Neutral Citation Number: [2019] EWCOP 48

Case No: 1337884

IN THE COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 24/10/2019

Before :

THE HONOURABLE MR JUSTICE HAYDEN
VICE PRESIDENT OF THE COURT OF PROTECTION

- -

Between :

London Borough of Southwark	**Applicant**
- and -	
NP	**1st Respondent**
(by her litigation friend, the Official Solicitor)	
- and -	
M	**2nd Respondent**
- and -	
South London and Maudsley NHS Foundation Trust	**3rd Respondent**

- -
- -

Ms Katie Scott, Mr Jack Anderson (instructed by **London Borough of Southwark**) for the **Applicant**
Miss Fiona Paterson QC (instructed by **McIntosh Law on behalf of the Official Solicitor**) on behalf of **NP**
Mr Tim Nesbitt QC (instructed by **Bindmans Solicitors**) for **M**
Miss Nicola Greaney (instructed by **Bevan Brittan Solicitors**) for the **NHS Foundation Trust**

Hearing dates: 2nd & 3rd October 2019

- -

Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

.....

THE HONOURABLE MR JUSTICE HAYDEN

Mr Justice Hayden :

1. I am concerned in this case with the welfare of NP who is a seventeen-year-old young person who has cerebral palsy, with diplegia (which affects her lower limbs). She uses a wheelchair outside her immediate home environment.

2. Until June 2019 NP lived at home with her mother (M), the second respondent. Her father died in January 2018. The family has a history of involvement with the applicant Local Authority, the London Borough of Southwark. NP has been on a child protection plan, under the category of 'neglect' since August 2018. During the course of their assessments the Local Authority received information that NP had been sexually abused by a male whom the mother had invited in to the family home. The Local Authority regard M as being entirely uncooperative with the services provided for the family.

3. NP has been diagnosed as suffering from 'Atypical Anorexia'. She was admitted to hospital on 9th April 2019 with a body mass index (BMI) of 10.9. It requires to be said that her condition has, periodically, reached life-threatening concern. In hospital NP was persuaded to submit to a re-feeding programme and within a few days she was assessed as ready for discharge. The hospital however, considered it unsafe for NP to be discharged into M's care because of her strikingly ambivalent support for the re-feeding regimen. Additionally, the home conditions are described as 'squalid'. Ms Scott, who appears on behalf of the Local Authority, summarises the concerns, at this time, thus:

    i) NP was living at home when she lost a significant amount of weight in a short period of time, during which her mother failed to seek any medical attention for NP;

    ii) While NP was in hospital, the second respondent was noted to undermine the re-feeding regime by making comments about the amount of food NP was eating (what obese people would eat) and the frequency with which she should eat. The applicant is not confident that the second respondent supports the re-feeding plan for NP while she is in her care;

    iii) NP has alleged that while in the family home she has been sexually abused by a male friend of the family;

    iv) The family home is extremely dirty and verminous.

4. When NP was hospitalised in April 2019, she was so profoundly malnourished that she was described as having been '*at risk of death*'. She was noted to be unkempt, frail and her general level of hygiene caused real cause for concern. She was observed to resort frequently to talking in a whisper. This was not however, continuous and the social worker, Ms Carleen Leslie, records that some professionals had speculated as to whether NP is *'selectively mute'*. The records reveal that those responsible for NP's care were concerned about the dynamic of the mother and daughter relationship. It was noted that M had been unhelpful in supporting NP to eat. I note that in recent

years the mother has also been resistant to social work input when they have tried to address general hygiene concerns within the home. Of particular note is a recording that M complained that NP was being encouraged to eat *'too much'*. The records reveal that M described the refeeding programme as being like *'the amount an obese person would eat'*. This led to the consultant paediatrician and the social worker concluding that it would not be appropriate for NP to return to M's care. M's counsel, Mr Nesbitt QC informs me that she disputes a number of these key observations made by different professionals and asserts that they arise from general misunderstanding and confusion.

