Neutral Citation Number: [2023] EWCOP 50

Case No: COP14152696

IN COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 6 November 2023

Before:

Mr Justice Poole

- -

Re GH (Mastectomy: Best Interests: Costs)

Between:

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST — **Applicant**

- and -

GH (BY HER LITIGATION FRIEND, THE OFFICIAL SOLICITOR) — **Respondent**

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Conrad Hallin (instructed by the Applicant Trust) for **the Applicant**
Claire Watson KC (instructed by the Official Solicitor) for **the Respondent**

Hearing dates: 26 and 28 September 2023

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JUDGMENT

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, and the place where they live, 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.

Mr Justice Poole:

1. GH is a 52 year old woman with a diagnosis of schizoaffective disorder. She was diagnosed with breast cancer in March 2023 but does not believe that she has cancer and refuses all treatment. The Trust responsible for managing her cancer treatment has applied to the Court of Protection for declarations and orders that GH lacks capacity to conduct these proceedings and make decisions about whether to undergo breast cancer surgery, and that it is lawful and in her best interests for the applicant to deliver care and treatment to GH in accordance with the care plan provided, which would involve sedation, anaesthesia, and a right mastectomy and axillary node clearance. For the reasons set out in this judgment I make those declarations.

2. This application first came before me on Tuesday 26 September 2023 in the urgent applications list at the Royal Courts of Justice. The application had been filed on 21 September but not issued and the application had not appeared on the published court list. The Official Solicitor had been given notice of the proposed application towards the end of the previous week. Family members joined the hearing remotely and demonstrated a lack of understanding of what surgery was proposed and the issues the court was invited to determine. Due to a number of other cases in the list, I was unable to reach the case until 3.10 pm, and I declined to conduct a full hearing that day. I listed the application for a half day hearing on 28 September 2023. I did so notwithstanding that the Trust had listed the proposed surgery for 27 September.

3. At the time of her diagnosis it was known that GH would be advised to undergo surgery as part of her treatment. It was also known that she had a longstanding diagnosis of schizoaffective disorder causing her to have delusional beliefs. The evidence records that consideration of an application to the Court of Protection was discussed as long ago as May 2023. In those circumstances it is troubling that the application was made nearly seven months after diagnosis and so shortly before the listed surgery. At the conclusion of the hearing the Official Solicitor, acting as GH's Litigation Friend, indicated that she wished to apply for a costs order against the Applicant Trust on the grounds of the excessive delay in issuing these proceedings. I directed evidence to be served regarding the Applicant's delay in making the application, and skeleton arguments on the issue of costs. I deal with the issue of costs in paragraphs [45] to [70] below.

4. At the hearing on 28 September 2023 I received written and oral evidence from Dr Aziz, Consultant Psychiatrist, Mr Mirza, Breast Surgeon, and oral evidence from family members. Broad agreement was reached that GH does not have the mental capacity to conduct the litigation or to make decisions about treatment for her cancer including surgery, and that it would be in her best interests to undergo the surgery.

5. The first question in this case is whether GH has the mental capacity to make decisions about her treatment for herself. The principles within sections 1 to 3 of the Mental Capacity Act 2005 (MCA 2005) apply. I need to repeat them in the body of this judgment.

6. By MCA 2005 s1(5), "An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests." MCA 2005 s4 sets out the principles to be applied when assessing the best interests of the individual who lacks capacity to make the decision in question.

7. GH has not made an advance decision and has not appointed an attorney. By ss 16 and 17 MCA 2005 the court may, by making an order, make the decision or decisions on P's behalf in relation to a matter or matters concerning P's personal welfare, including giving or refusing consent to the carrying out or continuation of a treatment by a person providing health care for P. The exercise of such powers is subject to the principles set out in ss 1 and 4 of MCA 2005, and therefore to the principles governing the determination of a person's best interests.

8. Decision-makers, including the Courts should have regard also to the Mental Capacity Act 2005 Code of Practice ("the Code"), issued under MCA 2005 s42.

9. In *Aintree University Hospital NHS Foundation Trust v James* [2013] UKSC 67 at [22] Baroness Hale said,

> "The focus is on whether it is in the patient's best interests to give the treatment, rather than on whether it is in his best interests to withhold or withdraw it. If the treatment is not in his best interests, the court will not be able to give its consent on his behalf and it will follow that it will be lawful to withhold or withdraw it. Indeed, it will follow that it will not be lawful to give it. It also follows that (provided of course that they have acted reasonably and without negligence) the clinical team will not be in breach of any duty towards the patient if they withhold or withdraw it."

And at [39]

> "The most that can be said, therefore, is that in considering the best interests of this particular patient at this particular time, decision-makers must look at his welfare in the widest sense, not just medical but social and psychological; they must consider the nature of the medical treatment in question, what it involves and its prospects of success; they must consider what the outcome of that treatment for the patient is likely to be; they must try and put themselves in the place of the individual patient and ask what his attitude to the treatment is or would be likely to be; and they must consult others who are looking after him or interested in his welfare, in particular for their view of what his attitude would be."

