This judgment was delivered in public and the proceedings are subject to the Transparency Order dated 14 November 2023. The anonymity of the first respondent, his family and his treating clinicians must be strictly preserved and nothing must be published that would identify the first respondent or his treating clinicians, either directly or indirectly. 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.

Neutral Citation [2023] EWCOP 51

IN THE COURT OF PROTECTION **Case No 13213291**

Royal Courts of Justice
Strand
London WC2A 2LL

15 November 2023

Before

JOHN MCKENDRICK KC
(Sitting as a Tier 3 Judge of the Court)
SITTING IN PUBLIC

Between:

(1) **MANCHESTER UNIVERSITY NHS FOUNDATION TRUST**

Applicant

AND

(1) Mr Y (By his litigation friend, the Official Solicitor)

(2) GREATER MANCHESTER MENTAL HEALTH NHS FOUNDATION TRUST

Respondents

Mr Vikram Sachdeva KC instructed by Hill Dickinson for the applicant and by DAC Beachcroft for the second respondent
Mr Ben McCormack instructed by the Official Solicitor for the first respondent

HEARING DATE: 14 NOVEMBER 2023

APPROVED JUDGMENT

This judgment was handed down remotely at 10.00 on 25.11.23 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

John McKendrick KC:

Introduction

1. These proceedings concern the health of the first respondent. The focus of the application before the court is: i. whether the first respondent has capacity to make a decision to consent to surgery to treat his fractured and dislocated left shoulder; and ii. if he lacks capacity in respect of this matter, whether the proposed surgery is in his best interests or not. He is a party to this application and the Official Solicitor acts as his litigation friend. The first respondent is anonymised in this judgment as Mr Y.

2. The applicant issued an application on 10 November 2023 for relief pursuant to the Mental Capacity Act 2005 (hereafter "the 2005 Act") seeking orders as follows:

> It is in [Mr Y's]'s best interests to undergo an open reduction and internal fixation of the L humeral head fracture, together with all ancillary treatment considered of clinical benefit by the Trust including anaesthesia and pain relief.
>
> The Trust may apply proportionate chemical and/or physical restraint necessary to safeguard [Mr Y].

3. The second respondent provides Mr Y with care and treatment for his mental ill-health. It supports the applicant's case for relief.

4. At the outset of the hearing on 14 November 2023, whilst sitting in public, I made a reporting restriction order prohibiting the reporting of the identity of Mr Y and his family members. This is necessary to protect his identity and other confidential information. I also prohibited the naming of the treating clinicians. Mr Y will need the skill and care of both the mental health and orthopaedic clinicians in the coming days and they should not be discomforted by being publicly named as they seek to care for him. There is no, or very limited, public interest in reporting this information. The

reporting restriction represents the correct balance between Article 8 and 10 ECHR for now. I have, however, made it clear that the naming of the clinicians is a matter that can be revisited.

5. Mr Y is a forty two year old man. He has an established diagnosis of Paranoid Schizophrenia. He has been successfully treated in the community with Clozapine for many years. His mental health relapsed recently. I am told he has had multiple periods of inpatient care over the years. He was discharged from his most recent inpatient admission in October 2021. In July 2023 Mr Y requested to be medicated with Olanzapine on discharge from his Community Treatment Order and his treating team agreed and switched his medication. Sadly his health and his engagement with secondary services began to deteriorate.

6. On 27 October 2023 Mr Y was brought to the Emergency Department of X Hospital. He had been found unresponsive in the community. He had sustained multiple injuries and suffered from a seizure which necessitated admission to the Intensive Care Unit. Investigations found that he has fractured the left humeral head and dislocated his left shoulder.

7. On 31 October 2023, after he had stabilised and had returned to the ward, he was assessed under the Mental Health Act 1983 (hereafter “the 1983 Act”) and detained pursuant to section 3. A symptom of his mental health crisis is an inability to believe what his treating clinicians were telling him. He has refused to consent to the proposed surgery and treatment.

8. Mr Y’s brother is a consultant orthopaedic surgeon. He has spoken with Mr Edwards, lawyer at the Office of the Official Solicitor, and emailed the applicant’s solicitor. He considers Mr Y lacks capacity to make a decision about medical treatment for his injured shoulder. He fully supports the surgery taking place as soon as possible. Mr Y’s brother was able to tell Mr Edwards some very helpful background about his brother. He had studied at a university in Scotland. He has lived alone with some support in Manchester for most of his adult life. He has not taken illegal drugs or alcohol and has no history of violent behaviour. Mr Y visits his brother and his family regularly and manages this travel backwards and forwards alone. Mr Y’s father has also emailed Mr Edwards, setting out his support for the surgery to take place.

