 2005.

55. In some ways this case is more straightforward. CC currently has capacity and is clear that he wants to have dialysis; that he does not want to die; and that he wishes to continue to have dialysis if he loses capacity. This is therefore in practice akin to an advance decision under section 24 MCA 2005, albeit that he has not gone through the formal processes of an advance decision contained in section 25 MCA 2005 and it is an advance decision to accept treatment not refuse it. It is in those circumstances relatively easy to declare that if CC loses capacity in respect of a decision about dialysis, then it is in his best interests to have dialysis in accordance with the care and treatment plan proposed. Such a declaration undoubtedly accords with CC's wishes and feelings, both because he has said so when he has capacity, but also because he is clear that he wants to live, and if he does not have dialysis then at some point he will die very prematurely.

56. By reason of the above, the Court finds that:

i. The physical condition CC is now in, by which dialysis is critical to keep him alive, is properly described as a manifestation of his mental disorder. There is a very real prospect that if he was not mentally ill he would self-care in a way that would have not led to the need for dialysis. Further, CC's refusal of dialysis is very obviously a manifestation of his mental disorder and dialysis treatment is therefore treatment within the scope of section 63 MHA 1983.

ii. CC's capacity to consent to dialysis treatment fluctuates, however his consent is not required in order to be treated, by way of dialysis treatment, under section 63 MHA 1983.

iii. The decision whether it is in CC's best interests to receive dialysis treatment is a matter for CC's responsible clinician (having consulted clinicians attending to his

physical health, including the consultant nephrologist), subject to the supervisory jurisdiction of the Court.

iv. Section 58 has no applicability. Section 62 disapplies section 58 in urgent treatment cases such as this where treatment is immediately necessary to save CC's life, to prevent a serious deterioration of his condition, and to alleviate serious suffering. Section 63 is the appropriate course.

v. As section 63 MHA 1983 can be used as authority to provide medical treatment to CC, including by dialysis treatment and by the use of light physical restraint and chemical restraint (if required), it is unnecessary for the court to exercise its discretion and make a contingent declaration pursuant to section 15(1)(c) MCA 2005 that it is lawful to treat CC in accordance with the proposed dialysis treatment plan in the event that he lacks capacity to make a decision regarding dialysis treatment at the relevant time.