10. Decisions concerning serious medical treatment for a person without capacity to make such decisions for themselves must take into account that person's Convention rights under Arts 2, 3 and 8 of the European Convention on Human Rights.

11. In *R(Burke) v GMC (OS Intervening)* [2005] QB 424, Munby J said at 425D:

> "There is a very strong presumption in favour of taking all steps which will prolong life, and save in exceptional circumstances, or where the patient is dying, the best interest of the patient will normally require such steps to be taken."

The burden of proof is on the person who asserts that life-sustaining treatment should be withdrawn or, as here, withheld. The civil standard of proof on the balance of probabilities applies, including in relation to any findings of fact.

12. I have received written and oral evidence from Dr Aziz, Consultant Psychiatrist at the Applicant Trust. GH is currently detained under s3 Mental Health Act 1983 (MHA 1983). She first presented to mental health services in 2006 when she was aged 35. She was then also detained under s3 MHA 1983 suffering psychosis: she was hearing voices coming from behind the television and from the radio. She thought that professionals were practising "black magic" on her. She was treated with anti-psychotic medication. In 2012, when she suffered a relapse, possibly due to non-compliance with her medication, she was diagnosed with schizoaffective disorder. In the period from then until February 2023 GH enjoyed some periods of stability but also periods of deterioration when she behaved bizarrely and expressed delusional beliefs. She was detained under the Mental Health Act on a number of occasions, one period being from mid-2022 to February 2023.

13. On 2 March 2023 GH was diagnosed with breast cancer and she refused treatment. On 5 May 2023 at an MDT meeting between a breast surgeon at the Applicant Trust and the Psychiatric team at Birmingham and Solihull Mental Health NHS Foundation Trust, it was decided that a formal capacity assessment should be undertaken by GH's GP and a Psychiatrist from the home treatment team. GH was receiving mental health treatment in the community and at that time was compliant with her medication. She was receiving depot injections under the Community Treatment Order. Nevertheless she was then detained again on 23 May 2023 for a period of about three weeks before being discharged back into the community. At an outpatient appointment a day after discharge, GH complained about her detention and said that the cancer diagnosis was part of a "cover up" to avoid paying her a seven figure sum of compensation. On 8 June 2023 at a further MDT meeting it was noted that no capacity assessment had been carried out and so one was arranged. The capacity assessment was carried out on 30 June 2023 by Dr Alwetayan, Community Mental Health Team Consultant, Mrs S, Breast Surgeon Consultant, and a Breast Nurse. GH expressed the view that her breast lump was due to "black magic" and made accusations against her family, a neighbour and a BBC presenter. She declined a breast examination and any treatment for her cancer. She was assessed as lacking capacity to make decisions about her treatment due to her ongoing psychosis.

14. Dr Aziz states that in the light of the capacity assessment, "it was decided, following liaison with the Sandwell and West Birmingham Trust legal team that an application to the Court of Protection would be pursued." Accordingly, Mr Lees, Head of Legal Services at the Applicant Trust was informed. It was also determined that GH needed to be recalled to hospital to be offered an alternative antipsychotic treatment for what was considered to be her treatment resistant schizoaffective disorder.

15. GH was admitted on 27 July 2023. Dr Aziz first had contact with GH six days earlier on 21 July 2023. GH refused to accept that she had any form of illness, saying that her blood tests were clear and that the supposed diagnosis was a cover up to prevent her being paid millions of pounds in compensation that she was owed by the government. At a Multidisciplinary Team Meeting which GH attended on 7 August 2023 she was told that the Court of Protection would be involved in her case.

16. On 6 September 2023, Dr Aziz has assessed GH's capacity in conjunction with breast surgeon Mr Mirza. Dr Aziz concurred with the assessment of the community psychiatrist Dr Alwetayan that GH lacks capacity to make decisions about her breast cancer treatment as she is unable to weigh the pros and cons of the decision due to ongoing psychosis. Dr Aziz has confirmed that GH's condition has remained the same since her assessment. She does not think it likely that GH will regain capacity in relation to the decision under consideration in the foreseeable future.

17. Mr Mirza, Consultant Surgeon at the Trust, also provided written and oral evidence to the court. He explained that after urgent referral by her GP for a right breast lump, GH was seen by Mrs S, Consultant Breast Surgeon in the Breast clinic on 21 February 2023. Triple assessment by examination mammography and ultrasound guided biopsy resulted in a diagnosis of invasive ductal carcinoma in the right breast, clinical stage IIB Grade 2, ER, PR and HER2 negative. The carcinoma has been assessed as being 58mm on imaging. This was explained to her at a clinic on 2 March 2023. GH had come to the clinic with her son but would not agree to him being involved in the discussion – he waited outside. GH was told that the prognosis for her cancer was 90% for five year survival – regarded as a cure – following treatment by way of adjuvant chemotherapy, surgery and most likely post operative radiotherapy. GH declined all treatment. She was advised that without treatment the disease would progress and may grow rapidly causing it to fungate, meaning that it could erode through the skin causing ulceration and pain. Still GH refused all treatment but agreed to think over her decision and to return for a further discussion in a month's time, but to speak again to Mrs S earlier if she changed her mind. During the consultation, it was noted that GH was calm, said that she understood the information, which she demonstrated by repeating it, but still refused treatment. It was felt at the time that she had mental capacity to make the decision. However, as noted, an assessment in June 2023 led by the community psychiatrist came to a different conclusion.

