Neutral Citation Number: [2025] EWCOP 41 (T3)

Case No: COP 20022915

IN THE COURT OF PROTECTION
IN THE MATTER OF THE MENTAL CAPACITY ACT 2005
AND IN THE MATTER OF BV

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 20 November 2025

Before:

MR DAVID REES KC

(Sitting as a Tier 3 Judge of the Court of Protection)

B E T W E E N :

(1) UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST
(2) MIDLANDS PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST
Applicants

and

BV
(By his litigation friend the Official Solicitor)

Respondent

- -

Ms Nageena Khalique KC (instructed by **Legal Department University Hospitals of North Midlands NHS Trust** and **Weightmans**) for the Applicants
Ms Sophia Roper KC (instructed by **the Official Solicitor to the Senior Courts**) for the Respondent

Hearing date: 3 November 2025

Approved Judgment

This judgment was handed down remotely at 10.30am on 20 November 2025 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

This judgment was delivered in public but a transparency order is in force. 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 BV and members of his family must be strictly preserved. All persons, including representatives of the media and legal bloggers, must ensure that this condition is strictly complied with. Failure to do so may be a contempt of court.

Mr David Rees KC:

Introduction

1. BV is a sixty four year old man. He has been diagnosed with a mild learning disability, autistic spectrum disorder, schizoaffective disorder, schizophrenia and depression. He is currently detained in a unit at Hospital A (a hospital that is under the management of the Second Applicant). He is detained under hospital and restriction orders that were made in 2024 under sections 37 and 41 of the Mental Health Act 1983, following a conviction for a criminal offence.

2. In July of this year BV was admitted to a hospital (Hospital B) managed by the First Applicant with abdominal pain and bleeding. Following tests, it is strongly suspected that BV has cancer of one of his kidneys. His treating doctors wish to undertake a radical nephrectomy of the affected kidney; that is to say they wish to remove it. The proposed treatment has been discussed with BV. However, as I explain below, it is the unanimous view of both his consultant psychiatrist from the Second Applicant and the treating team at the First Applicant that BV lacks capacity consent to this procedure. BV is able to express his wishes and feelings, and has done so, making clear that he does not wish to undergo the proposed surgery.

3. The matter therefore comes before the Court of Protection to determine (a) whether BV has capacity to consent to the proposed procedure and, if he lacks such capacity, (b) whether it is in his best interests to undergo the operation.

4. The Applicants are represented by Ms Nageena Khalique KC; BV is represented through his litigation friend, the Official Solicitor, by Ms Sophia Roper KC. I am extremely grateful to both counsel for their clear and helpful submissions, both orally and in writing.

5. I announced my decision at the conclusion of the hearing. I was satisfied that (a) BV lacked capacity to make decisions in relation to the proposed treatment and (b) that it was in his best interests to have the proposed treatment in accordance with the care plan that had been prepared by the Applicants. This judgment sets out my reasons for that decision.

The Law

6. In order for the Court of Protection to have jurisdiction in a case, it must be satisfied on the balance of probabilities that the person in question, referred to in the Mental Capacity Act 2005 ("the Act") as "P", lacks capacity to take the specific decision or decisions in question.

7. In determining this question (and every other decision it takes under the Act), the Court must keep in mind the principles enshrined at section 1 of the Act namely:

- A person must be assumed to have capacity unless it is established that he lacks capacity.
- A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
- A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
- An act done, or decision made, under the Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
- Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action."

8. Under the Act capacity is both time and decision specific. The test of capacity is set out at section 2 of the Act. This provides as follows:

> "(1) For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.
>
> (2) It does not matter whether the impairment or disturbance is permanent or temporary.
>
> (3) A lack of capacity cannot be established merely by reference to—
>
> (a) a person's age or appearance, or
>
> (b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about his capacity.
>
> …

Section 3 of the Act provides guidance on what is meant by "unable to make a decision for himself" in subsection 2(1) of the Act. This provides:

> (1) For the purposes of section 2, a 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."

