Neutral Citation No: [2023] NIFam 15 *Judgment: approved by the court for handing down (subject to editorial corrections)**	*Ref:* **SIM12319** *ICOS No:* **DECLAR0050** *Delivered:* **10/11/2023**

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

_____

FAMLY DIVISION
OFFICE OF CARE AND PROTECTION

_____

IN THE MATTER OF A PATIENT

Between:

A HEALTH & SOCIAL CARE TRUST

Plaintiff

-and-

A PATIENT
and
THE OFFICIAL SOLICITOR FOR THE COURT OF JUDICATURE IN NORTHERN IRELAND

Defendants

_____

Finbar Lavery (instructed by Directorate of Legal Services) for the Plaintiff
Sinead O'Flaherty (instructed by the Official Solicitor) for the first Defendant

_____

SIMPSON J

Introduction

[1] This application has been brought by Belfast Health and Social Care Trust for a declaration that doctors may lawfully carry out medical treatment on the first defendant ("the patient") who is under the care of doctors employed by the Trust. The Official Solicitor is named as the second defendant in the summons.

[2] The application invokes the court's inherent jurisdiction.

[3] I have anonymised the name of the patient so as to protect his identity.

[4] The Schedule to the originating summons identifies the declaratory relief sought in the following terms:

> "The medical practitioners responsible for [the patient's] care shall be permitted the following with respect to him:
>
> 1. The administration of all necessary anaesthesia.
>
> 2. The performance of surgery to the left leg and in particular the amputation of the left leg below the knee.
>
> 3. The administration of all such post-operative care as may be considered necessary including all such dressings, medication and antibiotics as shall be considered appropriate and in his best interests."

[5] Due to the urgency of this matter the summons also seeks an order abridging time for service of the summons.

[6] The patient's health background is explained in some detail in paras 4 and 5 of an affidavit grounding the application.

> "4. The patient has a complex medical history. The patient has a history of Type 1 diabetes, atrial fibrillation, mild atrial stenosis and hypotension. The patient's main concern at present though is that he has a diabetic foot ulcer on his left lateral heel. The patient was admitted to hospital on the 9th August 2023 and since then received various forms of treatment including intravenous antibiotics, larvae therapy and surgical debridement. The patient was then discharged home on the 23rd August 2023. The patient then had to be re-admitted following an Outpatient Clinic appointment on the 28th September 2018 due again to his left lateral foot ulcer. Since that time the patient has had debridement of his left foot performed on the 7th October 2023. He has received intravenous antibiotics and has had larvae therapy. On the 13th October 2023 the possibility of amputation was discussed but when the patient was being planned for surgery on the 17th October 2023 it became apparent that there were issues in relation to his capacity and the plan was then for psychiatric assessment to take place. The patient was seen by a member of the Mental Capacity Act Team and was deemed to lack capacity.
>
> 5. The patient has a history of heavy alcohol use. On the 13th July 2016, the patient had a fall whilst intoxicated and then had a CT scan of his brain. In August 2018, the

> patient sustained a traumatic brain injury (TBI) whilst intoxicated and was admitted to [hospital] from the 26th August 2018 until the 12th September 2018. Imaging demonstrated a brain hemorrhage and skull fracture and the patient was later referred to the Community Brain Injury Team on discharge. The injury affected the patient in terms of cognitive function and mobility."

Vascular surgical opinion

[7] There is available to me a medical report, dated 6 November 2023, from the Consultant Vascular Surgeon responsible for the treatment of the patient, Mr Abubakr Ahmed. He has expressed the opinion that the patient requires a left below knee amputation to remove the necrotic foot and to prevent further spreading of infection "which can lead to overwhelming sepsis (systemic infection) and death."

[8] Depending on the court's decision, it is intended that the surgery will be carried out "within the next few days." The report also identifies the anticipated post-operative treatment if the surgery is uneventful.

[9] Dealing with the risks associated with the operative treatment, the surgeon says:

> "Due to the occlusive arterial disease shown on ultrasound duplex scan, a below knee amputation carries a moderate risk of non-healing of wound (~20%). There are also other common complications associated with amputation in diabetic patients. These include anaesthetic risks, peri-operative cardiac events (myocardial infarction, cardiac arrhythmias, 10-20% risk), chest infection, thrombo-embolism, wound bleeding and infection. Long-term complications include phantom pain, poor mobility and functional dependency."

[10] However, he is of the opinion that:

> "without an amputation, it is inevitable that he will develop further cellulitis (soft tissue infection) with necrosis in the leg with more tissue loss and potentially life-threatening sepsis."