9. At the conclusion of the hearing on 14 November 2023, I announced my decision to accede to the relief sought. I endeavour to briefly explain my reasons for making the declarations and orders sought below.

The Evidence

Dr F

10. Dr F is a Consultant Liaison Psychiatrist employed by the second respondent. She has held that role for twelve years. She met with Mr Y on 9 November 2023 after having had the opportunity to review his notes and attend a case conference on 7 November 2023. Her witness evidence charts the background of the challenges to Mr Y's health of his 'established' diagnosis of Paranoid Schizophrenia.

11. She describes his immediate presentation before his admission to the Emergency Department. He had not attended follow up appointments with his treating community team and there were concerns he had not taken his antipsychotic medication. He was observed to be neglectful of his personal care and presented with irritability. After admission he was seen by the mental health team and denied requiring medication for his Paranoid Schizophrenia. He denied any mental ill-health. It was reported that:

> "He did express that he did not believe information given to him by the medical and surgical team about his treatment and care plan. These beliefs appeared to be delusional ideas that were a result of his psychosis returning due to a relapse of Paranoid Schizophrenia."

12. Dr F succinctly sets out her opinion on Mr Y's capacity to decide to consent to the surgical intervention to treat his dislocated shoulder:

> "[He] has an impairment of mind or brain in that he has a diagnosis of Paranoid Schizophrenia and is currently relapsing and psychotic. He is not able to understand the information around the operation as discussed with him by his treating teams due to his delusional beliefs that treatment is not required for his

injuries. He does not believe the medical team’s rationale for why he requires the treatment and is not persuaded by his family of the need despite some expressions that he would believe them at times. Mr [Y] is able to retain information pertinent to this decision. He is not able to weigh up the risks and benefits of the surgical treatment he requires due to his delusional ideas of not requiring treatment and his poor engagement with his treating team on discussing the operation. His delusions are difficult to fully explore as, due to his psychosis, he is suspicious of people (including family and the treating team) and disengages and refuses to talk after a short time (circa 15 minutes). However, he appears paranoid about staff, irritable and hostile and does not appear to believe that he will lose function and movement in his arm should he not have the operation which appears to be a delusion. Therefore it is my opinion that he does not have capacity to refuse the treatment of his shoulder injury at this time.”

13. She identifies the following relevant information for the purposes of section 3 of the 2005 Act:

    (1) the nature of each treatment option for his shoulder injury;
    (2) the purpose of each treatment option;
    (3) the risks and benefits of each treatment option;
    (4) what each treatment option will entail;
    (5) the likely outcome or success of each treatment option;
    (6) the potential consequences if treatment is not provided.

14. She further opines that Mr Y will need sedative medication and may need restraint to administer the necessary general anaesthesia. She sets out the risks of restraint which includes strain on his heart and psychological trauma. Dr F explains that there are also risks to him of psychotropic medication for sedation which includes the low risk of cardiovascular events such as sudden cardiac death and respiratory depression with a risk of death. She raises a concern that Mr Y will also be resentful and hostile to staff in the immediate aftermath of the use of restraint.

15. Dr F sets out Mr Y's wishes and feelings which are in opposition to the proposed surgical intervention.

16. She explains why she does not believe that section 63 of the 1983 Act provides lawful authority to treat Mr Y's dislocated shoulder. She explains why the surgical intervention is in his best interests.

17. Dr F gave brief oral evidence. She reiterated that Mr Y has a delusional belief. He stated when he met with her that he does not believe he needs surgery to optimise the movement of his arm notwithstanding the current dislocation and fracture. He did not explain his reasons but does not believe he needs surgery. He does not believe surgery is necessary to recover functional use of the arm. Mr Y is not able to believe the opinions of the orthopaedic surgeons and therefore cannot weigh up the information to make a decision. She had no doubt he has Paranoid Schizophrenia and requires surgery and therefore his thinking is delusional. It is false. He looked objectively in pain when she spoke with him. Dr F was satisfied all practicable steps have been taken to help Mr Y obtain capacity to make this decision, as she set out in her Form COP 3. Post-surgical explanations as to the surgery would be explained to him by the surgical team and not by the mental health team. Dr F said that a letter explaining that the decision in respect of his surgery was made by the court and not family members or his treating mental health team would be of great assistance.