9. The proper approach for a court determining the question of capacity was explained by the Supreme Court in *A Local Authority v JB* [2021] UKSC 52; [2022] AC 1322. The court must first determine whether the person in question ("P") is unable to make a decision for himself in relation to the relevant matter. If P is unable to make the decision, the court must then determine whether the inability to make the decision is "because of an impairment of, or disturbance in the functioning of, the mind or brain. There must be a "clear causative nexus" between the inability to make a decision in relation to the matter and the impairment of, or disturbance in the functioning of P's mind or brain (see *Re JB* at [78] per Lord Stephens JSC).

10. Where P lacks capacity to make the relevant decision, the court may make the decision on his behalf (section 16(2)(a)). Any such decision must be made in his best interest (section 1(5)). The Act does not seek to define "best interests"; instead setting out at section 4 a range of factors that have to be taken into account when determining what is in someone's best interests. The matters to be taken into account extend to "all relevant circumstances" and include:
(1) Considering, so far as is reasonably ascertainable:
(a) The person's past and present wishes and feelings (and, in particular any relevant written statement made by him when he had capacity);
(b) The beliefs and values that would be likely to influence his decision if he had capacity; and
(c) the other factors that he would be likely to consider if he were able to do so.
(2) Taking into account, if it is practicable and appropriate to consult them, the views of:
(a) Anyone named by the person as someone to be consulted on the matter in question or on matters of that kind;
(b) Anyone engaged in caring for the person or interested in his welfare;
(c) Any done of a lasting power of attorney granted by that person; and
(d) Any deputy appointed for the person by the court.

11. The importance of taking the person's wishes and feelings into account in the court's decision was emphasised by Baroness Hale JSC in *Aintree University Hospital Trust v James* [2013] UKSC 67; [2014] AC 591. At paragraph [39] she stated:

> "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."

The judge continued at [45]:

> "…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 in so far as it is possible to ascertain the patient's wishes and feelings, 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."

12. Additional useful guidance on this issue was provided by Munby J in *Re M; ITW v Z* [2009] EWHC 2525(COP); [2011] 1 WLR 344 at [35].

> " I venture, however, to add the following observations.
>
> (1) First, P's wishes and feelings will always be a significant factor to which the court must pay close regard: see *Local Authority X v M* [2009] 1 FLR 443, paras 121–124.
>
> (2) Secondly, the weight to be attached to P's wishes and feelings will always be case-specific and fact-specific. In some cases, in some situations, they may carry much, even, on occasions, preponderant, weight. In other cases, in other situations, and even where the circumstances may have some superficial similarity, they may carry very little weight. One cannot, as it were, attribute any particular a priori weight or importance to P's wishes and feelings; it all depends, it must depend, upon the individual circumstances of the particular case. And even if one is dealing with a particular individual, the weight to be attached to their wishes and feelings must depend upon the particular context; in relation to one topic P's wishes and feelings may carry great weight whilst at the same time carrying much less weight in relation to another topic. Just as the test of incapacity under the 2005 Act is, as under the common law, "issue specific", so in a similar way the weight to be attached to P's wishes and feelings will likewise be issue specific.

(3) Thirdly, in considering the weight and importance to be attached to P's wishes and feelings the court must of course, and as required by section 4(2) of the 2005 Act, have regard to *all* the relevant circumstances. In this context the relevant circumstances will include, though I emphasise that they are by no means limited to, such matters as:

(a) the degree of P's incapacity, for the nearer to the borderline the more weight must in principle be attached to P's wishes and feelings: *Local Authority X v M* [2009] 1 FLR 443, para 124;

(b) the strength and consistency of the views being expressed by P;

(c) the possible impact on P of knowledge that her wishes and feelings are not being given effect to: see again *Local Authority X v M* , at para 124;

(d) the extent to which P's wishes and feelings are, or are not, rational, sensible, responsible and pragmatically capable of sensible implementation in the particular circumstances; and

(e) crucially, the extent to which P's wishes and feelings, if given effect to, can properly be accommodated within the court's overall assessment of what is in her best interests."

BV's medical situation

13. I have been provided with evidence concerning BV's medical situation as follows:

(1) Dr A, a consultant Anaesthetist at Hospital B provided a witness statement dated 30 September 2025. He is the anaesthetist who was to carry out the operation on BV and his evidence explained the steps that would be taken should the court decide that BV should undergo the proposed surgery. He attended the hearing remotely, but was not required to give evidence.