5. Pursuant to my order on 25th June 2019, NP was placed in a residential unit by the applicant Local Authority. She was transported by a vehicle which permitted her to remain seated in her wheelchair. Ms Leslie recalls that on arrival NP did not speak or interact with staff members beyond nodding her head and speaking in the whisper that I have described. In the intervening period NP has continued to attend her appointments with the NHS Foundation Trust at the Maudsley Hospital with a senior clinical psychologist, Dr Rachel Loomes and a Consultant Child and Adolescent psychiatrist, Dr Darren Cuthina.

6. Initially, the plan had been for NP to stay at the residential unit on an interim basis until a bed could be identified at an eating disorder clinic. On arrival at the residential unit NP's weight was reported to be 31.1 kilogrammes. She declined all re-introductory small meals, preferring nutritional supplements (fortisips) of which she would take eight a day and diet coke. However, following a health appointment on 8th July 2019 NP agreed to resume eating *'normal food'*. The plan was that she would take seventy five percent of her calories in this way and the remainder by the supplement drinks. This agreement appears to have been an agreed compromise arising from NP's refusal to be admitted to an eating disorder clinic.

7. Of note is that NP and M have failed to participate with the review processes put in place. In July 2019 M contacted Ms Leslie's manager to explain that NP would not be consenting to a Looked After Child health review. I record that Ms Leslie's statement, prepared for this hearing reads: *'however NP later provided her consent to having a health review as she said this had been requested by her mother's solicitor'*. In the early weeks of her time at the unit it is recorded that NP would frequently take trips outside of the placement to the local shops and shopping centre. She was accompanied by staff. However, in August 2019, NP refused to leave her room other than for appointments or college. The reality, therefore, was that she spent most of the day in her room with the curtains drawn entertaining herself with her electronic devices. NP and her mother are often seen whispering together. The staff however, consider that M does try to encourage her daughter to go out. On Saturday 28th September 2019 M brought the family dog and they went for a walk in the park.

8. In September 2019 NP returned to college. It is very clear to me that this is something that she enjoys. Whilst there she will not eat but does take the fortisips, water and diet coke. She is putting on weight at a rate of between 500 grams and 1 kilogramme per week. This illuminates a striking contrast between NP's failure to gain weight whilst living with her mother between April and June and her consistent improvement whilst cared for by professionals. M asserts that NP was eating with her in exactly the same way that she had been in the unit. This, as Dr Cutinha pointed out in his evidence, to which I will refer shortly, can simply not have been the case. Following my order on

25th June 2019 NP agreed to return to the feeding plan which she started again on 9th July 2019.

9. Three matters arise for consideration at this hearing:

> NP's capacity to decide where she lives and to consent to treatment for her 'atypical anorexia';
>
> Whether it is in NP's best interests to remain at the residential unit and to continue to receive treatment, on an out-patient basis, from the third respondent, the South London and Maudsley NHS Foundation Trust;
>
> What planning needs to be undertaken by the Applicant, the London Borough of Southwark and the NHS Trust to ensure that the transition of NP's care (both social and medical) from child to adult services when she reaches her 18th birthday, on 20th December 2019, is effective.

10. Each of these issues has been broadly resolved by the parties. Whilst there was some ambiguity in respect of aspects of NP's decision-making capacity, this became settled during Dr Cutinha's evidence. Ms Paterson distils the Official Solicitor's position in relation to NP's best interests in crisp and unambiguous terms *'the OS considers that NP should remain at the residential unit. The increase in her weight while resident there, is in stark contrast to her potentially life-threatening weight loss whilst she was living with her mother. Furthermore, the description of the family home suggests that the environment itself presents a threat to NP's wellbeing. It is also unclear whether NP would still be at continued risk of emotional and or sexual abuse if she returned to live with her mother.'*