18. GH then failed to attend further clinic appointments in April and May 2023. Mrs S contacted GH's GP asking them to encourage GH to attend but GH emailed to ask Mr S to stop sending further appointments because it was causing her mental stress and she felt like she was being harassed and that she did not like people interfering.

19. Following the MDT on 5 May 2023 it was decided to change the treatment plan so that the first line of treatment would be surgery, namely a right mastectomy. Whilst GH was recalled as an in-patient under the provisions of the CTO to Newbridge House in May 2023 a CT scan of her breast was performed on 2 June 2023. The scan showed no evidence of metastases.

20. Mr Mirza says that several attempts were made to engage with GH's son. He did not respond but later reported that it is difficult for him to participate in discussions about his mother with professionals because she believes he is plotting against her.

21. Following the mental capacity assessment on 30 June 2023, the treatment plan of a right sided mastectomy with axillary node clearance was confirmed. Neo-adjuvant chemotherapy was not considered to be viable because of the level of compliance that it would require. Mr Mirza met GH for the first time, along with Dr Aziz, on 6 September 2023. GH said that she understood she had breast cancer but would not wish to have any treatment, whether surgery or otherwise, and that her wishes should be respected and accepted. She declined to be examined by Mr Mirza or the breast nurse. Mr Mirza concurs with Dr Aziz that GH "had no understanding or insight of the disease process and is unable to make a judgment about treatment." The use of the word "insight" here is, I believe, a synonym for "understanding". However, Mr Mirza also states that "GH's delusional thoughts continued during the conversation and she repeatedly spoke about her human rights to deny any examination or treatment." Of course, persons with capacity to make decision about their treatment have a right to refuse treatment, even potentially life-saving surgery.

22. Mr Mirza explains that a lumpectomy would be wholly inadequate and that a mastectomy is required. Axillary node clearance is also recommended because, although no axillary node involvement was demonstrated on scanning, there is a greater than 60% chance of lymph nodal involvement. For GH, reconstruction surgery is not recommended because of the risk of her requiring a second or more operations. A silicone prosthesis worn under garments would be offered to GH. The offer of post-operative radiotherapy and/or chemotherapy will be assessed after surgery.

23. The prognosis with recommended treatment including surgery and chemotherapy with or without radiotherapy is for a 90% chance of five year survival. One study shows that the median survival for patients with untreated invasive breast cancer is 2.7 years. Data is hard to collect for such patients because they are often lost to follow up. This median is for patients with a wide range of invasive breast carcinomas. GH is otherwise physically fit and well.

24. The surgery would be a day case operation. There are the general risks of any operation such as bleeding, infection, blood clot and complications of anaesthesia. There are specific risks of breast surgery including seroma (tissue fluid collection), haematoma, numbness, pain, skin necrosis, shoulder stiffness, lymphoedema (swelling of the arm or hand), arm weakness caused by nerve or blood vessel damage, and psychological harm caused by loss of the breast tissue.

25. There is a risk that since the last clinical examination, or imaging, the carcinoma has grown such that it may have become inoperable. An examination will be undertaken under anaesthesia if the court makes the declarations sought. If GH has developed a degree of skin or chest wall involvement then surgery may not be feasible.

26. In answer to questions put by the Official Solicitor on 26 September 2023, the Trust, relying on Mr Mirza, has replied that further scanning now would be unlikely to provide meaningful evidence on metastatic spread beyond that provided by previous scanning. Furthermore, surgery alone would lead to a 10 year survival chance of 60% if there is no axillary node spread or a 48% chance if one node is involved and 24% chance if 5 nodes are involved.

27. The plan for the surgery, reviewed and revised by Mr Mirza, is set out in the care plan document. He will conduct the surgery. GH is currently a psychiatric in-patient.

Transport to the hospital where surgery will be performed will be arranged, with GH to be accompanied by a psychiatric nurse. GH would be taken directly to the anaesthetic room. The surgery will last up to 2.5 hours. Post-operatively GH would be taken to a side room on the ward with a psychiatric nurse in attendance. Restraint may need to be used if she were to become agitated and the circumstances for the use of restraint are set out in the care plan.

28. On 25 September 2023 GH was visited at her psychiatric unit by Ms Kauser-Hussain a solicitor agent instructed on behalf of the Official Solicitor. At the meeting GH said that she did not have breast cancer and would not have surgery. She said that a relative must have told her neighbour "to do some witchcraft" and that the cancer issue was actually about compensation she was owed in the sum of 10 billion pounds. She wanted to be left alone – it was her body and her choice. She would "rather die than have surgery" and that no-one could force her to have surgery. She asked "who the hell" was the court to force her to have the operation.