(2) Dr B, a consultant urologist at Hospital B and BV's treating clinician provided a witness statement dated 1 October 2025 and attended the hearing remotely and gave oral evidence to the court.

(3) Dr C, BV's treating psychiatrist at Hospital A, provided a detailed COP3 Assessment and a witness statement both dated 9 October 2025. He attended the hearing remotely and gave oral evidence to the court.

(4) Dr D, a colleague of Dr B, also a consultant urologist at Hospital B, provided a witness statement dated 24 October 2025 which answered some questions that had been posed by the Official Solicitor in Dr B's absence. He was not required to attend the hearing.

14. In summary, BV attended the accident and emergency department at Hospital B in July 2025 with abdominal pain. A CT scan identified a large mass on his right kidney and internal bleeding. Following a MDT meeting the view was reached that this was highly suspicious of renal cancer. BV was discharged back to Hospital A. However, he was readmitted to Hospital B in late August with a suspected kidney infection. A further CT scan was carried out which indicated that the mass on his right kidney had grown.

15. There is no evidence that the tumour has metastasised, and any cancer is likely to be confined to the kidney.

16. Dr B's evidence was that if nothing was done, then if the tumour is cancerous (as is highly likely to be the case), the cancer would progress. Whilst it was difficult to say how quickly this would occur, he considered that without surgery BV would be unlikely to survive for more than 2-3 years. Left untreated BV would experience increasing pain and multiple admissions to hospital for internal bleeding. Even if the tumour were benign the risk of bleeding and pain would be the same and BV would be at a risk (approximately 5%) of death from a haemorrhage.

17. Dr B considered that the removal of BV's affected kidney by laparoscopic (keyhole) surgery offered an 80% prospect of the surgery being curative (that is to say no recurrence of the cancer within 5 years) without any follow up treatment being required. Such an operation would involve BV being in hospital for 1-3 days and a recovery time of 4-6 weeks. Whilst surgery itself carries risks (such as infection, bleeding, deep vein thrombosis, pulmonary embolism or damage to surrounding areas), and BV is considered to be at above average risk of complications (9.2% risk of a serious complication as opposed to a 6% risk for the general population and a 9.7% risk of any complication as opposed to an average risk of 6.9%), the surgery is still very likely to be successful.

18. Dr B considered that there was a less than 1% chance that technical difficulties would mean that it would be necessary to revert to open, rather than keyhole surgery. He identified that in those circumstances BV's stay in hospital would be extended to 5-7 days and his recovery time extended to around 3 months.

19. Dr B identified that, depending on the outcome of the surgery, further immunotherapy treatment might also be required. However, as set out above, he considered that there was an 80% prospect of the surgery being curative on its own without further treatment being required.

20. Prior to the hearing the Official Solicitor had posed some questions to BV's treating clinicians which were answered by Dr D. His evidence is that the shape of the tumour and its growth between BV's two CT scans point towards the tumour being both cancerous and aggressive. He has identified that there is a 95% likelihood that this particular type of tumour is malignant. He also explained that a biopsy prior to any surgery taking place was not recommended. He identified that a biopsy itself was an invasive procedure; the imaging that already been undertaken meant that the clinical team considered that there was a high likelihood that this tumour was malignant; and that in a biopsy there was a high risk of metastatic spread through cancerous cells leaking into the abdomen.

21. Dr C, BV's treating psychiatrist, indicated that if BV were successfully treated for his suspected cancer, then with the therapeutic risk reduction work that was being carried out at Hospital A, the best case scenario would be that he would be in a position to be discharged in around 2 years' time. Dr C considered that BV would benefit from being discharged into a supported placement with support staff available 24/7.

22. However, if BV's suspected cancer were left untreated, and his condition deteriorated (in accordance with Dr B's prognosis) then it was likely that any therapeutic work would cease. He did not consider that it would be possible to achieve a sufficient reduction in risk to enable BV to be released from detention within the time frame for the progression of the likely cancer. His frank evidence was that if the operation did not take place there would be a switch in the focus of the treatment of BV at Hospital A from therapeutic work to achieve reduction in the risks that he posed to supporting his physical health. In those circumstances BV was unlikely to be released, unless his physical condition deteriorated to the point where he was so incapacitated he no longer posed a risk.