11. At the hearing, on 25th June 2019, the parties and the Court were, as Ms Paterson correctly reminds me, dealing with a crisis. NP's long-term health and indeed her life were in peril. Accordingly, the orders made on that day reflect the need to act urgently but they do not establish any litigation case management. I agree with Ms Paterson that detailed directions would have been difficult in those circumstances. As Dr Cutinha described it, the objective in June was *'to put out the fire'*. In the days before this hearing the Official Solicitor recognised that nothing had been done in the interim, by way of updating the court, in a way which would enable it to take informed decisions for the immediate future. Thus, an ex parte written application was made for me to permit the filing of a statement by Dr Cutinha expressing his opinions both in the sphere of welfare and capacity issues and to provide for disclosure of records and assessments. I entirely understand why this was done. I granted the application on 30th September 2019 (the date the application was received). In my remarks below, I do not intend to be critical of anybody at all, quite the contrary. However, the situation illustrates a problem that is particularly acute in cases concerning anorexia but also has much more general application, namely the challenge to the Court of Protection in ensuring that decision making is driven by P's needs and not the exigencies of the litigation.

12. Despite these valiant efforts to share relevant information in anticipation of the forthcoming hearing, significant features of the material that I have reviewed above was not available to Dr Cutinha. Accordingly, he finds himself making recommendations, for example in relation to the extent of NP's contact with M, with only partial information. I have previously commented (see: **London Borough of Tower Hamlets v NB (consent to sex) [2019] EWCOP 27)** on the danger of what I have called *'conceptual silos'*, in which parties/experts/professionals fail adequately to share information which will inform their own decision making. This I emphasise again, is not intended to be a criticism here but, I hope, a constructive observation. It is rooted in the difficulty that the Court of Protection has in adhering to established case management processes. This arises, as I have alluded to above, in consequence of the dynamic nature of the cases that come, particularly, before the Tier 3 Courts and which frequently involve (as here) a reaction to crisis. I address this in greater detail in para 30 et seq., below.

13. Dr Cutinha confirmed a diagnosis of Atypical Anorexia. This, he said is an informal term for Other Specified Feeding and Eating Disorder (OSFED) in the DSM-V Diagnostic and Statistical Manual of Mental Disorders 5th Edition, American Psychiatric Association. He considered the diagnosis 'Atypical' because of NP's presentation, history and clinical features. For example, there was no clear story of an initial desire to lose weight. It was unclear about the presence, strength, or severity of NP's eating disorder *'cognitions'*. Dr Cutinha wondered, to some degree, whether it was possible that NP's weight loss had been due to other emotional, social or *'relational factors'*, or a combination of them, rather than an eating disorder. The fact that NP has been able to gain weight relatively easily and quickly, with minimal resistance, has added further weight to the working diagnosis that NP's presentation is atypical.

14. Dr Cutinha initially gave evidence on the telephone having been called by the Official Solicitor but was able to come to court to conclude his evidence the following day. If I may say so, his willingness to vary his own professional arrangements and his obvious desire better to understand how he could most constructively assist the Court of Protection was extremely impressive, as is his obvious professionalism and expertise. He told me that the treating team received the case in crisis and that their first job was to *'try to put out the fire'*. In this he echoed (though he had not heard it himself) Ms Paterson's observation in respect of the Court's approach at the June 2019 hearing. Dr Cutinha analysed the focus as having now changed to seeking to identify the underlying cause of the disorder.

15. Given Dr Cutinha's view, summarised in para 13 above, he was asked whether he had seen or requested NP's medical records. Rather to my surprise he told me that he had not and that these were rarely requested in his unit.

16. NP's father died in 2018. His death was sudden and entirely unexpected. It plainly altered the whole framework of NP's life and it seems clear to me, from what I have read, that her grief was intense. She would have been sixteen years old. Dr Cutinha was asked whether there had been any indicators of eating disorder before that. Absent the medical records it is difficult to see how he could answer that question with any confidence. I am bound to say, that in an equivalent enquiry in the Family Division disclosure of this material to the doctors would automatically be considered. Additionally, in some eating disorder cases there may be unnoticed physiological or

contributory factors. This too may be illuminated by sight of the medical records. I have already indicated to Ms Paterson that I consider that the records should be obtained here and shown to the treating clinicians. My impression of Dr Cutinha is that he saw the sense of this and is open-minded.

