Neutral Citation Number: [2020] EWCOP 71 (Fam)

Case No: COP13638589

IN THE COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 21/12/2020

Before:

MRS JUSTICE THEIS

- -

Between:

An NHS Trust	**Applicant**
- and -	
XB	**1st Respondent**
(by his litigation friend, the Official Solicitor)	
- and -	
YB	**2nd Respondent**
- and -	
ZB	**3rd Respondent**

- -

Mr Vikram Sachdeva Q.C (instructed by **An NHS Trust**) for the **Applicant**
Mr Scott Matthewson (instructed by **OS**) for the **1st Respondent**
YB & ZB Appeared In Person

Hearing date: 11th December 2020; Judgment 21st December 2020

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Approved Judgment

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MRS JUSTICE THEIS

A Transparency Order dated 2 September 2020 prohibits the publication of:
(i) any material or information that names
(a) XB as the subject of these proceedings (and therefore a P as defined in the Court of Protection Rules 2017) or
(b) that names any person who is a member of the family of the subject of these proceedings, XB, or
(c) that names XB as a party to these proceedings, or that
(d) any person has been involved in delivering clinical or social care to XB and has taken part in or been referred to in these proceedings.

(ii) the address or contact details of any person listed above.
(iii) The fact of XB's detention in a mental health hospital.
(iv) XB's forensic history.
(v) XB's ethnic origin.

Mrs Justice Theis DBE :

Introduction

1. This case concerns an application by an NHS Trust (hereafter referred to as the 'Trust') relating to the first respondent, XB, who has serious hypertension that is placing his life in danger. This condition requires urgent medication with antihypertensives which the Trust wish to administer to XB, but he is refusing to take it.

2. The Trust consider XB lacks capacity to consent to treatment by this medication due to his diagnosis of resistant paranoid schizophrenia. The Trust state if such medication is given it would have to be covertly administered. The Trust therefore seek a declaration regarding XB's capacity and that it is XB's best interest to covertly administer certain antihypertensive medication in accordance with the Covert Medication Care Plan.

3. The declarations sought are not opposed by XB's litigation friend, the Official Solicitor.

4. Two of XB's siblings, YB and ZB, are parties to the application and have attended this hearing. Their position has been that whilst they understood the need for XB to have the medication due to the urgent medical need and did not actively oppose the declaration, they have fairly and repeatedly made the point of the need for this issue to be brought before the court. whilst they can see no alternative due to the significant risk to XB's health of any other option they have sought, since at least October 2019, for the issue to be the subject of an application to the Court of Protection.

5. Although this application is being heard in open court the proceedings are subject to a Transparency Order made by MacDonald J on 2 September 2020. This order prohibits publication of any information relating to any individual having day to day care or medical responsibility for XB, and/or any employees of the Trust including the Trust witnesses, in order to protect their privacy. In addition, it prohibits identification of XB's detention in a mental health hospital, his forensic history, his ethnic origin, hospital and Trust in order limit the risk of jigsaw identification.

6. The hearing took place on 11 December 2020. At that hearing the court raised the issue of delay in issuing these proceedings and directed the parties to provide further submissions that address that issue by 14 December 2020. That further information was provided on 16 December by the Trust and the Official Solicitor, together with subsequent emails from YB and ZB commenting on the additional information. The matter was listed for judgment on 21 December 2020.

7. A summary of the court's decision is set out below.

8. The court is going to make the declaration sought that XB lacks capacity to consent to antihypertensive medication and it is lawful for XB to be given antihypertensive medication covertly, in accordance with the Covert Medication Care Plan dated March 2020. The medical evidence is clear that if XB does not receive that medication going forward there is a very serious risk to his health, including his death. XB lacks the capacity to make that decision regarding medical treatment as he does not accept he has hypertension due to his mental ill-health and consequently is unable to weigh the advantages and disadvantages of taking the medication prescribed.

9. The administration of covert medical treatment is a serious interference with an individual's right to respect for private life under Article 8 ECHR. whilst the family may have realistically recognised the need for such treatment to be administered if the position was urgent and life threatening, they continued to express concern about it and wanted the matter considered by the court where XB would have the opportunity of representation, and the decision would be taken separately from those who have a therapeutic relationship with XB and the family who seek to support XB.