23. Dr C has identified that the court authorising the surgery to take place against BV's will carries with it a risk to his mental health. He considers that there would undoubtedly be heightened anxiety and distress in the short term, as BV would potentially be subject to an altered and unpredictable routine due to invasive procedures that he was not in agreement with and / or did not fully understand. The care plan that has been prepared for the operation identifies lower and higher impact interventions that may be required, depending upon BV's reaction. Dr C considered that if BV's reaction to the procedure was at the lower end of the spectrum (such that lower impact interventions, such as anti-anxiety medication were used) he did not consider that the operation would have any significant impact on his mental health prognosis or on his ongoing care or the duration of his stay at Hospital A.

24. If BV was more actively resistant (such that higher impact interventions such as the use of physical restraint was required) Dr C considered that this would have a more profound impact on his mental state. He would be less likely to be reassured by staff and could see them as a threat. This could rupture his therapeutic relationship with the treating staff at Hospital A and this would take longer to repair. Dr C considered that this may increase the complexity of BV's longer term care and treatment at Hospital A, leading to a longer period of detention under the Mental Health Act 1983 before a safe and effective discharge could be achieved. Dr C identified that in a worst-case scenario BV could experience a significant trauma which could lead to the emergence of post-traumatic stress disorder, an increase in self-harm and suicidal ideation. However, he explained that he had managed very complex presentations in the past (in relation to other patients) and he considered that it would be possible to manage a recovery for BV from this worst case scenario.

25. Even if the therapeutic relationship between BV and his current treating team was irreparably ruptured, it would be possible for him to rebuild a relationship with a new team at a different placement. Thus, even the worst-case scenario should only delay, rather than prevent, BV's treatment journey. Dr C, understandably, was reluctant to put percentages on the likelihood of the various outcomes. However, based upon his knowledge of BV, on a very approximate basis he considered that there was perhaps a 10% prospect of BV suffering a more severe depressive disorder as a result of the proposed operation.

26. As mentioned above, a detailed care plan has been prepared identifying a range of interventions from the least restrictive, to the most restrictive, that may be required at various stages of the operation (including pre and post operative stages), together with an assessment of the potential impact that these may have on BV. The worst case scenario identifies a need for physical restraint in conveying BV to hospital and whilst he is there. The plan is reactive to what may be a dynamic situation with decisions as to the level of support being taken by Dr C. Based on his knowledge of BV, he was hopeful in his oral evidence that the interventions required would be at the lower end of the scale.

BV's wishes and feelings.

27. Dr C confirmed BV's diagnoses of a mild learning disability and autistic spectrum disorder, explaining that the latter diagnosis had been formalised since the date of preparation of his written assessment. He explained that following his admission to hospital in July, BV had been told that it was likely that he had cancer of his kidney.

28. BV evidenced a superficial understanding and retention of this information. However, he has, on multiple occasions expressed a wish not to have the surgery. This view appears to arise from a number of different factors:
    (1) BV has indicated his belief that the cancer will not spread and that he will be healed without intervention. BV believes that has had cancer in his groin area since he was 28 and that this has not spread. In short, he believes that he has been living with cancer for many years without any form of treatment and that it has not caused him pain or shortened his life. This is a false belief. There is no evidence that BV has cancer in his groin area, let alone that he has lived with it for more than 30 years.
    (2) BV is a deeply and actively religious man who reads the Bible and sees the chaplain regularly. He has described the tumour as an indication of God's will. He has said that the tumour was indicative of a sin that only God could understand and that he needed to accept this. He has also expressed a wish, linked to his religious faith, to be buried whole, without having an organ removed. BV has suggested that prayer will help his prognosis and described a fellow churchgoer of having a tumour reduced to the size of a pea following prayer and faith healing.

(3) BV is also fearful about the operations. He has formed a further false belief, that his father died of the complications of kidney surgery. This is not the case. Although his father did receive kidney dialysis, he is understood to have died from a stroke. More generally, BV has a significant level of anxiety about the procedure.

29. BV has not expressed any wish to die. Rather he has told staff that he "wanted a future and to live in the community close to his family".