29. As to the consequences of the decisions to be made, Dr Aziz has advised that,

> "If GH undergoes surgery without her agreement, it is likely that she will experience distress and worsening of her delusional ideation post-surgery. She will be supported by the staff from the Mental Health Ward where she is in the Acute Hospital… we will request our psychology team to review and support GH making sense of the situation…. She will undergo sessions with a psychologist talking through coping mechanisms … There is a full care plan in place…"

However, Dr Aziz notes that if GH were to undergo a full mastectomy "this could impact her mental health in the long term as she may be paranoid around why she no longer has a breast." She says that if GH does not undergo surgery this would impact her physical health which

> "could impact on her mental health as she may become paranoid about why she is becoming unwell and this could be blamed on others around her, resulting in worsening mental health."

She concludes that

> "The medication she receives is unlikely to ever resolve her paranoid delusions completely and therefore this could be worsened in any event whether or not she has the surgery."

In further responses to questioning by the Official Solicitor, the Trust, relying on Dr Aziz, has said that although mastectomy against her will is likely to contribute to GH's delusional ideas, she has lived with such delusions for many years and it is likely that she will be able to continue to function in the community at her baseline

level. In other words, any deterioration in her mental health caused by the surgery being performed against her wishes is unlikely to lead to a deterioration in her ability to function.

30. Members of GH's family including her father and son attended remotely. They confirmed that they had had discussions with the Trust between 26 and 28 September and now understood the nature of the proposed surgery and its risks and benefits. They supported the Trust's treatment proposals as being in GH's best interests.

Conclusions on Capacity

31. Conclusions on capacity cannot be influenced by the desire to achieve a best interests outcome or to avoid an outcome not considered to be in the best interests of the individual. I remind myself of the presumption of capacity and other core principles set out above. The decision-making in question is in relation to GH's treatment for her breast cancer. I have to determine GH's capacity now to make decisions about that treatment, but the evidence is that her ability to make such decisions has remained quite constant over the past few months and is unlikely to change in the foreseeable future. I have assessments led by Consultant Psychiatrists at the Trust, in late June and again in September 2023 which concluded that GH lacks capacity to make the decisions in question. Her presentation at those assessments is consistent with her presentation at the attendance on behalf of the Official Solicitor only three days ago. However, the earlier impression of professionals involved with GH's care in March to May 2023, was that she did have capacity to refuse treatment.

32. I am satisfied that all practicable steps to help GH have been taken without success. There have been a number of discussions with her and professionals have tried to strip down the information to the basic information she requires, using straightforward language. The problem for GH is not that she cannot understand the key concepts involved, it is that she has delusional beliefs that prevent her from understanding and therefore weighing and using relevant information, namely that she has breast cancer. She undoubtedly has cancer in her right breast. Whilst on occasion she has stated that she accepts that she has breast cancer, when treatment has been discussed she has consistently denied it. She maintains that the suggestion that she does have cancer is part of a cover up to prevent her being compensated by the government or public authorities, and that she is a victim of "black magic" or "witchcraft". These delusional beliefs are a consequence of her schizoaffective disorder and the "diagnostic test" for a finding of incapacity is met. These delusional beliefs prevent GH from understanding the relevant information for the decision-making in question. She does not understand that she has cancer and so cannot weigh or use that information. The evidence shows that she cannot understand, weigh or use information about her breast cancer, treatment for it, or the foreseeable consequences of the decision whether or not to undergo treatment. She cannot do so because of her schizoaffective disorder.

33. I have considered whether the true position is that GH does understand that she has cancer, understands the consequences of not being treated, but has weighed that information and decided not to undergo any treatment. Her decision may be unwise but her autonomy to make it must be respected if she has the mental capacity to make it. Her very clear assertions that her autonomy must be respected demand careful

consideration when assessing her capacity. However, the overwhelming balance of the evidence is that the presumption of capacity is displaced.

34. I find that GH lacks capacity to conduct the litigation and to make decisions about her treatment. The Official Solicitor supports these conclusions regarding capacity.

Best Interests

35. Again, the principles set out in the MCA 2005 direct the court as to the matters that must be considered. The evidence is very clear that if GH does not undergo breast surgery, she will be very likely to suffer very unpleasant physical consequences as the carcinoma develops, and that her life expectancy will be reduced significantly. Her mental health is likely to suffer further as physical changes which she will not understand, begin to affect her. On the other hand she will not have undergone invasive surgery, she will not have had her right breast tissue removed and the axillary clearance, she will avoid the risks associated with that surgery, and she will have had her own clearly expressed wishes respected.

36. If GH undergoes the planned surgery, she will benefit from having a better prognosis. He overall prognosis will not be as high as 90% survival for 5 years because she will not have had chemotherapy or radiotherapy. The best evidence before me is that surgery alone will confer a 60% chance of survival for 10 years provided there are no axillary nodes involved. I have been told that there is a 60% chance of some nodal involvement, therefore the prospects of survival for ten years are more likely to be less than 50%. However, if the surgery is successful then her chance of a cure will be enhanced compared to the chance of survival with no treatment at all. GH is otherwise in good physical health.

37. There is a risk that the cancer in GH's right breast has developed since last examined or imaged to such an extent that surgery will not be possible. That will only be known once GH is sedated or anaesthetised so as to allow an examination to which she does not give her consent.