10. In those circumstances the application to the court should have been made earlier, or at the very least very serious consideration given to doing so, in accordance with the Supreme Court decision in *An NHS v Y [2018] UKSC 46 [2019] AC 978 at [125] and [126]*. An application was required due to the circumstances of this case namely the nature of the proposed course of action (administration of covert medication), the position of the family and their wish for this matter to be considered by the court, the potential impact of this course of action on the relationship XB has with the clinical team involved in the covert medication decision and XB's relationship with the family due to their involvement with the clinical team responsible for that decision.

11. Making an application to the court was raised by YB and ZB as long ago as July 2019, albeit in the context of proposed urology treatment, and was repeated again by them in October 2019, in the context of antihypertensive medication. By then this medication was being given covertly to XB following a Best Interests meeting on 26 September 2019 where the family views were reported. YB and ZB were not invited to this meeting, which the Trust now accept was a mistake. Whilst XB discovered he was covertly being given this medication on 30 November 2019, the management of that did not obviate the need for an application. It remained clear XB was likely to continue to object to having the medication and the medical evidence was likely to remain the same regarding the urgent need for him to continue to have it.

12. Further avoidable delays resulted in the application not being made until 6 August 2020, even though the Trust accept they had received legal advice on 16 April 2020 that an application was necessary. The hearing not taking place until 11 December 2020 was largely due to the failure to secure a fixed hearing date in the directions order made on 2 September 2020.

13. The consequence of these avoidable delays is that the court is being asked to consider declarations over 7 months after the Trust had re-started covert administration of antihypertensive medication on 23 April 2020, and at a time when it is recognised that XB should be informed of the administration of the covert medication in the next few weeks.

14. In making these observations the court does not seek to undermine the declarations it has made and the evidence that support those declarations being made, but it remains the position that this application and this hearing should have taken place much earlier than it has. This view accords with the Guidance issued by the Vice President of the Court of Protection dated 17 January 2020 *[2020] EWCOP 2*, in particular paragraphs 8 c) and 10.

Relevant Background

15. XB, who is in his 50's, is detained at a Special Hospital (a high security mental health hospital, hereafter referred to as 'the Hospital') following a serious assault on a medical professional. He has been there for a number of years and is diagnosed with treatment resistant paranoid schizophrenia. His beliefs have remained largely the same for a significant number of years.

16. In early 2020 XB seriously assaulted a member of staff. Following that assault XB was placed in seclusion. He was then managed by way of being in Long-term Segregation ('LTS') on the High Dependency Ward due to the risks he poses to other people. This ward is for patients who require a structured and safely staffed ward offering care and treatment for patients with mental illnesses.

17. Proceedings in the First Tier Tribunal relevant to XB's Mental Health Act detention were adjourned, subject to review, as XB was not considered to be well enough to participate in the hearing. More recently they have been adjourned for more up to date evidence to be filed.

18. The reviews of XB's long term segregation were not effective for some time due to XB's inability to engage with the medical staff conducting the reviews. However, following improvement in XB's position the LTS was terminated on 19 August 2020.

19. XB suffers from severe hypertension with systolic blood pressure readings of over 200. These give rise to a very significant risk of serious complications such as heart attack, stroke, heart failure, peripheral vascular disease and end stage renal disease.

20. Regular assessments as to XB's capacity in January 2019 (Dr H and Ms J), June 2019 (Dr T), January, April and August 2020 (Dr G) each concluded that XB lacked capacity at the time of each assessment to make decisions about his medical treatment. whilst XB may be able to understand the parameters of a healthy blood pressure range he does not accept it could relate to him and is not able to balance the risks and benefits regarding the medical advice about the need for him to take the medication recommended to avoid serious physical ill health, or death. The impediment is that he disbelieves the diagnosis, despite clear evidence to the contrary. The source of his disbelief is his delusional thinking caused by his treatment resistant paranoid schizophrenia.

21. The chronology demonstrates the steps the Trust have taken to manage XB's medical position.

22. At a Best Interests meeting in January 2019, attended by YB and ZB, there were discussions regarding XB's capacity and urological tests (CT Urogram and Cystoscopy) that were then considered to be needed. A further meeting to discuss this proposed treatment took place on 2 April 2019 attended by XB, YB and ZB. The Trust accept that at that meeting the Safeguarding Lead did consider XB had capacity to decide about having the tests although the meeting records notes that Dr H (Consultant Forensic Psychiatrist and XB's responsible clinician) raised the issue as to whether that assessment of capacity had been thorough.