30. BV has a sister and two brothers. They have played no part in these proceedings (although they were given an opportunity to do so). However, their views have been made known. His sister and one of his brothers support the surgery taking place (albeit that the brother thinks that it should ultimately be up to BV to decide). BV's other brother believes in divine healing and "does not actively support surgery".

Capacity

31. Dr C has formed the view that BV lacks capacity to consent to the proposed treatment for his cancer. He confirmed that BV has a diagnosis of a mild learning spectrum disorder and in his oral evidence he was also able to inform the court that BV's diagnosis of Autistic Spectrum Disorder ("ASD") had recently been formally confirmed. His assessment also makes reference to previous diagnoses of schizoaffective disorder, schizophrenia and anxiety and depression. Having regard to the elements of section 3 of the Act Dr C's evidence was as follows:

(1) BV was unable to understand and weigh up information relevant to the decision in question:

(a) On a basic level BV is aware that he has cancer and can recall the treatment options and the basic consequences.

(b) However, he had difficulty in appreciating the small percentage risk of serious peri/post operative complications and struggled to accept reassurance regarding support.

(c) He was scared and anxious about having the operation, saying he would not be able to mentally or physically recover from it, despite reassurance that this was unlikely. Dr C considered that BV's fear and anxiety was out of proportion to the relatively low risk of complications. He considered that whilst BV could understand the words used and retain the information, he was unable to apply the information to himself.

(d) BV referred to a previous cancer diagnosis, and was dismissive when told that this was not supported by his medical records. He remained of the view that he has lived with cancer from the age of 28 and due to prayer and healing, it has not affected his life.

(e) Dr C considered that the fact that BV refused to accept this medical fact showed rigidity of thought as part of his autistic presentation. This rigidity of thought similarly affects BV's current view that his likely kidney cancer

will once again have minimal impact if he relies on "God's will and religious healing".

(f) Dr C also considered that this demonstrated an inability on BV's behalf to cognitively understand his condition (as it is not currently experienced by him in terms of a contemporaneous bodily experience but is rather a hypothetical future event). He considers that BV's ASD and consequent difficulty with abstract thought restricts him from fully understanding this and renders him unable to make the decision.

(2) BV is able to retain information. He was able to confirm to Dr C that he had been diagnosed with a tumour and that with an operation he would have a 90% chance of being alive after 10 years and without it he would live 2 years.

(3) BV is unable to weigh up information. In individuals with a learning disability, confabulation can often be utilised to mask deficits in memory, executive functioning, and understanding and in BV's case, this has resulted in his somewhat confusing narrative and impacted on his ability to explain his thoughts and decisions regarding the surgery.

(a) Dr C considered that BV's deficits in executive functioning leads to a limitation of his ability to process the information and apply it to his current situation and to appropriately think and plan for the future. This was evidenced by his ongoing belief around a past cancer diagnosis, and the fact that this had had no significant impact on his life due to this being "God's will".

(b) BV's deficits in abstract thinking and theory of mind arising from his ASD lead to an inability to weigh up relevant factors in the balance. Therefore, whilst he understands some of the surgical facts relevant to the decision, he is not processing these to weigh up his situation as only his fixed and overvalued thoughts and feelings are relevant. He has been unable to take on medical opinions and his family's thoughts, concerns and distress caused by his potential refusal of treatment.

(4) Dr C confirmed that BV was able to communicate his wishes and feelings.

32. Thus Dr C's overall conclusion was that as a result of his diagnosed conditions, BV was unable to make a decision to consent or to refuse to consent to the proposed treatment. He also considered BV to lack litigation capacity.

Discussion

33. Following the conclusion of the evidence there was agreement at the Bar as to the way forward. Both Ms Khalique KC on behalf of the Applicants and Ms Roper KC, on behalf of BV through his litigation friend, submitted that I could be satisfied that (a) BV lacked capacity to consent to the proposed operation and that (b) it was in his best interests to have it.

34. I accept Dr C's conclusions as to BV's capacity. Although, it seems that BV is able to understand in simple terms that he is likely to have a form of cancer and he is clearly able to retain that information, I am satisfied, in the light of Dr C's evidence that BV is unable to use and weigh the information that he has been provided with about his condition and the proposed course of treatment and that inability arises from his diagnosed conditions, namely his learning disorder and ASD which, I am satisfied amount to an impairment of, or a disturbance in the functioning of, his mind or brain.