17. To his observations above, Dr Cutinha highlights the following caveat. There are, he says, features similar to Anorexia Nervosa that are present. Despite the positive progress that NP has been making, he considers her eating continues to be very restricted. For example, so far, it has not been possible to persuade NP to replace her supplement drinks with normal / solid food. She has been unable to increase the range and variety of her food. NP says that when she gets to a weight where she can maintain her weight, she would not want to eat any more normal / solid food than she is eating now.

18. In respect of the dichotomy between NP's weight gain in the unit and weight loss at home, Dr Cutinha considers the explanation is likely to be multi-factorial. His analysis is striking and requires to be set out:

> *'In April 2019, when NP was admitted to Kings College Hospital as an emergency, Dr Simon Chapman, a consultant paediatrician in our team, said that NP was the most underweight patient that he had worked with in his 10 years in our service. NP's BMI then was 12.0. Whilst NP was staying at home, NP's mother had always maintained that she had been giving NP all the food that was on the meal plan that we recommended and NP was eating it all. However, NP did not gain any significant amount of weight whilst receiving treatment at home.*
>
> *NP's mother appeared to imply that there was perhaps a medical reason for NP not gaining weight. NP's meal plan was increased to 3000kcal / day. This is more than our standard weight gaining meal plan of 2500kcal / day. NP's weight still did not increase, even though NP was reported as eating everything on her meal plan. It was not clear whether NP's mother was not giving her the food, not supervising NP's eating, NP was refusing to eat, hiding food, or vomiting after meals, or some combination of all of these factors. NP's mother never reported that NP was resisting her attempts to support her eating. Similarly, there were no concerns about hiding food. NP had vomited after meals on one or two occasions, however, this was not being a regular occurrence.'*

19. To the above must be emphasised and at risk of repetition that Dr Cutinha considered that it would have been ***'medically impossible for [NP] not to be gaining weight if she had been following the meal plan at home'*** (my emphasis). Quite what has happened was a matter of speculation but Dr Cutinha hypothesised that NP may have found it difficult to eat at home because of a post-traumatic stress disorder relating to the sexual abuse she alleges within the home. The reasoning behind this being that she may associate home with trauma and feel unable to eat. It is observed that when in

Kings College Hospital, London NP described finding certain foods and drink difficult because she associated them with her abuser. I do not seek in any way to undermine the hypothesis but I am struck by the fact that at college, which NP plainly enjoys, she will only take the fortisips, water and diet coke. I was also told when she came to court that she declined her breakfast, any lunch or any liquid throughout the day. I should record also, that it was apparently her decision to come to court. I had not been expecting her attendance.

20. NP has declined offers of additional psychological help beyond that directly focused on her eating disorder. Dr Cutinha is not particularly concerned by that at present, his experience being that such treatment is likely to be far more effective when patients are restored to a reasonable weight. He reminds me and I consider it to be important to highlight to the variety of professionals who may read this judgment, NP continues to be very underweight, notwithstanding her positive progress. In the three months from April to June 2019, when NP was being treated as an out-patient, she was only able to acquire 0.2 kilograms. In the three months from June to this hearing she has gained 9.1 kilograms. This simple fact, to my mind, speaks volumes. Moreover, having reviewed the records from the unit Dr Cutinha notes that NP has always managed to complete her meal plan satisfactorily. There have been no concerns about NP resisting attempts to help her eat, hiding food or vomiting after meals. To date, she has not lost any weight.

21. NP's meal plan continues to be a mixture of normal food and supplement drinks. The percentage of energy supplied by supplement drinks is just over 30%. As previously stated, NP continues to have significant difficulties eating. She finds it difficult to eat in front of other people, and she says that if she needed to maintain weight, once reaching a healthy weight, she would not want to eat more than the amount of normal food that she is currently having.