23. At a further Best Interests meeting on 31 July 2019 both YB and ZB attended and the possibility of an application to the Court of Protection for urological purposes was discussed. YB observed that if the matter went to the court that would be viewed as

something independent and the family would still be able to support XB. The meeting decided an application would be made to the court regarding the proposed urology treatment.

24. Both YB and ZB attended a Care Programme Approach (CPA) meeting on 28 August 2019.

25. In September the medical records note Dr G (Consultant Forensic Psychiatrist) spoke to XB's brother just prior to a Best Interests meeting on 26 September 2019. The options were considered and discussed in the context where there was a significant elevation in XB's blood pressure and he was continuing to refuse to take medication to treat his hypertension. XB's family were not invited to and did not take part in the subsequent Best Interests meeting, which the Trust accept was a mistake. The views of the family were recorded in the meeting as being they would prefer medication is not administered against his wishes and would go ahead with it if treatment is urgent and his condition is life threatening. The decision was made at that meeting to put in a structured plan to covertly administer the antihypertensive medication doxazosin.

26. A letter dated 3 October 2019 from Consultant Cardiologist, Dr N confirmed that any interventions to force administration or cannulations for intravenous treatment should be avoided as it would very likely further exaggerate XB's blood pressure response and therefore his risk. The letter also confirmed there is no antihypertensive depot preparations available.

27. At a meeting between YB and Dr G on 8 October 2019 YB repeated her request for an application to the Court of Protection to be made. In her email dated 2 October 2019 to XB's social worker YB stated 2019 *'...if the assessment given by [the Hospital] and the medical assessment given by [another hospital] is that administration of medication is paramount in saving his life then it would be in everyone's best interest for the hospital/hospitals to* ***speedily*** *put through the application to the Court of Protection in order for an Official Solicitor to be appointed and the final decisions be made independently'(emphasis added).* The internal notes of the meeting on * October record *'the current plan is to prescribe doxazosin which can be administered covertly if refused in view of the severity of the hypertension and the risk to his health. If this were to be a longer term plan, court of protection proceedings may be required'.*

28. On 30 November 2019 XB became aware the antihypertensive medication was being given covertly in his coffee. Staff sought to persuade him to continue to take the medication but with no success. XB refused to see Dr F(Consultant Forensic Psychiatrist) and Dr G, with the result that Dr G wrote to him on 4 December 2019 explaining the reasons for the decision and that he was the responsible clinician for the decision regarding administration of covert medication. That letter explained the reasons for the decision, the life threatening medical risks if the medication was not taken and recognised XB's anger. The letter concluded as follows *'..that I want for you more than anything else is for your heart to be ok and for you not to have a heart attack. So, I'd ask you now to consider taking the same medicine that we put in your coffee in the same way as you would other tablets. It's called doxazosin ad I know it works for you. It really has helped your blood pressure. If you don't take it or another blood pressure tablet like it then you may die. If you like you can help us choose the medicine. It may save your life.'*

29. This letter did not bring about any change and XB continued to refuse to take this medication.

30. In January 2020 Dr G became XB's Responsible Clinician. Dr G' involvement in XB's care in late 2019 was due to the need to cover in Dr F's absence.

31. Following this letter an agreement was entered into with XB, as set out in the document dated 10 March 2020, signed by XB, Dr G and Dr K. That confirmed XB agreed to take the antihypertensive medicine and continue to have his blood pressure monitored each day.

32. At a Best Interests meeting on 12 March 2020 YB and ZB were invited, but were unable to attend. They had raised in a communication before this meeting that an application to the Court of Protection should be considered as in their words it would *'safe guard my brother(s) rights and also the hospital from any fall out from the situation'.* The meeting recorded what YB had said in an email on 2 October 2019 (as set out in paragraph 27 above). The decision was taken at that meeting that covertly administering medication was in XB's best interests and an (undated) Care Plan was subsequently produced to minimise any discovery by XB that this is being done. The meeting also decided to make an application to the Court of Protection noting that *'The family have sought a Court of Protection ruling to further safeguard [XB's] rights and so that any future decision regarding the management and treatment of hypertension can be an objective one'.* The meeting record notes the risks around covert medication including that XB may again discover the decision to administer cover medication, which could cause reluctance around dietary intake, an increase in paranoid feelings and fracture therapeutic and other relationships.