35. I will declare under section 15(1)(a) of the Act that BV lacks capacity to consent or to withhold consent to medical and surgical treatment for his suspected renal cancer. It therefore falls for the court, under section 16(2)(a) of the Act to take the decision on BV's behalf as to whether he should have the proposed surgery.

36. Having regard to all relevant circumstances, and in particular to the medical evidence that I have been provided and to BV's wishes and feelings, I have concluded that it is in BV's best interests to have the surgery, in accordance with the prepared care plan.

37. The medical evidence clearly points towards BV having the surgery. There is a very high (95%) chance that the tumour on his kidney is cancerous. If nothing is done, then his life expectancy is likely to be limited to 2 to 3 years. During that time his physical condition will deteriorate; he will be in pain; the cancer is likely to metastasise and spread. He is at risk of further hospitalisation and has a 5% prospect of dying as a result of a haemorrhage. Doing nothing will mean that BV's therapeutic work for his mental health is also likely to cease. There is little prospect of him reaching a point where he could be considered for release within his likely life expectancy, and he would instead be supported as his physical health deteriorated.

38. By contrast the proposed surgery affords a very high prospect of being curative without any further treatment being required, although further treatment would be available if required. The risks to BV of complications from the surgery are relatively small. The advantages to BV of having the surgery is that there are good prospects that the therapeutic work being carried on at Hospital A will lead to him being released within perhaps 2 years to a supported placement which would meet his needs. This would meet BV's wish to live in the community.

39. However, I am conscious of BV's expressed wishes and feelings that he does not wish to have the treatment. As set out above these wishes and feelings are based on a number of different, and not necessarily consistent, factors. In part they arise from BV's deeply and sincerely held religious beliefs. However, they are also partly based upon an operative false belief; namely that he has successfully lived with cancer for many years without needing treatment. They are also based upon BV's overwhelming anxiety about undergoing the proposed operation.

40. I recognise also that were I to decide that BV should have the operation notwithstanding these expressed wishes, the procedure is likely to have complications for the treatment that he is currently receiving for his mental health, and there is a risk of the rupture of the therapeutic relationship that he enjoys with his treating team, or even in a worst case scenario, of PTSD emerging. That said, although Dr C was reluctant to put a precise percentage on these risks emerging, he considered that there was a relatively low (10%) prospect of a severe depressive disorder emerging as a result of the imposition of the operation on BV against his will.

41. I have taken BV's views fully into account in making this decision, and I recognise that his wish not to have the operation increases the likelihood of an adverse reaction. However, I consider that the very clear evidence of the benefits to BV of having this operation mean that it is in his best interests to have it. Having it offers a very good chance of wholly removing the cancer, and gives BV a real prospect of enjoying a high quality of life in the future. Not having the operation may avoid the risk of BV suffering the immediate anxiety and potential trauma of an operation. However it is very likely to mean that he will be on a pathway that will see his life end within two or three years, and which holds out little hope for the release from that detention that he wants.

42. Taking everything into account, I am satisfied that BV's best interests require me to provide consent to the operation on his behalf under section 16(2) of the Act in accordance with the prepared care plan and I accordingly do so. My order will authorise the use of physical and/or pharmacological restraint as set out in the care plan, provided that at all times no more than the necessary and proportionate amount of restraint is used and that all reasonable steps are taken to minimise BV's distress and to protect his dignity.

Transparency

43. The hearing before me took place in public, pursuant to a Transparency Order that had been made by the Vice-President of the Court of Protection, Theis J, on 16 October 2025. This order is in standard terms. In order to prevent the jigsaw identification of BV, it also prevents the naming of members of his family, his care team, Hospital A and Hospital B and his treating clinicians, Doctors A, B C and D. Two members of the public attended the hearing on 3 November and were provided with copies of the transparency order.

44. The transparency order of 16 October was expressed to apply until 23.59pm on 3 November 2025, it being left to me to determine the length of time that it should continue in force after the hearing.