38. Considerable importance must be given to providing treatment that will prolong GH's life and prevent her from dying prematurely from her cancer. The risk-benefit analysis for GH's physical health and life expectancy, weighs very heavily in favour of surgery being performed. However, GH has a very serious mental health condition and the impact of the decision in question on her psychiatric state requires careful consideration. Dr Aziz advises that GH's mental health is likely to suffer whether or not surgery is performed. Whether she suffers the physical change of the loss of her right breast, or the development of the untreated carcinoma, she will struggle to cope and she is likely to suffer paranoid delusions about the changes. It seems to me that, in particular, the loss of a breast through surgery which she will see as having been forced upon her, is liable to feed her delusional beliefs about a "cover up" and about others using "black magic" to cause her harm.

39. GH's own wishes and feelings and her strong view that her autonomy should be respected must be taken into account. She has been unwavering in her insistence that she should not receive treatment. I do, however, have to weigh her wishes and views

in the light of the fact that they are based on a delusional belief that she does not have cancer and that she is being somehow tricked into undergoing treatment. As part of my consideration of her wider best interests, I must consider the impact of imposing the proposed surgery against her wishes on her relationships with professionals and with her family. Whatever residual trust she still has in those others is likely to be undermined. She has previously engaged to a limited extent with healthcare professionals (for example by attending the breast clinic in February and again in March 2023) but she might be less inclined to do so in the future if she feels they have forced her to have treatment against her will. GH was asked if she wanted to speak to me as the judge hearing her case but she made it clear that she did not want to do so.

40. The process of transferring GH to the hospital where surgery is to be performed, of administering sedatives and anaesthetic against her will, possibly having to use physical restraint for a short period, is likely to cause GH stress and anxiety. Likewise, on recovering from her anaesthetic post-operatively, the physical changes caused by the surgery will be distressing to her.

41. GH's Independent Mental Capacity Advocate, Stefan Carter has concluded (as long ago as 5 July 2023) that,

> "It appears to me that the benefits of treatment would outweigh the burdens … and that there is therefore a strong argument to make to the court that it is in GH's best interests to undergo surgery and associated treatment for the breast cancer. I am therefore also fully in support of an urgent application being made to the Court of Protection in respect of this matter."

42. The Official Solicitor's position is to support the proposed treatment plan as being in GH's best interests.

43. Following the short hearing on 26 September 2023 in the urgent applications court, a best interests meeting involving members of GH's family – her father, son and sister – was convened. I have been provided with a minute of the meeting. I do understand that GH's son had previously been reluctant to be involved in any decision-making for fear that his mother would consider him as conspiring against her, but every effort should have been made to involve family members before the urgent application was made. The family's position is to support the Trust's plan.

44. Taking into account all the evidence and the positions of the parties, and the matters I am required to consider by the MCA 2005, I have concluded that it is in GH's best interests to undergo the proposed surgery and that accordingly I shall make the declarations sought. This is not an easy decision to make due to the nature of the surgery and GH's unwavering opposition to it.

Costs

45. Pursuant to my directions on 28 September I have received a statement from Mr Lees, Head of Legal Services at the Trust, dated 11 October 2023. He sets out the history of the case which I have largely reflected in the judgment above. He points to a change in the surgical consultant when the first consultant went off on long term sick and Mr Mirza replaced her. The Trust did not employ Dr Aziz and so had no control over her evidence which required revision. He also points to the difficulties caused by GH being treated in the community, by initial uncertainty as to her capacity, difficulties obtaining evidence from busy Consultants, especially during the summer vacation period, which was further exacerbated by the industrial action by Consultants and others, and various other difficulties. He concludes that there were "multiple reasons as to why the application could not be filed earlier." The Trust was mindful of the short time between the application and the planned date of surgery but did not want to delay the surgery further. The Trust then accommodated a change in the date for the surgery, creating a special list for GH, when it became clear that the court could not make a final determination on 26 October 2023.

46. The Official Solicitor (OS) invites the court to make an order that the Applicant Trust should pay 100% of her costs of the application.

47. Section 55 of the Mental Capacity Act 2005 ("MCA") provides,

> "55 Costs
>
> (1) Subject to Court of Protection Rules, the costs of and incidental to all proceedings in the court are at its discretion.
>
> (2) The rules may in particular make provision for regulating matters relating to the costs of those proceedings, including prescribing scales of costs to be paid to legal or other representatives
>
> (3) The court has full power to determine by whom and to what extent the costs are to be paid…"

48. By COPR 2017 r19.3,

> "Where the proceedings concern P's personal welfare the general rule is that there will be no order as to the costs of the proceedings or of that part of the proceedings that concerns P's personal welfare".

49. However, COPR r19.5 provides that the court may depart from that general rule if the circumstances so justify and in deciding whether departure is justified the court shall have regard to all the circumstances including,

> 19.5 (1)
>
> (a) the conduct of the parties;

(b) whether a party has succeeded on part of that party's case, even if not wholly successful; and

(c) The role of any public body involved in the proceedings.