33. On 22 March 2020 XB withdrew his consent to taking the antihypertensive medication.

34. On 24 March 2020 the Trust sought legal advice as to the need for a COP application for covert medication. On 27 March 2020 the Trust were advised that an urgent COP application was not necessary for covert medication on the basis that there appeared to be no dispute as to best interests.

35. The minutes of the 12 March 2020 Best Interests meeting were received by the Trust's solicitors on 15 April 2020 and they advised the Trust on 16 April 2020 that a COP application was necessary.

36. An updated capacity assessment was undertaken on 20 April 2020 by Dr G.

37. Covert administration of antihypertensive medication, amlodipine, commenced on 23 April 2020 and continues to date. At the same time Dr G has continued to prescribe doxazosin, another antihypertensive medication, in case XB changes his position and agrees to take it. Dr G is of the view that XB knows about the covert medicine regime as it has been reported that he asks his MHA solicitor about this.

38. The Trust sought to instruct an independent Consultant Cardiologist regarding treatment options. Dr Braganza was instructed on 11 May 2020 and her final report is dated 19 July 2020.

39. Dr G signed his first statement on 6 August 2020 and this application was issued on 6 August 2020. It was listed for directions on 2 September 2020. The parties agreed directions for the filing of updating evidence and the order provided for the listing of the matter on the first open date after 15 September 2020. It is unfortunate the parties did not seek or request a fixed hearing date in the order, which would have readily been given. By not doing that it has caused further delay. Mr Mathewson's clerk emailed dates convenient for him to the court on 7 October, the court responded on 14 October listing the matter for this hearing. All parties in these cases should in future ensure orders have, if possible, the next hearing date in them to avoid what occurred in this case.

40. The evidence of the risks to XB's health if he does not take the antihypertensive medication are set out in the expert report from Dr Braganza, an experienced Consultant Cardiologist, who was instructed by the Trust. Her report dated 19 July 2020, makes clear that without treatment XB's health will seriously decline and that he will probably die. Her report set this out as follows:

"3.15 With level peaking at 231 mmHg systolic XB has an 80% 2 year mortality risk if left untreated; if adequately treated, his risks would reduce to near that of a normotensive individual.

3.16 I am concerned that untreated at these levels he is at risk of development of malignant hypertension which carried life threatening risk of acute stroke, heart failure, encephalopathy and aortic dissection and hence classified as a medical emergency.

3.17 I estimate 1% of my patients who have hypertension, have levels above 200mmHg systolic. In my experience no individual with a level above the severe threshold of 180mmHg systolic has refused drug treatment.

3.18 Since the introduction of amlodipine on 23/4/20 XB's BP has steadily improved to safe levels approaching treatment targets of [less than] 140/90 mmHg.

3.19 Amlodipine is a well tolerated safe medication with a low side effect profile….

3.22 I appreciate this is a highly unusual case but I feel covert medication to treat his life threatening hypertension is justified, particularly when the risk of treatment is confined to mild side effects as a consequence of drug therapy."

41. In her oral evidence Dr Braganza described XB's blood pressure readings as being in the '*extremely high risk category'* and considered without treatment there was an 80% chance he would die within a year.

42. In his statements filed in these proceedings, Dr G has set out the risks of the covert treatment being discovered by XB. He described that in the documents he has found which offer opinions about covert treatment none went so far to address the matter of a strategy to end the procedure, and how one might best achieve this. Dr G hoped that by his continued intervention to treat XB's mental disorder that XB might enjoy a recovery to a degree that would enable him or a colleague to explain to XB the rationale for the decision to treat covertly. In Dr G's view one benefit of Court of Protection proceedings is that it may provide a means to assist XB in his longer term recovery and to help

facilitate a frank discussion. He notes that this would require a significant improvement in XB's mental state, as the disorder he suffers from is very resistant to treatment and his previous attempt to do this in writing was unsuccessful.

43. In his second statement, dated 16 September 2020, Dr G notes the improvements in XB's mental health, such that the LTS was discharged in August. He concludes in that statement that he considers there is a time soon when the covert medication practice can be revealed to XB, underlying that the Trust are responsive to improvements in XB's mental state. Dr G considers that with a decision by the Court of Protection, evidence of how the medication has assisted his blood pressure readings, XB's acceptance on a rehabilitation ward, an endorsed MHA for T3 and engagement with XB all lead towards that position being reached.

