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This judgment was delivered in private. The judge has given leave for this version of the judgment to be published. Other than the fact that it was an application by a Midlands NHS Trust and the names of any expert witnesses and the lawyers instructed in the case, nobody may be identified by name or location. The anonymity of everyone other than the expert witnesses and the lawyers must be strictly preserved. All persons, including representatives of the media, must ensure that this condition is strictly complied with. Failure to do so will be a contempt of court.

Case No: 13697877

Neutral Citation Number: [2021] EWCOP 35

IN THE COURT OF PROTECTION and
IN THE HIGH COURT OF JUSTICE, FAMILY DIVISION

Royal Courts of Justice
Strand
Holborn
London
WC2A 2LL

BEFORE:

MR JUSTICE MOOR

BETWEEN:

A MIDLANDS NHS TRUST

APPLICANT

- and -

RD (via her Litigation Friend, the Official Solicitor)

1st RESPONDENT

-and-

SD

2nd RESPONDENT

-and-

LD

3rd RESPONDENT

-and-

A Midlands Clinical Commissioning Group

4th RESPONDENT

Legal Representation

Mr Conrad Hallin (Counsel) on behalf of the Applicant and the Fourth Respondent

Ms Emma Sutton (Counsel) on behalf of the First Respondent

Mr John McKendrick QC (Counsel) on behalf of the Second and Third Respondents

Judgment

Judgment date: 12 January 2021

Moor J:

1. I am concerned with RD, a 37 year old woman, who lives in a property on her own in the Midlands, albeit with very significant support. The application is brought by a Midlands NHS trust. RD is the First Respondent, represented by her litigation friend the Official Solicitor. Her two parents, SD and LD, are the Second and Third Respondents. The Fourth Respondent is a Midlands Clinical Commissioning Group, although it has not played any significant part in the case and has basically just allowed the Midlands Trust to conduct the litigation.
2. The reason why RD is subject to these proceedings, brought under the Court of Protection and, as a result of the order that I make today, under the inherent jurisdiction of the High Court, is that RD has suffered since approximately the age of 13 from an extremely serious and debilitating condition, namely anorexia nervosa.
3. It was in the year 2000 that she was first diagnosed with anorexia nervosa restrictive subtype, with clinical features of depression and she was admitted to an inpatient unit. Thereafter, there have been 14 further admissions for her to receive care and treatment. On most of those occasions, but not all, there has been some weight gain but it has virtually always been lost almost immediately following her discharge. Starting in 2013, there have been approximately four admissions pursuant to the Mental Health Act, effectively on a compulsory basis. Yet again the pattern was the same. There was some weight restoration, although I do not believe ever to a healthy weight since 2013 but the weight was loss after discharge.
4. In 2019, the Applicant perceived a significant deterioration in RD's physical health and there began to be allegations of vomiting, whether voluntary or involuntary.
5. In February 2020, she was admitted again to the a specialist ward, I think pursuant to the Mental Health Act. When she was discharged, she had a BMI of 13.4 and a regime of support workers which was hoped to be four times per day but, in fact, became three times per day at her request. The meal plan was that she should take seven Fortijuices per day although I do not believe that has ever been achieved or even close to it.
6. Whilst she was on the Ward, a report was commissioned by the Applicants from Dr Matthew Cahill, a consultant psychiatrist. It is right to say that he was critical that RD had been treated in the community for too long when in her 20s without admission to an EDU unit. I take the view that this is now water under the bridge and I am here to deal with RD's best interests as they are at today's date. He was, however, in complete agreement with the Applicant Trust that she was suffering from a severe and enduring anorexia nervosa, that the prognosis was very poor and her recovery was very unlikely. Having said that, he took the view that there should be two further interventions attempted to see whether or not there could be a significant improvement before applications were made, effectively to authorise no further compulsory admissions or treatment.
7. The first of these two interventions was the discharge on a Community Treatment Order, with four visits per day and the second was the possibility of her being admitted to a specialist rehabilitation unit. The second possibility proved impossible because

she did not meet the requirements of the unit. First, her BMI had to be above 13 and it was not. Secondly she had to demonstrate a willingness to engage and make changes and, regrettably, she did not. Thirdly, she had to be stable physically in terms of her health and again that was not the position at the time. Such an admission, therefore, was not available and the return home onto the Community Treatment Order was equally not successful.