Mr D and Dr K

18. Mr D is a consultant orthopaedic surgeon who specialises in shoulder and elbow surgery. He is employed by the applicant. Dr K is an orthopaedic registrar also employed by the applicant. Mr D drafted the witness statement filed. It was signed by Dr K in Mr D's absence to avoid delay.

19. Mr D explains there are two options: perform the shoulder surgery or do nothing. He describes the surgery as the 'best treatment' for Mr Y's presenting complaint. The surgery is required to be performed under general anaesthetic to put the shoulder back into joint and to fix the fracture. The surgery is performed through a cut in the front of the shoulder. The surgery reduces but does not eliminate the risk of further shoulder

surgery if the fracture does not heal. He proposes surgery on Thursday 16 November 2023. There are risks to the surgery as follows:

a. the risk of on-going pain;
b. a 1 % risk of infection which may require antibiotics or further surgery;
c. a less than 1 % chance of a bleed requiring a blood transfusion;
d. nerve or blood vessel damage;
e. risks of anaesthesia which include a 1 in 10, 000 risk of a heart attack, stroke or blood clot.

20. The option of doing nothing would result in Mr Y's shoulder remaining dislocated which would likely result in long term pain and the loss of function which would affect daily activities. He explains that the surgery cannot await a resolution of Mr Y's mental ill-health because it becomes technically un-feasible three weeks after the injury. He also states that it is not clear how long Mr Y would need to remain an in-patient for shoulder care post operatively.

21. Mr D's evidence is that Mr Y declined surgery but did not provide a clear reason. A best interests meeting took place on 6 November 2023. Mr Y's brother and father were consulted and explained that if Mr Y were to have capacity he would want the surgery.

22. Dr K gave brief evidence. The diagnosis is a fracture of the left humeral head. He has seen the x-rays and the CT scans. There is no doubt over the diagnosis. Mr Y has shoulder pain and his shoulder is not fully functioning. Mr Y was asked again this morning and he was "unsure" about whether to have the surgery. Without treatment the injury can lead to a significant disability and on-going pain.

Dr W

23. Dr W is a consultant anaesthetist employed by the applicant. As with other witnesses, he sets out admirably succinct and clear evidence. He explains:

> "There are various options for getting [Mr Y] to theatre for safe general anaesthesia and surgery.

1. He comes to theatre voluntarily and complies with all the theatre checks, including the monitoring and placement of an intravenous cannula. This is clearly the preferred option.
2. He refuses to come to theatre but agrees to take oral sedation. He would then be given a mixture of midazolam and ketamine to drink. This would work in 20-30 minutes. He may need a further dose if the result of this is sub optimal. Once he is sedated he can be brought to theatre with minimal resistance and anaesthesia induced.
3. If he refuses all the above then sedation can be administered by an intramuscular (IM) injection of ketamine. This should ideally be given in theatre as he will be closer to all the anaesthetic equipment that will be required to safely anaesthetise him. He may need to be physically restrained to bring him to theatre and for this injection. Again, once he is sedated, anaesthesia can be induced.
4. If he refuses to come to theatre then IM ketamine can be administered in the ward but again he may need to be physically restrained for this. He can then be taken to theatre in a sedated state for induction of general anaesthesia."

24. He sets out the risks to Mr Y and staff of injury if the above restraint were required. There are also risks of a large intramuscular injection causing persistent pain at the site of the injection and muscle fibrosis and possible abscess, and nerve vascular injury.

25. He notes that Mr Y weighs 104 kg and has a body mass index of 30. He is large and strong. He concludes that the general anaesthesia should be low risk.

Ms B

26. Ms B is a ward manager at X Hospital. She provides a short statement explaining that she took the lead in preparing a care plan and exhibits the same.

Hayley Jade Buchan

27. Ms Buchan is a solicitor employed by Simpson Millar. She was instructed by the Official Solicitor to meet with Mr Y and did so at 09.30 on the day of the hearing. Mr Y explained he was in a little pain. He emphasised that he was keen to speak with his

brother about the planned surgery and wished to ensure everything was done correctly. He said they must "stick to the plan". When asked what he though was wrong with his shoulder, Mr Y stood up to leave and said he wanted the conversation to end. Ms B told Ms Buchan that Mr Y may have been a rugby player and his brother had visited in the past and they had gone to rugby matches.