Anaesthetic opinion

[11] A report from a Consultant Anesthetist, Dr Nilay Mankad, identifies the options for anaesthetic for the surgery: either a general anaesthetic or a spinal

anaesthetic. He sets out the precise mechanism of each anaesthetic procedure and describes the risks associated with both, in the following terms:

"**Risks of General Anesthesia**

Very common risks (1 in 10)

- Nausea and Vomiting
- Sore throat – Thirst
- Temporary Memory Loss (increased risk over 60's)

Common Risk (1 in 10 – 1 in 100) - Pain at the injection site

- Minor tongue or lip injury
- Uncommon (1 in 100 – 1 in 1000)
- Minor nerve injury

Rare (1 in 1000 – 1 in 10,000)

- Permanent peripheral nerve damage (1 in 1000)
- Corneal abrasion (1 in 2,800)
- Dental Damage (1 in 4500)
- Anaphylaxis (1 in 10,000)

Very rare (1 in 10,000 to 1 in 100,000)

- Accident awareness under General Anaesthesia (1 in 20,000)
- Permanent loss in vision (1 in 100,000)
- Death as a direct result of anaesthesia (1 in 100,000)

Risks of spinal anaesthesia

Very common and common

- Low blood pressure (easily treated with medication)
- Difficulty passing urine (a temporary urinary catheter will be inserted to drain the bladder, this is usually removed the following day)
- Headache (occurs in approximately 1 in 500)

Rare complications

- Nerve damage (altered sensation, pins and needles or muscle weakness)
- This occurs rarely but if it occurs usually resolves within a few weeks (1 in 10,000), the risk of permanent damage is approximately 1 in 50,000.

These risks above are generalised for healthy patients undergoing surgery. When considering anaesthesia and surgery for patients with multiple medical problems undergoing major surgery prediction of risk is more difficult.

The factors which influence risk of a major complication (heart attack/heart failure, chest infection, kidney impairment, stroke, delirium) or death will include anaesthetic and surgical factors, the patients' medical history, and their physiological condition at time of surgery. These factors will all interact with each other and can be difficult to separate. Therefore, it is difficult in these cases to quantify an exact anaesthetic risk for each individual patient. Instead, all factors must be evaluated together to consider a patient's overall risk of major complication (morbidity) and death (mortality)."

[12] In relation specifically to the patient Dr Mankad says:

"… there are many factors which will contribute to his perioperative risk. These include his medical history of poorly controlled diabetes, alcohol excess and previous traumatic brain injury, as well as his current impairment to his kidney function. He is also anaemic, which is a recognised risk factor for worse outcome after major operation. He has been hospitalised for the past 6 weeks means there will be an overall deterioration in his physical condition which will hamper his ability to recover from an operation."

[13] Although the actual choice of anaesthetic procedure will be made by the anaesthetist present on the day of surgery, Dr Mankad's view is that the patient would probably benefit from spinal anaesthesia rather than a general anaesthetic.

[14] He concludes his report, thus:

"Proceeding with the surgery does put [the patient] at risk of morbidity and mortality as outlined above. However, if the option is taken not to proceed with

> surgery, progression of the infection and spread to the rest of the body represents a higher risk of morbidity and mortality. Overall, I think [the patient] would benefit from proceeding with the planned Below Knee Amputation."

[15] From the medical evidence available to me it is clear that the surgery planned by the medical staff is necessary for the present and future health of the patient and, notwithstanding the identified risks associated with surgery and anaesthetic, provides the potential for a better outcome for the patient that would the option of doing nothing. It is clearly, therefore, in the patient's best interests.

Capacity

[16] Every person's body is inviolate and in almost all circumstances it is both a crime and a tort to perform invasive surgery on a patient without the consent of that patient — *Collins v Wilcock* [1984] 1 WLR 1172, 1177; *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1, 11 (Court of Appeal), 72 (House of Lords).

[17] A mentally competent patient has an absolute right to refuse such treatment for any reason, however irrational, and whether or not such a refusal will significantly compromise the patient's health, or even life — *Re T (An Adult) (Consent to Medical Treatment)* [1993] Fam 95, 102.

[18] Every adult is presumed to have the mental capacity to make such a decision, but that presumption is rebuttable — *Re T* at 112.

[19] In *Re MB* [1997] EWCA Civ 3093 Butler-Sloss LJ considered the issue of capacity. At para [30] she said:

> "A person lacks capacity if some impairment or disturbance of mental functioning renders the person unable to make a decision whether to consent to or to refuse treatment. That inability to make a decision will occur when —
>
> (a) the patient is unable to comprehend and retain the information which is material to the decision, especially as to the likely consequences of having or not having the treatment in question.
>
> (b) the patient is unable to use the information and weigh it in the balance as part of the process of arriving at the decision…"

[20] With that guidance in mind, I turn to consider the issue of capacity in this case.