8. In July 2020, she had to be re-admitted, first to a local Hospital for re-feeding and physical health monitoring, pursuant to the Mental Health Act and on 2 September 2020, she was transferred to the specialist ward where she had been before. Her BMI on admission was 10.9. She was put on an NG tube feeding regimen of 6.5 bottles of Fortisip across three nasogastric bolus feeds per day. She struggled to tolerate it. There had to be some physical restraint. There were new symptoms of vomiting, although these were denied by RD.
9. Sedation and extended restraint was rejected due to the risks to her and, by the end of her stay there, she was struggling to finish four Fortijuces per day and there was no significant improvement in her BMI. In consequence, she was discharged home on 22 December 2020 with a BMI very similar to that at which she was admitted.
10. In consequence, the application was made on 22 December 2020 to the Court of Protection for declarations, first that she lacked capacity to make decisions in relation to litigation and to take decisions about her nutritional intake and about her care and treatment in general. Second, for declarations that it was in her best interests to receive the care in her care plan, specifically that it was lawful not to take any steps towards forcing nutrition against her wishes, notwithstanding that, by so doing, it might, in the short-term, prevent her death and to provide palliative care when appropriate. At the time, she had a dangerously low BMI of around 11.3. She was at high risk of death and treatment in the community could well result in her death if she is not compliant with the treatment proposals made by the Applicant Trust.
11. A capacity assessment was produced and there is no disagreement that she lacks capacity in all respects. I have read the capacity assessments with care. In particular there is one from Dr T dated 22 December 2020. The conclusion is that she is able to understand and retain information but she is simply not able to weigh that information. In other words, she understands that, if she does not eat or drink her juices, it will not be good for her, but she simply does not understand that it will lead to her death and she cannot understand that it means that she has to comply with the treatment.
12. On 22 December 2020, Dr T filed a statement. She took the view that it would not be clinically appropriate for RD to be detained under the Mental Health Act 1983 any further. It was likely to have a detrimental effect on her wellbeing and make the situation worse, increasing the chance of a sudden death. RD regularly experiences muddled head or disorientation. She has many symptoms of chronic anorexia nervosa. Her prognosis is poor. She lacks insight into the severity of her presentation. She believes her intake of juices and nutrients will improve if she is left alone, but there is no history to suggest that is correct. A healthy BMI for her would be between 18.5 and 24.9, but her BMI, at the time, was approximately 11.7.
13. The doctor took the view that all viable inpatient treatment options were exhausted. Unlike previous admissions she was vomiting up her feed so was not gaining weight. The risks of force-feeding under sedation or physical restraint far outweighed any

likely benefit, and she relied on the opinion of Dr E in that regard. There was a risk of choking on her vomit, or aspiration pneumonia. It would cause extreme distress and psychological trauma and, in consequence, also significant physical harm as there was a risk of bone fracture, bruising and the like.

14. Altogether the doctor was clear that the treatment was causing more harm than good. She made the point that RD was desperate to return home. The supportive package should be put in place to allow RD her privacy and independence. The doctor's summary was that RD was in the end stage of her life. Further forced treatment was unlikely to be of benefit, would not preserve her life, was likely to cause significant distress and result in an undignified death.
15. On 6 January 2021, a second report was filed by Dr Cahill. His summary was that the further interventions that he had recommended had not been successful. Her eating disorder remains severe and entrenched. There is evidence of physical deterioration. He was struck by her lack of understanding of the seriousness of her condition. He agreed that the inpatient options had been exhausted; that further attempts were extremely likely to be futile; that the potential risks do not justify the likely gains; and that they were increasingly unethical and disproportionate if administered coercively. The shift should focus to the quality of her life. He did take the view, however, that it was likely she would deteriorate within weeks and require palliative care within months.
16. Poole J made various Case Management Orders on 6 January 2021, including a Transparency Order. He listed the case today for a final hearing before me. It is right to say in this judgment that, this morning, I varied the Transparency Order. Submissions were made to me by all three counsel that RD was extremely distressed by this case proceeding in public, albeit subject to the Transparency Order. I was clear that I should convert this into a private hearing. In fairness, the one member of the public who attended accepted this before I gave judgment, without reservation, and agreed voluntarily to leave the hearing. I reminded him, as he did so, of the order preventing any publicity in relation to this case.
17. Following the orders of Poole J, Ms Kate Jackson, the solicitor instructed by the Official Solicitor to attend upon RD in this matter, went to see RD. On 6 January 2021, she produced her statement. RD told Ms Jackson that she agreed with the NHS Trust that, if she refuses treatment, it should not be forced on her, despite the possible grave consequences. However she was clear that she wants to live but did not want nasogastric feeding. She did not want to go back into hospital and specifically she did not want to go to an eating disorder hospital. She wants to be at home. She would accept IV fluids and treatment for electrolyte imbalances. She wants to live but her mind is making her do things against it. She would like to speak to me but she would rather not have people watching.
18. Indeed, I did speak to her this morning in the presence of Ms Sutton and her instructing solicitor. I did not see her but I was able to hear her. I told her that I understood how difficult this process was for her. I asked her how she was and she told me she was OK. She was clearly very nervous. I said I understood that she did not want treatment forced on her against her wishes and she confirmed that this was the case. She told me that, if she was in the community, she would comply with the treatment plan and drink her juices. I said that I was very concerned for her and only wanted to do what was best for her. She said she understood that. She was, however, adamant to me that she

did not want to go back to a hospital under compulsion. I asked her if there was anything else she wanted to say and she told me there was nothing. I did ask her to give very careful consideration to my judgment, on the basis that I come to this fresh and simply want to do what is best for her and she said she would do so.