45. Initially, Ms Khalique KC for the applicants suggested that it should only remain in force for a limited period of time. However, on behalf of BV, Ms Roper KC argued that the

order should remain in force for his lifetime and ultimately I did not understand Ms Khalique to dissent from that view.

46. In determining the duration of a transparency order the court needs to balance the Art 8. rights of P against the Art 10. rights of the press, members of the public and indeed P and his family. These are matters that I have taken into account and in reaching my decision I have applied the "intense focus" on the comparative importance of these rights identified by Lord Steyn in *Re S (A Child) (Identification: Restrictions on Publication)* [2004] UKHL 47; [2005] 1 AC 593 at [17].

47. So far as the identification of BV is concerned, I have heard evidence from Dr C about his anxiety. I consider that his being publicly identified as a subject of Court of Protection proceedings and having his private medical information placed in the public domain is a matter that is likely to be upsetting for him and exacerbate this anxiety. As such, identification may adversely affect BV's response to the treatment that he is receiving for his mental health, both now and in the future.

48. I accept that continuing the prohibition on the identity of BV adversely impacts the Art. 10 rights of others that are engaged by this case, and I recognise that the ability to name an individual makes a story more attractive to readers (see *Re Guardian News & Media Ltd* [2010] EKSC 1; [20210] AC 697 per Lord Rodger at [63]). However, save for the identity of BV and that of the hospitals and clinicians involved in his care, all other details of this case are in the public domain and may be reported. This is not a case where BV is a public figure or there are other specific reasons which might weigh in favour of identifying BV during his lifetime. None of BV's family members has participated in the hearing, and I am not aware of any other individual who may have a legitimate interest in identifying BV as the subject of these proceedings. I gave the two members of the public who were observing the hearing (one of whom was Professor Celia Kitzinger, co-founder of the Open Justice Project) an opportunity to make representations on this point, and neither sought to argue for the identification of BV during his lifetime.

49. In my judgment, BV's legitimate interest in confidentiality regarding his medical treatment, coupled with the potential for the identification of BV to impact on his mental health and the treatment that he is receiving in that regard outweighs the Art 10 rights of any individual or body who may wish to name him as the subject of these proceedings. Moreover, I consider that the risks to BV of identification and his interest in preserving the privacy of his medical treatment are likely to be life-long. The mere fact that these proceedings will now come to an end does not, in my judgment, diminish the importance to BV of his right to keep his confidential medical information private or the risks posed to his mental health should his identity become publicly known. The effect upon his right to a private life and the impact on him will be the same if he is named now, or in a year's

time or at any other point during his life. I have therefore concluded that the transparency order, insofar as it prohibits the naming of BV, should continue throughout his lifetime.

50. I am not aware of any feature of this case which would justify continuing the transparency order beyond BV's death and I do not do so. The order will prevent the identification of BV, and other information that may enable him to be easily identified that is to say (a) that any person is a member of his family, (b) the identification of his care staff or (c) the name of any hospital or care home that he has attended or it is proposed that he should attend.

51. The position is slightly different in relation to the continuation of the order insofar as it relates to the clinicians treating BV, particularly Dr B and Dr C who both gave evidence in open court. In contrast to the position in *Abassi v Newcastle* [2025] UKSC 15, [2025] 2 WLR, it is not suggested that the clinicians themselves have any need for their identity to be protected. The only reason for their identification to be prohibited is to prevent jigsaw identification of BV. In my judgment, this can reasonably be achieved by continuing the prohibition on their identification for a more limited period, until the risks of jigsaw identification have sufficiently reduced.

52. I have decided that six months is a reasonable period to prevent the identification of BV's treating clinicians. That will give an opportunity for him to undergo the operation and any immediate follow up medical treatment that may be required and for there to then be a cooling-off period so that, by the time that the injunction is lifted, jigsaw identification of BV as one of their patients should no longer be straightforward. I will therefore extend the transparency order insofar as it prevents identification of BV's treating clinicians until 23.59pm on 3 May 2026. If there continues to be a risk of jigsaw identification as at that date, it will be open to the parties to return to court to seek a further extension.

Postscript

53. Finally, I am pleased to record that following my decision, BV underwent the operation on 6 November. I am told that all went well.