22. Concerning the assessment of capacity, Dr Cutinha was clear that NP did not have the ability fully to understand or to evaluate and weigh up the risk and benefits of returning home, in relation to her treatment for anorexia. Dr Cutinha thought that the relationship with her mother eclipsed NP's capacity to process her reasoning. NP also wishes to be able to re-join her brothers and this too was considered to impact on her capacity to weigh up risk. I should record, though it is no longer an issue that needs to be determined, NP was assessed as having capacity to choose between her current placement and an Eating Disorder unit. In this, it was noted she could understand, recall, communicate and evaluate pertinent information to make these decisions.

23. Ms Scott explored with Dr Cutinha the physical impact that nutritional stress and weight loss has on NP's decision-making processes. Dr Cutinha had identified these as relevant considerations. He was prepared to accept that on the issue of returning home this may be a relevant consideration. I confess however, that I do not find it easy to understand why this would not be a global consideration i.e. across the whole sphere of NP's decision-making. It plainly is not, given the above. However, the relationship between NP and her mother is extremely troubling and I accept that it impacts significantly on her capacity to understand the potential consequences to her treatment if she were to return home.

24. On the morning of the hearing NP indicated to me directly and in a strong and robust voice that she wanted to speak to me privately. This arose shortly before one o'clock.

I told her that we would make appropriate arrangements and that I would speak to her after lunch i.e. two o'clock. When I returned to court NP had changed her mind. She had also changed in her demeanour. This time she averted her eyes and spoke in a barely audible manner (as the social worker had described, see para 4 above). I had the impression of a much younger child. Her physical presentation had also changed. She seemed less upright and confident. She proffered no explanation for her change of decision. What was striking to me is that before lunch she had seemed quite insistent on speaking to me privately. From what I had read I was not expecting her to generate an application to speak to me. I was, inevitably, rather frustrated that I had not decided to hear her immediately. I would, of course, have required the Official Solicitor to be present.

25. When Dr Cutinha gave his evidence on the telephone, NP turned her body so that she could see her mother. I record that she fixed her eyes on her. Their mutual gaze remained almost entirely uninterrupted throughout the whole of Dr Cutinha's telephone evidence. It was intense, dramatic indeed almost melodramatic. NP watched her mother's reaction to what Dr Cutinha was saying. There was virtually no reaction on M's part but I noticed on two occasions that she raised her eyebrows where she did not agree with his evidence and withdrew her smile. It was subtle and barely perceptible but it was, in my view, a calculated antilocution. M's counsel, Mr Nesbitt, saw none of this and urges me not to give it any weight. I consider it would be irresponsible to disregard it, particularly as the mother / daughter dynamic is so central to the case. I record my observations in order that they are not lost but I go no further than interpreting them as a facet of a relationship which appears to the professionals to be off kilter or dysfunctional. It also requires to be said that the evidence points to Ms Leslie being rather more alert to this than Dr Cutinha. Ms Leslie's concerns were put to the doctor in cross-examination. He seemed perturbed by them but was, for understandable reasons, unable to process their potential significance in the witness box.

26. In his report Dr Cutinha made this observation:

> *'Due to the conditions of the court order, it has not been possible for NP's mother to be part of treatment sessions with NP. Our family therapy model works on the principle of trying to harness the strengths and resources of parents and carers, rather than seeing them as the cause of the eating disorder. We would be happy to include NP's mother in treatment sessions if the legal situation around her involvement in NP's treatment changes.'*

27. When he was asked why he would be happy to include NP's mother in treatment sessions Dr Cutinha said that this is *'normally helpful'* in bringing the family on board. He recognised, with a wry smile, that there was an obvious tension between an *'atypical'* disorder and the concept of a *'normal'* approach. With respect to Dr Cutinha and for all the reasons analysed above I consider that this is, on my broad survey of the evidence, likely to risk the progress that NP is making and I do not endorse it.