The evidence on the issue of capacity

[21] I was provided with a report, dated 29 October 2023, from Dr Grainne Donaghy Consultant Psychiatrist, who is a Consultant in Liaison Psychiatry in the Belfast Trust. She explains that 'Liaison' is the sub-specialty of psychiatry which deals with patients who require psychiatric assessment/management while in the general hospital.

[22] She was specifically asked to assess the patient and "to provide an opinion on his capacity with regards to consenting to a below knee amputation." Before providing the report Dr Donaghy had discussions with the treating physicians and with nursing staff on the ward. She also had access to his medical notes from his admission to [hospital], and she reviewed information available on the Northern Ireland Electronic Care Record and electronic psychiatric records for the Trust. In addition, she discussed the matter with the patient's partner and their daughter, noting that both were desirous that the patient would get the treatment proposed by the treating physicians.

[23] Dr Donaghy records, inter alia, that the patient was referred to the Community Brain Injury Team ("CBIT") following his sustaining the traumatic brain injury in August 2018. Following his discharge, he was re-referred in 2021 following family concerns about his worsening cognitive impairment. She records that the correspondence from the CBIT:

> "noted that his heavy alcohol use had also impacted on his cognition and there was a degree of alcohol related brain damage. They did not feel he would benefit from further rehabilitation and commented that he would likely need life-long support."

[24] Following her interview with the patient Dr Donaghy stated that he "did not demonstrate a clear understanding of the proposed treatment." Having discussed with him, as best she could, the treatment and the likely risks associated both with the proposed treatment and absent the proposed treatment, she stated that she did not "believe [the patient] is able to therefore appropriately weigh up the risks and benefits of this procedure in order to make his decision."

[25] Her summary was expressed in the following terms:

> "It is my opinion that, on the balance of probabilities, at the time of my review [the patient] lacks the capacity to make a decision regarding a left below knee amputation. I base this on the fact that his mind is impaired through

> an acquired brain injury, alongside a likely degree of alcohol related brain damage. He was unable to demonstrate adequate understanding of the proposed procedure, retention of the relevant information with regards the procedure and potential risks and benefits, or the ability to weigh up his decision-making process."

The involvement of the Official Solicitor

[26] I am grateful to Ms Emma Liddy, Solicitor for the Official Solicitor, for her involvement in this case and for clearing her diary so as to take the time and make the effort to meet the patient and to discuss the issues with his immediate family and one of the nurses caring for the patient.

[27] She met the patient on 8 November and discussed the proposed treatment with him. Following her discussion with him, and having considered carefully Dr Donaghy's report, she is satisfied that the patient "does not have capacity to consent to the proposed surgery and treatment plan." Although he expressed agreement to the treatment — "If it has to go, it has to go" — and apparent understanding that the outcome would not be good if surgery did not take place, Ms Liddy states:

> "Notwithstanding [the patient's] attitude to the proposed treatment, I do not believe [he] has any understanding or the ability to retain information regarding the risks of surgery/anaesthesia or what complications may arise post-surgery."

[28] She also took the opportunity to discuss the matter, by telephone, with the patient's partner and his daughter. She records that both "very much support this procedure taking place." She also notes that they are currently seeking assistance from the Northern Ireland Housing Executive to obtain a suitable property with a view to the patient moving in with them following his discharge from hospital. They also indicated that the patient is due to be assigned a social worker when discharged.

[29] She concludes her report by stating that "it is therefore necessary and proportionate for the court to consider all of the evidence to determine what action may or may not be taken in his best interests" and that it is her "respectful position that on balance the procedure is necessary and in the best interests of the patient."

Conclusion

[30] In light of all the evidence I am satisfied that the patient lacks capacity to make an informed decision about the proposed treatment. I am further satisfied

from the medical evidence that the proposed treatment is both necessary and in the best interests of the patient.

[31] I have considered also the patient's rights under article 8 of the ECHR and I consider that the treatment proposed is a proportionate response to his medical problems.

[32] Accordingly, I grant the declaratory relief sought in the originating summons and I approve the draft order helpfully prepared in advance of the hearing.

[33] Finally, I record my thanks to the medical personnel involved for the clear and balanced reports provided to the court, and for taking the time out of busy medical schedules to provide urgent reports for the benefit of the court.