The Law

28. All three parties submit that section 63 of the 1983 Act does not provide authority for the treatment the subject of this application. I agree.

29. Sections 1- 4 of the 2005 Act set out the statutory framework in respect of mental capacity and best interests.

30. Serious medical treatment applications are subject to the '*Practice Guidance (Court of Protection: Serious Medical Treatment)'* [2020] EWCOP 2 issued by Hayden J in January 2020. It makes clear an application to court may well be required in situations where:

> "Further, in a case involving serious interference with the person's rights under the Convention for the Protection of Human Rights and Fundamental Freedoms or where the proposed procedure or treatment was to be carried out using a degree of force to restrain the person concerned and the restraint might go beyond the parameters set out in sections 5 and 6 of the 2005 Act amounting to a deprivation of the person's liberty, the authority of the court would be required to make that deprivation of liberty lawful."

Capacity

31. MacDonald J set out the relevant capacity principles in the light of the Supreme Court decision in *A Local Authority v JB* [2021] UKSC52; [2022] AC 1322 in *North Bristol NHS Trust v R* [2023] EWCOP 5. Paragraphs 43 and 46 state:

> "The foregoing authorities now fall to be read in light of the judgment of the Supreme Court in *A Local Authority v JB* [2022] AC 1322. The Supreme Court held that in order to determine whether a person lacks capacity in relation to "a matter" for the purposes of s. 2(1) of the Mental Capacity Act 2005, the court must first identify the correct formulation of "the matter" in respect of which it is required to evaluate whether P is unable to make a decision. Once the correct formulation of "the matter" has been arrived at, it is then that the court moves to identify the "information relevant to the decision" under section 3(1) of the 2005 Act. That latter task falls, as recognised by Cobb J in *Re DD*, to be undertaken on the specific facts of the case. Once the information relevant to the decision has been identified, the question for the court is whether P is unable to make a decision in relation to the matter and, if so, whether that inability is because of an impairment of, or a disturbance, in the functioning of the mind or brain.
>
> …
>
> In *A Local Authority v JB* at [65], the Supreme Court described s.2(1) as the core determinative provision within the statutory scheme for the assessment of whether P lacks capacity. The remaining provisions of ss 2 and 3, including the specific decision making elements within the decision making process described by s.3(1), were characterised as statutory descriptions and explanations in support of the core provision in s.2(1), which requires any inability to make a decision in relation to the matter to be because of an impairment of, or a disturbance in the functioning of, the mind or brain. Within this context, the Supreme Court noted that s.2(1) constitutes the single test for capacity, albeit that the test falls to be interpreted by applying the more detailed provisions around it in ss 2 and 3 of the Act. Again, once the matter has been formulated and the information relevant to the decision identified, the question for the court is whether P is unable to make a decision in relation to the matter and, if so, whether that inability is *because of* an impairment of, or a disturbance, in the functioning of the mind or brain."

32. Mr Sachdeva KC also relies on the recent decision of Roberts J in *A NHS Trust v ST And Others* [2023] EWCOP 40.

Best Interests

33. These proceedings concern serious medical treatment. Best interests are determined by sections 1 and 4 of the 2005 Act and by following the dicta of Lady Hale DPSC (as she then was) in *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67; [2014] A.C. 591. At paragraphs 18 and 22 the role of the court and its proper focus pursuant to the 2005 Act is identified:

> "Its [the court's] role is to decide whether a particular treatment is in the best interests of a patient who is incapable of making the decision for himself.
>
> …
>
> Hence 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."

34. At paragraph 39, Lady Hale encapsulated the best interests test and held:

> "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."

35. At paragraph 45, Lady Hale described the correct approach to the court's assessment of the patient's wishes and feelings, within the context of the statutory factors identified in section 4 of the 2005 Act (emphasis added):

> "Finally, insofar as Sir Alan Ward and Arden LJ were suggesting that the test of the patient's wishes and feelings was an objective one, what the reasonable patient would think, again I respectfully disagree. The purpose of the best interests test is to consider matters from the patient's point of view. That is not to say that his wishes must prevail, any more than those of a fully capable patient must prevail. We cannot always have what we want. Nor will it always be possible to ascertain what an incapable patient's wishes are. Even if it is possible to determine what his views were in the past, they might well have changed in the light of the stresses and strains of his current predicament. In this case, the highest it could be put was, as counsel had agreed, that "It was likely that Mr James would want treatment up to the point where it became hopeless". But insofar as it is possible to ascertain the patient's wishes and feelings, <u>his beliefs and values or the things which were important to him, it is those which should be taken into account because they are a component in making the choice which is right for him as an individual human being</u>."