19. There was then one further piece of evidence. The Official Solicitor put a number of questions to Dr Cahill and his answers were received this morning. I pay tribute to him for dealing with this case on such an urgent basis and effectively out of hours. He said that he considered this case on a seriousness scale to be 9 out of 10. He was of the view that there was no evidence that any further attempts by compulsion to improve RD's BMI would be any smoother than before. He reminded the court that there had been months of treatment without success and there would need to be months of further treatment. He considered that this would cause further distress to RD. He said that restoring her weight has had no impact on her cognitions or behaviours and the chance of success was less than 5%. It was very likely, moreover, that she would suffer physical, emotional and psychological harm and it would rekindle previous trauma that she had experienced. He accepted that restraint was extremely risky.
20. So far as the law is concerned, I have read in great detail the submissions made to me by all three counsel and particularly the law as it is set out by Mr Hallin in his document on behalf of the Applicant. I do not need to deal with capacity. It is clear that RD lacks capacity for the reasons already given.
21. So far as the legal framework for determining best interests is concerned, that is to be found in section 4 of the Mental Capacity Act 2005. Pursuant to s4(2), the person making the determination must consider all the relevant circumstances and, in particular, take the following steps. Under s4(3) I must consider (a) whether it is likely that the person will at some time have capacity in relation to the matter in question. I am clear that RD will not. Pursuant to (b), if it appears likely that she will, when that is likely to be.
22. S4(4) requires me, so far as reasonably practicable, to permit and encourage the person to participate, or to improve [her] ability to participate, as fully as possible in any act done for [her] and any decision affecting [her]. I have certainly done that and indeed have heard from her this morning.
23. S4(5) provides that, where the determination relates to life-sustaining treatment, I must not, in considering whether the treatment is in the best interests of the person concerned, be motivated by a desire to bring about [her] death. I make it clear that I most certainly am not.
24. Pursuant to s4(6), I must consider, 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 [her] when [she] had capacity). I have considered her wishes and feelings carefully. It is absolutely abundantly clear that she does not, under any circumstance, want any further compulsory treatment, whether pursuant to the Mental Health Act or otherwise. I also have to consider (b) the beliefs and values that would be likely to influence [her] decision if [she] had capacity, and (c) the other relevant factors that [she] would be likely to consider if [she] were able to do so.
25. Turning to s4(7), I must take 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 [her] welfare,
- (c) any donee of a lasting power of attorney granted by the person, and
- (d) any deputy appointed for the person by the court,

as to what would be in the person's best interests and, in particular, as to the matters mentioned [above].”

26. Of course, again I have done so. I make it clear that RD’s parents are extremely loving and concerned for her. They have played a full part in this procedure and they are in agreement with the Applicant Trust’s position, subject to one caveat that I will deal with in due course.
27. There are a number of Authorities in relation to the whole question of how one approaches these cases. I remind myself of the sanctity of life. It is embedded as a fundamental principle in any case of this nature. Sir Thomas Bingham said in the Court of Appeal in *Airedale NHS Trust v Bland*:

“a profound respect for sanctity of human life is embedded in our law and our moral philosophy.”

But as Lady Hale said in *P v Cheshire West* [2014] UKSC 19:

“It is axiomatic that people with disabilities, both mental and physical, have the same human rights as the rest of the human race. It may be that those rights have sometimes to be limited or restricted because of their disabilities, but the starting point should be the same as that for everyone else. This flows inexorably from the universal character of human rights, founded on the inherent dignity of all human beings, and is confirmed in the United Nations Convention on the Rights of Persons with Disabilities.”

28. I have also reminded myself of Part 5 of the MCA Code of Practice and in particular [5.31] where it says:

“All reasonable steps which are in the person’s best interests should be taken to prolong their life. There will be a limited number of cases where treatment is futile, overly burdensome to the patient or where there is no prospect of recovery. In circumstances such as these, it may be that an assessment of best interests leads to the conclusion that it would be in the best interests of the patient to withdraw or withhold life-sustaining treatment, even if this may result in the person’s death. The decision-maker must make a decision based on the best interests of the person who lacks capacity. They must not be motivated by a desire to bring about the person’s death for whatever reason, even if this is from a sense of compassion. Healthcare and social care staff should also refer to relevant professional guidance when making decisions regarding life-sustaining treatment.”