44. The third statement from Dr G, dated 10 December 2020, sets out the more structured and improved arrangements that have been put in place for communication between the Trust and the family, with the named forensic social worker being the first point of contact. He stated that the planned date for XB's transfer to the rehabilitation ward will be considered following the conclusion of these proceedings and confirmed the review of the use of covert medication takes place at the weekly meetings of the clinical team.

45. In his oral evidence Dr G set out that it was likely there would be a discussion soon with XB about the use of covert medication due to the increased stability in his mental health and the difficulties in continuing covert medication within a rehabilitation ward setting. After the hearing concluded on 11 December 2020 a meeting took place between the clinical team and the family present at the hearing as to how and when that discussion with XB was likely to take place.

46. The evidence from the family comes from discussions with the Official Solicitor's representative and the joint statement from YB and ZB. Their position can be summarised as follows; they do not consent to what has taken place, wish there had been more consultation or engagement with them earlier but realistically understand the necessity for covert medication in light of the very serious risks to XB's health if the medication is not taken.

47. Both YB and ZB were present at this hearing and listened to the evidence and submissions. They were clear in their continuing wish to constructively engage with those who are responsible for XB's care and to provide what support they can for XB.

48. Following the hearing on 11 December 2020 the Trust filed a detailed chronology, a document setting out their observations on matters raised during the hearing regarding the timeframes for this application and the plan going forward. The Trust filed two additional witness statements. The first from the Trust solicitor setting out the background and chronology of the timeframe for making this application. The second was from Dr G, giving further details about his involvement in the decisions relating to covert medication and his rationale regarding the decision to make this application.

49. Both YB and ZB have responded to this additional material in a number of emails.

Legal Framework

50. In relation to the issue of capacity s 3 Mental Capacity Act 2005 (MCA 2005) provides that a person lacks capacity for the purposes of s2 if that person is *'…unable to make a decision for himself if he is unable*

(a)to understand the information relevant to the decision,

(b)to retain that information,

(c)to use or weigh that information as part of the process of making the decision, or

(d)to communicate his decision (whether by talking, using sign language or any other means).

(2) A person is not to be regarded as unable to understand the information relevant to a decision if he is able to understand an explanation of it given to him in a way that is appropriate to his circumstances (using simple language, visual aids or any other means).

(3) The fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him from being regarded as able to make the decision.

(4) The information relevant to a decision includes information about the reasonably foreseeable consequences of—

(a)deciding one way or another, or

(b)failing to make the decision.

51. The court has been referred to the helpful summary of the relevant law on capacity as set out by MacDonald J in *Kings College NHS Foundation Trust v C* [2015] EWCOP 80 at paragraphs 24 – 39.

52. Any decision relating to a person who lacks capacity is governed by what is in their best interests, having regard to the matters set out in s 4 MCA 2005.

53. When assessing those interests the court is required to form an evaluative judgment having regard to the matters set out in s4 including considering matters, so far as the court can, from the point of view of the protected party and viewing their best interests not only from the medical perspective but also socially and psychologically as well (*Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67 at paragraphs 39 and 45).

54. In relation to covert medical treatment Baker J (as he then was) emphasised in *A Local Authority v P & ors* [2018] EWCOP 10 that such treatment is a serious interference with an individual's right to respect for private life under Article 8. He noted in that judgment that the Supreme Court decision in *An NHS Trust v Y [2019] AC 978* was awaited but he observed that in the case he was concerned with (involving the covert insertion of a contraceptive device) *'it is in my judgment highly probable that, in most, if not all, cases, professionals faced with a decision whether to take that steps will conclude that it is appropriate to apply to the court to facilitate a comprehensive*

analysis of best interests, with P having the benefit of legal representation and independent expert advice'.

55. In *An NHS v Y* Lady Black recognised at paragraphs 125 and 126 that although an application to the court is not necessary in every case [126] *'there will undoubtedly be cases in which an application will be required (or desirable) because of the particular circumstances that appertain, and there should be no reticence about involving the court in such cases'.*

56. The principle that underpinned the Guidance issued by Hayden J (Vice President of the Court of Protection) on 17 January 2020 relating to applications concerning medical treatment was that where there was agreement at the end of the relevant decision making process in accordance with the MCA 2005, with any relevant professional guidance being observed and relevant guidance in the Code of Practice being followed regarding the decision making capacity and best interests of the person in question then, in principle, medical treatment may be provided without application to the court (see paragraph 6). However, the Guidance equally makes clear at paragraph 8 that if at the end of the medical decision making process there remains concerns that the way forward in any case there is a *'lack of agreement as to a proposed course of action from those with an interest in the person's welfare'* (paragraph 8 (c)) then *'it is highly probable that an application to the Court of Protection is appropriate. In such an event consideration must always be given as to whether an application to the Court of Protection is required'* (paragraph 8). The Guidance also makes clear at paragraph 10 that in any case that *'involves a serious interference with the person's rights under the ECHR'* it is *'highly probable'* that an application should be made.