36. Any decision of this court, as a public authority, must not violate any rights set out in Schedule 1 to the <u>Human Rights Act 1998</u>. The best interests test should accommodate an assessment of the patient's rights.

<u>The Parties' Submissions</u>

37. Mr Sachdeva's written position statement set out the positions of both the applicant and second respondent Trusts that Mr Y lacks capacity to conduct the proceedings and to make a decision to consent to the surgical intervention. The surgery was in his best interests because without it Mr Y would likely have lifelong pain and a reduction of function in his left arm. He asked the court to authorise restraint.

38. Mr McCormack on behalf of the Official Solicitor agreed that Mr Y lacked capacity to conduct the proceedings. He agreed he also lacked capacity to make the relevant

decision to consent to the surgery because he had false beliefs in respect of the need for the surgery and as to whether he was correctly diagnosed with Paranoid Schizophrenia at all. As a result he is unable to make a decision which is caused by the delusional symptoms of his Paranoid Schizophrenia. Mr McCormack submitted that surgery was in his best interests and, in an insightful submission, picked up on the need in the section 4, 2005 Act analysis to give effect to Mr Y's values, and in particular his independence. He noted he lived alone and travelled alone to London to meet his family. This might be put at risk if he was in pain and lost function in his arm in circumstances where he did not have the surgery. He referred me to Mr Edwards' helpful note of his conversations with Mr Y's brother.

39. Mr Y's father and brother were served with the application. Neither sought to be joined as parties and neither attended the hearing. They had very understandable reasons for not wanting to further complicate their fatherly and brotherly relationships. Both however supported the surgery taking place as soon as possible.

Analysis

40. It is necessary to consider the following issues: i. whether Mr Y has capacity to conduct the proceedings; ii. whether Mr Y has capacity to consent to the surgical intervention to treat his dislocated left shoulder; iii. if he lacks capacity, whether it is in his best interests to undergo the surgical intervention; and lastly, iv. the role, if any, of restraint.

41. I was referred by Mr Sachdeva to the cases of *Re P* [2021] EWCOP 27; [2021] 4 WLR 69 at paragraph 33 and the decision of *Re Q* [2022] EWCOP 6; [2022] COPLR 315 at paragraph 22. He submits it is clear that Mr Y lacks capacity to conduct the proceedings. The Official Solicitor did not contest this issue. Mr Y was not able to engage in the underlying medical issues with Ms Buchan. The evidence of Dr F as to the impact of his Paranoid Schizophrenia on his ability to make relevant decisions is clear. I make the necessary declaration.

42. Mr Y cannot make a decision within the meaning of section 3 of the 2005 Act in respect of whether to provide his consent to the surgical intervention. He is unable to understand and weigh up the risks of the procedure and make a decision not to have

treatment. The matter for the purposes of section 2 (1) of the 2005 Act is whether or not to consent to the surgical intervention to treat his fractured, dislocated shoulder. I largely accept the relevant information identified by Dr F above. I have amended the information as follows:

a. the nature and purpose of the sole treatment option for his shoulder injury;
b. that there are risks to this treatment option;
c. the likely outcome or success of the treatment option;
d. the potential consequences if treatment is not provided.

43. Mr Y's delusional beliefs and thinking result in him not believing the surgery is necessary in order to avoid future pain and the loss of function in his left arm. As a result he cannot weigh up the relevant information to arrive at a decision. He is unable to make a decision within the meaning of section 3 of the 2005 Act. The delusional thinking is caused by Mr Y's diagnosis of Paranoid Schizophrenia. He therefore lacks capacity in respect of the relevant matter, the giving of his consent to the surgical team for the shoulder operation. All practicable steps have been taken to assist him to make a capacitous decision, without success.