(2) The conduct of the parties includes—

(a) conduct before, as well as during, the proceedings;

(b) whether it was reasonable for a party to raise, pursue or contest a particular matter;

(c) The manner in which a party has made or responded to an application or a particular issue;

(d) whether a party who has succeeded in that party's application or response to an application, in whole or in part, exaggerated any matter contained in the application or response; and

(e) any failure by a party to comply with a rule, practice direction or court order."

50. By COPR r19.6,

> "(1) Subject to the provisions of these Rules, Parts 44, 46 and 47 of the Civil Procedure Rules 1998 ("the 1998 Rules") apply with the modifications in this rule and such other modifications as may be appropriate, to costs incurred in relation to proceedings under these Rules as they apply to costs incurred in relation to proceedings in the High Court."

51. The Civil Procedure Rules (CPR) Part 44 gives the court a very wide discretion in relation to the form of the costs orders it may make and includes rules about the standard and indemnity basis of costs assessment. The court's relevant powers in relation to misconduct are set out at CPR r44.11:

> "(1) The court may make an order under this rule where –
>
> (a) a party or that party's legal representative, in connection with a summary or detailed assessment, fails to comply with a rule, practice direction or court order; or
>
> (b) it appears to the court that the conduct of a party or that party's legal representative, before or during the proceedings or in the assessment proceedings, was unreasonable or improper.

> (2) Where paragraph (1) applies, the court may –
>
> (a) disallow all or part of the costs which are being assessed; or
>
> (b) order the party at fault or that party's legal representative to pay costs which that party or legal representative has caused any other party to incur."

52. COPR r19.9 provides,

> "19.9. Any costs incurred by the Official Solicitor in relation to proceedings under these Rules or in carrying out any directions given by the court and not provided for by remuneration under rule 19.13 shall be paid by such persons or out of such funds as the court may direct."

Rule 19.13 does not apply to the present case. I accept that a practice has developed in cases involving serious medical treatment that applicant public bodies voluntarily agree to pay 50% of the Official Solicitor's costs. This is a convention only and is a departure from the "general rule".

53. The approach that should be adopted in relation to costs is as articulated by Peter Jackson J in *London Borough of Hillingdon v Neary & Ors* [2011] EWHC 3522 (COP) at [9],

> "The questions that must be addressed are these:
>
> (1) Is departure from the general rule justified in all the circumstances, including the conduct of the parties, the outcome of the case and the role of Hillingdon as a public body?
>
> (2) If so, what order should be made?"

54. Ms Watson KC for the OS accepts that there are pressures on public bodies, and in particular on the resources of the NHS, but submits that the delay in bringing this application to court is such that a departure from the general rule as to costs is clearly justified. She points to the parties' duty to help the court to further the overriding objective under COPR r1.4(3) and that if a party has failed without reasonable excuse to satisfy the requirements of COPR r1.4(3) that would justify a departure from the general rule. Ms Watson KC suggests that the relevant caselaw provides "useful examples of the manner in which the court has exercised its powers", *London Borough of Hillingdon v Neary & Ors* (above). Each application must be considered on its own merits, *VA & Ors v Hertfordshire Partnership NHS Foundation Trust & Ors* [2011] EWHC 3524 (COP) again Peter Jackson J. The Court of Appeal endorsed a "broad brush" approach to making costs orders in these cases in *Manchester City*

Council v G & Ors [2011] EWCA Civ 939. Ms Watson KC refers to recent examples of costs orders which departed from the general rule including *Re JB (Costs)* [2020] EWCOP 49 per Keehan J, and *A Local Authority v ST (by her litigation friend, the Official Solicitor)* [2022] EWCOP 11, per HHJ Burrows.

55. Ms Watson KC describes the delay by the Applicant Trust as "unacceptable" and as having had a number of adverse consequences including that it undermined the role of the OS herself. As early as 5 May 2023 it was recorded that GH did not appear to have capacity to make decisions about her treatment. Ms Watson points to an email from that time from GH's community psychiatric nurse to the breast surgeon caring for GH relaying advice from the legal team at the mental health trust that the matter would need to be brought to the Court of Protection. It is no excuse that GH was living in the community – that is a common situation in such cases. The OS is concerned that in too many cases of this kind (not necessarily involving this Applicant) Trusts make very late applications, thereby undermining her role.

56. For the Trust, Mr Hallin says that there must be a "good reason" to depart from the general rule, *Re G* [2014] EWCOP 5. For example, in *Re SW* [2017] EWCOP 7 the court had found that the application was "scarcely coherent … totally without merit…" He submits that at the outset of the proceedings the parties agreed the conventional arrangement that the Trust would pay 50% of the Official Solicitor's costs and that the OS now appears to be seeking to withdraw its agreement.

57. I note that it is standard practice for the OS to seek agreement as to the conventional payment of 50% of her costs before agreeing to become involved in proceedings of this kind in the Court of Protection. This is not a formal contract and, I find, it is implicit in the agreement that, depending on the circumstances as the OS later finds them to be or as they develop, the OS may in certain cases seek a costs order for more than 50%. That has happened in a number of other cases. I find, the Trust did not rely to its detriment on the agreement and that the OS is not estopped or otherwise prevented from seeking a greater proportion or indeed the whole of her costs. She will only do so when she considers that the circumstances justify it.