57. Attached to the first statement of Dr G is information from the Psychiatric Bulletin from the Royal College of Psychiatrists in January 2018 detailing the College Statement on Covert Administration of Medicines.[1] This statement recognises the key importance of the autonomy of individuals who refuse treatment but recognises there are times when severely incapacitated patients can neither consent or refuse treatment. In those circumstances the treatment should be made available to severely incapacitated patients judges according to their best interests and administered in the least restrictive way. In exceptional circumstances, this may require the administration of medicines within foodstuffs, when the patients is not aware that that is being done. The College advocates in such circumstances the need to keep clear records of the decision making process and the need to keep the decision under regular review.

Submissions

58. In the written skeleton arguments on behalf of the Trust and the Official Solicitor they both emphasise

(1) XB's inability to

(i) understand he has hypertension and that the risks, which he does understand, apply to him;

[1] https://www.cambridge.org/core/journals/psychiatric-bulletin/article/college-statement-on-covert-administration-of-medicines/F0FAD544C59EF28D167D49A8F4BA921E

(ii) understand that antihypertensive medication is in order to keep him well and prolong his life not to harm him or control his life.

(2) The clear medical evidence that underpins the decision for covert medication due to the serious risks to XB if he does not take it. Dr Braganza's evidence is unequivocal that unless he has this medication his health will seriously deteriorate in the short term, with a consequent risk to his life.

Discussion and Decision

59. There are a number of features of this case where there can be no dispute.

60. First, XB suffers from serious hypertension as outlined in the report from Dr Braganza. XB's blood pressure readings when he is not on antihypertensive medication have reached very high levels. The goal is to reduce the levels to below 140/90 mmHg. All the guidelines agree that by the time the levels reach 150-160/95-100 mmHg drug treatment is recommended to reduce the risks of stroke, heart attack, heart failure, peripheral vascular disease and end stage renal disease. Severe hypertension is defined as over 180/100 mmHg. XB's highest recording has been 231 systolic and between October 2019 and May 2020 averaged at 184/122 mmHg. Dr Braganza's report sets out at para 2.5.7 the clear reduction in blood pressure readings during the time XB has been in receipt of amlodipine, nearly reaching the treatment targets of less than 140/90. It is noted in the recent statement from Dr G he sets out that since 4 October 2020 only one reading has been less than 140/90 mmHg, so the position remains serious. Consequently, there is a continuing need for the medication to be administered to prevent the serious risks to XB's health as outlined above.

61. Second, XB lacks the capacity to make the decision about the need to take the antihypertensive medication. XB understands what hypertension is and the serious consequences if left untreated. However, he continues to refuse treatment because he does not believe that he suffers from hypertension. He considers staff are lying to him about his diagnosis in order to damage or control him. As a result of his mental ill health he is unable to use or weigh up the information about the benefits and risks of taking or not taking the medication, as he does not believe he suffers from the condition being treated.

62. As regards XB's best interests, as Mr Matthewson outlines in his written submissions, there are four ways the Trust could approach treatment:

(1) Give up and offer no treatment, which would expose XB to serious and significant health risks of death or serious health complications.

(2) Offer treatment, as the Hospital have continued to do which XB has refused, leaving XB open to the same risks as in (1).

(3) Force XB to take the medication against his will with the associated risk of physical injury to himself and others due to his aggression and the risk of mental deterioration to XB and/or death or serious illness due to the strain on his cardiovascular system.

(4) Administering medication covertly.

63. Options (1) and (2) will probably lead to premature death or serious illness and (3) could be worse as it might accelerate those consequences. No party suggests that any of these options would meet XB's best interests.

64. The evidence demonstrates that (4) has been effective in treating XB's hypertension, as demonstrated in Dr Braganza's report. The benefits of taking the medication clearly outweigh the risks, which XB's family recognise.

65. The main risk that needs to be considered is if XB discovers that he has been deceived, which would confirm his suspicions. There is a risk he could react to such a discovery with aggression, refusing some or all of his medication (which he currently takes) or by refusing to co-operate generally.