29. There is one further matter that I should mention and that relates to the question of the interaction between the Mental Capacity Act and the Mental Health Act. I am quite satisfied that I should apply Paragraph [21] of the judgment of Mostyn J in *Nottinghamshire Healthcare NHS Trust v RC* [2014] EWCOP 1317 where he said:

“In my judgment where the approved clinician makes a decision not to impose treatment under section 63, and where the consequences of that decision may prove to be life-threatening, then the NHS trust in question would be well advised, as it has here, to apply to the High Court for declaratory relief. The hearing will necessarily involve a ‘full merits review’ of the initial decision. It would be truly bizarre if such a full merits review were held where a positive decision was made under section 63, but not where there was a negative one, especially where one considers that the negative decision may have far more momentous consequences (i.e. death) than the positive one.”

30. In fact, there was going to be a full merits review in this case in any event, pursuant to the Mental Capacity Act, but I take the point that questions involving the Mental Health Act engage public law matters. In particular, the safety of the public is one factor that doctors have to take into account. I do therefore take the view that I should make the declarations that I am invited to make, pursuant both to the Mental Capacity Act and the inherent jurisdiction of the High Court for the avoidance of any doubt.
31. I therefore turn to my decision. I make it clear at the outset that the application that is made by the Midlands trust is supported by the parents of RD, subject to one point that I will deal with shortly. The Official Solicitor’s position is that she does not actively oppose the order being made.
32. RD’s life is undoubtedly a life worth living. I am told that she enjoys living in her privately rented house. She has regular contact with her parents. She has a cat that she loves very much. She does jigsaws and other crafting. She has a sister and, I believe, nephews and nieces. I am quite clear that she does want to live.
33. The problem is that she is completely overwhelmed by the anorexia nervosa from which she so clearly suffers. It means that she lacks capacity, both to take decisions and to implement those decisions and, although she wishes to live, she is completely unable to take the steps to give her body the sustenance that she desperately requires and needs to enable her to lead what could be such a happy and fulfilling life. I therefore, clearly, have jurisdiction, but I must decide what orders I should make.
34. I am quite clear that the cycle of compulsory admissions to hospital has been distressing to her. They have achieved very little in the sense that, whilst historically they did improve her BMI to a certain extent, it was achieved under compulsion and probably after causing her distress, discomfort and psychological trauma. Moreover, as soon as she returned into the community, she immediately lost that weight again and did so in an extremely short timescale. She cannot be kept in hospital under compulsion for an indefinite period and, if she is going to lose any weight that she did gain as soon as she is back in the community, it is difficult to see what it is achieving.
35. In the autumn of last year, the position became even more stark, because the treatment did not even work in the hospital. It may well be that this was caused by her vomiting. She denies that and therefore I do not intend to make a Finding of Fact. The simple

fact of the matter was that, notwithstanding this extremely invasive, compulsory treatment which she hated, she did not put on any significant weight.

36. I have read, with great care, the reports of the various doctors and I am quite satisfied that requiring her to go through any such further compulsory detention would achieve nothing and would merely cause her further trauma, upset and psychological and emotional damage, whilst doing nothing significant to ameliorate her terrible anorexia nervosa. I am quite satisfied that I should make the declarations that this Trust asks me to make to authorise no such further compulsory admissions.
37. I do accept that everything should be done in the community to convince RD to take, voluntarily, the nutrition, treatments and drinks that she so desperately needs and I agree with the various amendments to the care plan put forward on her behalf by her parents and the Official Solicitor to do everything possible to encourage her to comply.
38. Dr Cahill told me about one case in which the removal of the compulsory element actually led to the patient complying much better in the community with the treatment plan. That particular patient, he tells me, is still alive after five years. I so desperately hope that there may also be such an outcome in this case.
39. I am removing any threat of compulsion or compulsory admission to hospital under the Mental Health Act from RD. I am not going to require her to have NG feeds, unless of course she wishes to have them and agrees to such treatment. I do, however, urge her to comply with what the doctors recommend and what I, myself, ask her to do, namely to take the nutrition that she so desperately needs so her life can be prolonged. If she does not do so then I fear it will lead, quickly, to a further deterioration and indeed to the need for palliative care and eventually, or even quite soon, her death, possibly in an unpleasant way. I so hope that that will not be the case.
40. Despite that fact, I am quite clear that further compulsory treatment is not in her best interests. It will achieve nothing and be futile. I therefore authorise and make the declarations sought on behalf of the Applicant Trust.

This Transcript has been approved by the Judge.

The Transcription Agency herRDy certifies that the above is an accurate and complete recording of the proceedings or part thereof.

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