58. Mr Hallin submits that "if the Court does not consider the Official Solicitor bound by this agreement at the outset of these proceedings" then the circumstances under which the Court may depart from the general rule are set out in COPR r19.5. Mr Hallin submits that departure from the general order is not warranted because,

    i) Satellite costs litigation should not be encouraged in this welfare jurisdiction.

    ii) The bar should not be set too low for departing from the general rule. The pressures on NHS trusts and very busy clinicians are such that if there is a departure on the basis of delay in making applications in such cases, there will be many such applications and the conventional arrangement will be jeopardised.

    iii) If there is a departure from the general rule due to conduct, then the conduct should not only be serious, but it should have very clear costs consequences. Here the OS did not incur additional costs because of the timing of the application.

59. Mr Hallin has referred to an open offer from the Trust to pay 75% of the OS's costs up to and including the first hearing on 26 September 2023 and 50% of her costs thereafter.

60. In obstetric cases the parties have clear guidance from Keehan J in *NHS Trust v FG* [2014] EWCOP 30 designed to avoid late applications. Keehan J noted that late applications have very undesirable consequences,

> "i. the application is more likely to be dealt with by the out of hours judge and without a full hearing in public;
>
> ii. the available written evidence is more likely to be incomplete and necessitate substantial oral evidence;
>
> iii. it seriously undermines the role that the Official Solicitor can and should properly play in the proceedings; and
>
> iv. it deprives the court of the opportunity to direct that further evidence, including independent expert evidence, if necessary, is obtained in relation to the issue of capacity or best interests.
>
> This approach is dictated by P's Article 5, 6 and 8 rights and best interests."

61. In the present case, the lateness of the application has:

i) Undermined the role that the OS should play in the proceedings. The importance of this should not be overlooked. The OS represents the interests of GH. The OS needs time to consider the evidence, meet GH and ascertain her wishes and views, probe the evidence, ask questions, seek independent expert evidence if necessary, liaise with GH's family, and form a view of GH's capacity and best interests. The OS does not have unlimited resources and has responsibilities in many other cases.

ii) Placed the court under considerable pressure to find precious time, on a very urgent basis, to hear the application. There was no opportunity to give directions in relation to evidence other than within a very short period from 26 to 28 September 2023. An application of this kind is very unlikely to be determined within an hour. The urgent applications list will often have six or more cases, sometimes several more, to be heard within the day. If an urgent application can be avoided it should be avoided. This application only became urgent because of the delay in making it.

iii) Risked undermining open justice - this application did not appear on the list on September 2023 because of the lateness of the application. Hence, those who might have wished to observe this important application did not have advance notice of what might have been a substantive hearing on 26 September.

iv) Caused disruption to the surgeons, clinicians, and staff at the Trust because the planned surgery on 27 September 2023 had to be postponed and hastily re-

arranged.

v) Contributed to a delay in treating GH. The need for surgery was known at diagnosis on 2 March 2023. The surgery took place nearly seven months later. A key performance standard for NHS England is for a 62 day period between referral and treatment for cancer (the target being for this standard to be met in 85% of cases). For a person with capacity who had refused adjuvant chemotherapy but consented to surgery (which is effectively the corresponding position for GH following my decisions above) the target date for surgery (the first line of treatment in those circumstances) would therefore have been in late April 2023, about five months before the application was made. The consequences of the delay in treatment are unknown (but see postscript below).

62. The stages for me to address are (i) whether a departure from the general rule is justified in all the circumstances; and (ii) if so, what costs order should be made. Close attention to the facts of the particular case is required when addressing each stage. The circumstances to be taken into account at the first stage include but are not restricted to those set out within COPR r19(5). The court has a broad discretion in relation to the second stage.

63. There is no suggestion, nor could there be, of bad faith in this case, but the Applicant Trust's pre-issue conduct is raised. I have taken full account of the evidence of Mr Lees and of the difficulties generally for hard-pressed staff within the NHS, the strains on resources, and the particular difficulties in this case. I understand that because of the challenges presented by GH's case, the 62 day standard may not have been realistic for her. GH missed appointments and that caused delay in March and April. In any event, I am not here concerned with delays within the NHS that might have affected GH even if she had had capacity. However, it must have been clear, if not in early March certainly by early May, that a Court of Protection application may well be required and that, given the nature of GH's condition and the surgery required, the delays up to that point, and the pressing need for surgery to be performed sooner rather than later, expedition was required. I do not accept that the difficulties set out in Mr Lees' statement provide a reasonable excuse for the delay in making an application to this court until the second half of September 2023. If a potential witness was ill or on holiday, then urgent steps should have been taken to find another witness who could provide relevant evidence. With each delay the need for urgency increased.