66. In his third Dr G set out the difficulties of continuing to administer covert medication after transfer to a rehabilitation ward. The intention is to manage informing XB of what has taken place and why. Dr G's evidence is that that discussion would take place in weeks. In discussions after the hearing concluded between the clinical team and the family it was decided a further meeting would take place in the next two weeks to discuss and finalise the plan for informing XB about the covert medication and strategies for minimising any consequences to the relationship between XB and his family. Going forward, the Trust are committed to appropriately involving the family in discussions over XB's treatment in the future.

67. In the additional material provided after the hearing the Trust submitted the rationale for making the application to the Court was

    (i) the risk that a second course of covert treatment could jeopardise Dr G' relationship with XB;

    (ii) concern that the family should not endure any kind of fracture or collapse in the quality of their relationship with XB caused by their involvement with Dr G; and

    (iii) continuing awareness of the family's views about the role of the court.

68. The Trust accept the time taken to prepare the application was perhaps longer than would have been ideal, given the family's desire for a court determination. They fairly make the point that the Trust was under great strain during the relevant time due to Covid-19.

69. Since mid 2019 both YB and ZB have been anxious for the decisions being made about XB's medical treatment to be the subject of an application to the Court of Protection. This was agreed by the Trust in July 2019 in relation to the proposed urology treatment, then acknowledged again in October 2019 regarding the covert administration of antihypertensive medication and repeated again in March 2020. Save for a brief period in October 2019, YB and ZB only had the benefit of legal representation between May and September 2020 and relied on others for the necessary steps to be taken.

70. Drawing the matters set out above together the following conclusions are reached.

71. On the evidence there is no dispute regarding XB's lack of capacity to make decisions about his medical treatment. Due to his mental ill health he is unable to accept the clear

medical evidence that supports his diagnosis of hypertension and, as a consequence, is unable to understand the need to take the antihypertensive medication, or balance the serious consequences for his own health if he doesn't take it.

72. The decision taken at the Best Interest meetings on 26 September 2019 and 12 March 2020 to administer antihypertensive medication covertly may have been recognised by the family as being necessary due to the serious risks to XB's health if it wasn't taken, however that was in the context that they have repeatedly made clear they consider an application should be made to the Court of Protection. This view is consistent with the views expressed by the family in July 2019 relating to the proposed urology treatment. As was acknowledged by the Trust at the hearing, both YB and ZB have always sought to assist and support XB in any way that they can. In the light of the history to this matter they were entitled to rely on the Trust making an application in a timely way. The Trust acknowledge the family should have been invited to the September 2019 Best Interest meeting and the family had made clear prior to that meeting and afterwards that a court application should be made.

73. In those circumstances it is difficult to understand the rationale of the Trust who now state they did not consider an application to the Court of Protection was necessary prior to March 2020. I do not accept, as the Trust submit, that the family were aware that until 12 March 2020 the Trust did not consider that an application to the Court of Protection was necessary. On the contrary, there was a positive decision to issue proceedings in July 2019 (albeit in the context of the urology treatment), YB had stated in October she still wished that to happen and there is a reference buried in a case note of the discussion between YB and Dr G that proceedings may be required if covert medication was to be a longer term plan.

74. The rationale relied upon by the Trust for issuing proceedings in March 2020, as set out in paragraph 68 above, were as applicable in September 2019 as they were in March 2020. The evidence demonstrates the continuing anxiety expressed by both YB and ZB about the administration of covert medication to XB. Such a course is a serious interference with XB's Article 8 rights and, in my judgment, falls within the category of cases where because of the particular circumstances there should be no reticence about involving the court.

75. The further delays after March 2020 are unfortunate. In my judgment the application should have been issued and not awaited expert evidence. Such evidence could have been sought after the application was issued. The Trust had the primary evidence to support the decision to administer covert medication from the treating Consultant Cardiologist, Dr N. By issuing proceedings earlier XB would have had the benefit of independent representation, the parties would have been assisted by the structure of the court proceedings and it is very likely the hearing would have taken place much earlier.

76. The court recognises this decision is being made with the benefit of hindsight, and understands the need to take account of the very real pressures on the Trust due to Covid-19. However, in my judgment, what happened in this case demonstrates the need in cases such as this for very serious consideration to be given by any Trust in a similar situation of the need for an application to be made to the court.