44. Section 4 of the 2005 Act governs the best interests analysis. Ultimately there was little dispute about this between the parties. I find it is overwhelmingly in Mr Y's best interests to consent to the surgery to treat his injured shoulder. I consider the following section 4, 2005 Act factors:

a. there are medical and anaesthesia risks to the surgery but these are relatively low and I accept the orthopaedic evidence as to the risks set out above;
b. I accept the clinical evidence that without the surgery Mr Y will be left in pain and this pain will be significant enough to impact on his daily activities;
c. I also accept the clinical evidence that without the surgery, and aside from the pain impacting on function, the functioning of the left arm will be impaired;
d. I accept the information from the family that if Mr Y were not mentally unwell he would have had the surgery to remain active with a fully functioning left arm;

e. I note Mr Y's recent wish is not to consent to the operation. I am not entirely clear why he has been opposed to it. Ms Buchan's note suggests that more recently he has been slightly less opposed to the intervention. For the purposes of the hearing it is right, however, to proceed on the basis that the evidence taken as a whole demonstrates that Mr Y is opposed to the surgery. I firmly take into account his opposition and place weight on it. I do not apply an "off-switch" to his present wishes.
f. I accept Mr McCormack's submission that 'independence' is a value which Mr Y prizes and it is right that significant weight is given to this value pursuant to section 4 (6) (b). If Mr Y had capacity I accept his independence of spirit and his independent lifestyle would likely influence his decision;
g. I accept his father's and his brother's wish for him to have the surgery;
h. I accept the treating psychiatric team and orthopaedic clinicians consider it is in Mr Y's best interests to have the surgery.

45. Lady Hale in *Aintree* focussed the court on the need to understand that "*[t]he purpose of the best interests test is to consider matters from the patient's point of view*." As she goes on to say, values can account for what is 'right' for the patient. Both values and present wishes can furnish the court with the patient's point of view. At times they may be in conflict. In an appropriate context, the patient's history may paint a picture of who they are through their lived values, more accurately than their present day wishes. That is not to discount their wishes. Each part of the picture must be considered to focus the court, as accurately as possible, on the point of view of the subject of the proceedings. In the context of a patient with recurrent severe psychiatric ill-health, their ordinary day-to-day existence may permit the court an understanding of who they are and what they might want with greater clarity than their recorded wishes at the moment of crisis from a hospital bed. Giving effect to Mr Y's value of independence more effectively respects his dignity and promotes his autonomy than seeking to follow his currently expressed wishes and feelings. This underlines the importance of all parties seeking to provide the court with evidence as to who P is, as Mr Edwards helpfully sought to do.

46. For these reasons, considering all the section 4, 2005 factors, it is necessary to place considerable weight on the value of Mr Y's independence, when determining where his best interests lie. I will make a section 16, 2005 Act order that the surgical procedure

is in Mr Y's best interests. I hope it will be carried out on Thursday of this week to avoid any delay.

47. Lastly, I consider whether the court should authorise restraint to give effect to the principal best interests order. The applicant invites the court to authorise a care plan which would permit up to four members of the applicant Trust's security team to use reasonable and proportionate force to administer an intra-muscular injection to provide for sedation to permit the administration of anaesthesia. I was concerned that the acute Trust's 'security' team was being tasked with this sensitive task and not the trained support workers from the second respondent's mental health Hospital. I briefly adjourned to obtain greater clarity. Dr F explained that:

> "[Mr Y] has consistently been more guarded around mental health staff than physical health staff. Currently on the ward if he wishes to have cigarettes he has these with security staff who he is familiar with. There was one incident of him having crisps when he was meant to be nil by mouth. Security attended and he was compliant and gave over the crisps without incident. There has not been any incidents of restraint from security on the ward. I am of the opinion that it is more likely that [Mr Y] will comply with the medication without the need for restraint if security are present rather than mental health staff.
>
> The security staff at [X] Hospital are restraint trained. They work with our team closely and it is a significant part of their role that they are working with patients with mental disorder. For that reason there is a Mental health and governance lead at MFT and they provide appropriate training not only in restraint but in mental health. They have completed similar restraints in the past within the hospital and are in my recall the last team who completed a restraint in the hospital where an anaesthetic level of sedative had to be administered to achieve restraint in a highly agitated patient with psychosis in an emergency."

48. The Official Solicitor raised no objection to restraint in the light of this information. Restraint must be carried out in accordance with terms of section 6 of the 2005 Act and consistently with paragraphs 6.40 to 6.48 of the 2005 Act Code of Practice. Further, it must only be applied by suitably trained staff, as a last resort, whilst always respecting

Mr Y's dignity. I will authorise the same as it is necessary to ensure he safely undergoes the surgical procedure to protect him from harm.

49. I shall also send Mr Y a short letter explaining that the court – and not his family or his mental or physical health team – is responsible for authorising the surgery.

50. I thank all solicitors and counsel for their assistance and ask they amend the care plan and draft an order to give effect to this decision.