64. The convention that a public body such as the Applicant Trust will meet 50% of the OS's costs is itself a departure from the general rule. I take into account the OS's acceptance at the outset of this case of that conventional arrangement, but I do not accept the agreement prevents the OS for seeking a more advantageous costs order if the circumstances justify such applying for such an order. The agreement was designed only to allow the OS to act. The Trust could not subsequently offer to pay less than 50% but it was implicit that the OS could seek a greater proportion of her costs if subsequent circumstances allowed. In large part due to the timing of the application, at the time the OS agreed to act having been offered the usual arrangement as to costs, she did not know of the full circumstances and evidence, including the degree of delay.

65. As was made clear to me in oral representations, and has been reflected in other judgments such as *University Hospitals Dorset NHS Foundation Trust & Anor v Miss K* [2021] EWCOP 40, Lieven J, the OS has previously made clear her exasperation at the frequency of late, urgent applications of this kind. I am afraid that notwithstanding the difficulties faced in this case, I do find it to be a clear example of a long and unjustified delay with adverse consequences of the kind that have been recognised in similar previous cases.

66. Mr Hallin submits that the OS would have incurred the costs of the hearing on 28 September 2023 in any event. Indeed, had a timely application been made, it may well be the case the OS would have had to do more work on the case and so would have incurred more costs. I have set out CPR r44.11 above because it applies in the Court of Protection by reason of COPR r19.6 and it is right to consider it in the present context. Costs orders for misconduct, which may include unreasonable conduct prior to proceedings being issued, may include an order that "the party at fault or their legal representative should pay the costs of the other party *which that party or legal representative has caused any other party to incur*" [emphasis added]. Thus the costs order made following misconduct is compensatory. Can a costs order be made that is not purely compensatory if the conduct of the paying party does not amount to misconduct? In my judgment, it can. The pre-issue conduct of the Applicant Trust in this case appears to me to be close to that of a party who has been successful in civil litigation but who had unreasonably refused to mediate. In such cases the courts may take into account the refusal to mediate as being conduct that justifies a departure from the usual order that costs follow the event – *Halsey v Milton Keynes General NHS Trust* [2004] EWCA Civ 576, [2004] 4 All ER 920. Such costs orders will not require payment of costs over and above the costs actually incurred, but they are not purely compensatory because it cannot be known with certainty what costs would have been incurred had mediation taken place. As Dyson LJ held in *Halsey*, the party who unreasonably failed to engage in mediation may "for that reason alone …be penalised in costs." [31] The costs order is designed to encourage appropriate pre-issue conduct.

67. In the present case the Applicant Trust's pre-issue conduct undermined the role of the OS and prevented pre-issue work which may or may not have helped to resolve some of the issues which the making of the application required the court to determine. Just as an unreasonable failure to mediate can justify a departure from an order that costs follow the event in civil proceedings, even if the costs incurred may have been incurred had mediation taken place, so, in my judgment, a failure to issue an application in the Court of Protection in relation to a question of serious medical treatment within a reasonable time, may justify a departure from the general rule as to costs even if another party's costs may not have been avoided had the application been brought timeously.

68. On the facts of the present case a departure from the general rule as to costs is justified due to the Applicant's unreasonable conduct in delaying the issue of proceedings and thereby undermining the role of the OS, as well as exposing GH, whose interests the OS represents, to a risk of harm.

69. What costs order should be made? The OS does not seek a costs order for more than the costs she has actually incurred, so an award of 100% of her costs would not breach the indemnity principle. All of her actual costs have been incurred dealing with

a very late application. Whilst other work might have been required had the application been made earlier, the costs sought all arose after the Applicant's unacceptable delay. I accept that in exercising a discretion as to costs the court should consider what costs might have been incurred in any event but that is not an accounting exercise in a case such as this.

70. The convention is for the Trust, as a public body, to pay 50% of the OS's costs in any event. The OS, acting in accordance with that convention, sought and obtained an agreement to such a payment at the outset of the proceedings. I have found that the agreement does not bind her only to seek 50% of her costs, and she is not estopped from seeking further costs from the Applicant Trust. An order now that the Trust should pay 50% of the OS's costs would not reflect the seriousness of the unreasonable delay and its consequences. The assessment of the appropriate level of costs is a broad brush exercise. I must take into account all the circumstances which include the degree of unreasonableness and the extent of the delay, the impact of the delay on GH and the OS, the costs actually incurred by the OS and to what extent those costs have been incurred as a result of the paying party's default. Exercising my discretion I am sure that an issue based costs order would not be appropriate and I do not have adequate information on which to make an award for a fixed amount of costs. I take into account my power to order assessment of costs on the standard or indemnity basis. In my judgment an appropriate order is for the Applicant Trust to pay 80% of the OS's costs of and occasioned by the application to be assessed on the standard basis if not agreed. An order for 100% of costs might have been made if the Trust's failings had been egregious and/or the consequences, including the costs consequences, for the OS even more serious.

Postscript

I announced my decisions on capacity and best interests at the hearing on 28 September but reserved my full reasons and my decision on costs to this written judgment. After the judgment was drafted, I was informed that the mastectomy was performed early in the week following the hearing on 28 September. No restraint was required and GH was compliant. The tumour was operable. I have no information as to the histological findings. GH has seemingly recovered well from the operation and there are no signs of any adverse impact on her mental health. I wish her well for the future.