28. Dr Cutinha later makes the following observations in his report, which I set out in full:

> *'If the Court is of the opinion that there the original concerns about NP's home environment and / or care she was receiving at home, that led to her removal and placement in* [residential unit], *have changed for the good, then recognising NP's desire to have as much contact with her mother as possible, I believe that it would now be appropriate to consider a trial of increasing contact with her mother, followed by increasing amounts home leave. If there is any evidence of deterioration in NP's well-being or progress then this will need to be reviewed.*
>
> *I think NP would be ready to be discharged home from* [residential unit] *once she has reached a healthy weight, can demonstrate that she is able to also eat appropriately outside this context e.g. at college / and at home, and is able to increase her flexibility around eating further by eating a wider range of foods. It would also be important to establish that increasing amounts of contact with her mother and time at home was not having any adverse impacts on NP's emotional or physical wellbeing or recovery. If contact, however, goes well, then this could prove to be a powerful reward, which may accelerate NP's rate of recovery and ultimate return home.'*

29. I believe that Dr Cutinha is here basing his recommendations on the principles of the *'family therapy model'* which he has highlighted and to which I have referred above. They cannot be applied with cogency to the facts of this case, as it has evolved. Increasing contact with M, at present, strikes me as being speculative at best and dangerous at worst. It is not a plan that has been rooted in the evidence in the case either by the Local Authority or by the Trust. Indeed, it is a proposal which is contrary to the preponderant evidence. All this is because the Trust and the Official Solicitor have, with undoubtedly good intentions, nonetheless found themselves in the position of taking important decisions, with limited time available and in the absence of adequate sharing of information which would have allowed people time properly to reflect and plan.

30. I enquired of the very experienced counsel in this case whether in Court of Protection proceedings, they have ever had experience of an Expert's Meeting being conducted. Only Ms Paterson had and then only on two occasions. For my part, I do not remember a document reflecting such a meeting being filed in any proceedings that I have heard. In a court arena where conflicts of expert evidence arise regularly and in which such evidence is commonplace this is, to my mind, very unusual. Additionally, I note that I am rarely called on to make Disclosure Orders and have frequently been concerned by blockages in channels of communication which ought otherwise to have been regarded as integral to informed decision taking. At real risk of labouring the point, I emphasise again that I am not here intending to be critical. I have extremely able and highly regarded advocates before me, solicitors who I know to be conspicuously competent and medical witnesses who are manifestly of the highest calibre. What requires to be considered, to my mind, is whether the Court and the lawyers can improve case management more generally. I am convinced that we can.

31. Some general principles must be identified:

i. Though the avoidance of delay is not prescribed by the Mental Capacity Act 2005, the precept should be read in to the proceedings as a facet of Article 6 ECHR (see: **Imperial College Healthcare An NHS Trust v MB & Ors [2019] EWCOP 29)**. Any avoidable delay is likely to be inimical to P's best interests;

ii. Effective case management is intrinsic to the avoidance of delay. Though the Court of Protection, particularly at Tier 3, will frequently be addressing complex issues in circumstances of urgency, thought should always be given to whether, when and if so in what circumstances, the case should return to court. This will require evaluation of the evidence the Court is likely to need and when the case should be heard. This should be driven by an unswerving focus both on P's best interests and the ongoing obligation to promote a return to capacity where that is potentially achievable;

iii. Where, at any hearing and due to the circumstances of the case, it is not possible prospectively to anticipate what future evidence may be required, the parties and particularly the Applicant and the Official Solicitor (where instructed) should regard it as an ongoing obligation vigilantly to monitor the development of the case and to return to the Court for a Directions Hearing when it appears that further evidence is required which necessitates case management;

iv. Practice Direction 15A, Court of Protection Rules 2017 is intended to limit the use of expert evidence to that which is **necessary** to assist the court to resolve the issues in the proceedings;

v. The Practice Direction sets out the general duties of the expert, the key elements of which require to be emphasised:

> *1.It is the duty of an expert to help the court on matters within the expert's own expertise.*
>
> *2.Expert evidence should be the independent product of the expert uninfluenced by the pressures of the proceedings.*
>
> *3.An expert should assist the court by providing objective, unbiased opinion on matters within the expert's expertise, and should not assume the role of an advocate.*
>
> *4.An expert should consider all material facts, including those which might detract from the expert's opinion.*
>
> *5.An expert should make it clear—(a) when a question or issue falls outside the expert's expertise; and(b) when the expert is not able to reach a definite opinion, for example because the expert has insufficient information.*

> *6.If, after producing a report, an expert changes his or her view on any material matter, such change of view should be communicated to all the parties without delay, and when appropriate to the court.*

vi. In Court of Protection proceedings, the Court will frequently be asked to take evidence from treating clinicians. Invariably, (again especially at Tier 3) these will be individuals of experience and expertise who in other cases might easily find themselves instructed independently as experts. Treating clinicians have precisely the same obligations and duties upon them, when preparing reports and giving evidence as those independently instructed. Further, it is the obligation of the lawyers to ensure that these witnesses are furnished with all relevant material which is likely to have an impact on their views, conclusions and recommendations. (see: **Re C Interim Judgment: Expert Evidence) [2018] EWFC 89**). This should not merely be regarded as good litigation practice but as indivisible from the effective protection of P's welfare and autonomy;

vii. Evidence of clinicians, experts, social workers, care specialists etc is always to be regarded as individual features of a broader forensic landscape in to which must be factored the lay evidence. One expert or clinician is unlikely ever to provide the entire answer to the case (see: **Re T [2004] 2 FLR 838**). It follows that Experts meetings or Professionals meetings should always be considered as a useful tool to share information and to identify areas of agreement and / or disagreement;

viii. When evaluating the significance of expert evidence and particularly when the issues being considered are, as has regularly been the case in the Court of Protection, at the parameters or frontier of medical or expert knowledge, this should be properly identified and acknowledged. In considering the evidence, it is always helpful to reflect that yesterday's orthodoxies may become today's heresies. (see: **R v Harris and Others [2005] EWCA Criminal 1980**);

ix. Witnesses from whatever disciplines may be susceptible to *'confirmation bias'*. This is to say they may reach for evidence that supports their proffered conclusion without properly engaging with the evidence that may weaken it. ((see: **Cleveland Report (report of the enquiry in to Child Abuse in Cleveland 1987 Cm 412 London: HMSO 010/1041225)**);

x. Consideration must always be given to relevant, proportionate written questions to an independently instructed expert.

32. I have taken this opportunity to address case management concerns, some of which go beyond the reach of this particular case. They are not intended to be all embracive, merely to identify areas where there must be real and immediate improvement if the Court is to be able to give real effect to the principles underpinning the MCA 2005.

33. Absorbing some of these principles, I am satisfied, on the evidence, that NP lacks the capacity to determine the best options in relation to her treatment and where to live

for the period of that treatment. The preponderant evidence points compellingly against the inclusion of M in any of NP's therapy at present. NP is still very underweight and there is significant evidence to suggest that M has been ambivalent in the encouragement of the regime designed to promote NP's return to a healthy weight. Similarly, given the progress that has been made so far, I do not consider that the time has yet come to increase NP's contact with her mother. This mother / daughter dynamic requires to be more fully explored by the relevant professionals. It has already been identified as potentially associated, in some way, with the cause of the underlying disorder. It is undoubtedly a fact that NP does not thrive in her mother's household. To promote the relationship in the way suggested strikes me as having the real potential to send entirely the wrong messages to NP and to jeopardise the progress she has made, which ought properly to be identified as tentative. Investigation of the mother and daughter relationship requires careful and properly considered planning. Any alteration to the core arrangements presently in place is, in my judgement, pre-emptive. Ms Paterson has suggested that the case should return to the Court in November. I agree. I should be grateful if counsel, having regard to what I have said in paras 30 et seq., would draw up draft case management directions.