[2022] EWHC 2440 (Admin)

Case No: CO/2309/2022

IN THE HIGH COURT OF JUSTICE

KING'S BENCH DIVISION

ADMINISTRATIVE COURT

Before HHJ Sephton KC, sitting as a Judge of the High Court

Between :

The King (on the application of JJ)	Claimant
- and –	
Spectrum Community Health CIC	Defendant

- -

- -

Ms Leonie Hirst instructed by SLS Legal/ Tuckers, Manchester for the Claimant

Mr David Lock KC and Mr Leon Glenister instructed by Hill Dickinson LLP, Manchester for the Defendant

Handed down 30 September 2022.

JUDGMENT

1. The claimant is a prisoner who is so profoundly disabled that he needs to be fed by a care team employed by the defendant. Because of his condition, eating *any* food poses a risk of death or serious injury by choking or aspiration, but some foods pose a more significant risk than others. The defendant refuses to feed the claimant food that it has been advised poses an elevated risk to the claimant. The claimant, who is of full age and capacity, wishes to eat the food of his choice, even though he appreciates that doing so may carry with it elevated risk. The issue in this case is whether the defendant's refusal to feed the claimant the food he wishes to eat is unlawful.

The background

2. The defendant is a community interest company that provides NHS funded healthcare services to (amongst others) prisoners at a prison in the north of England. The defendant is registered with the Care Quality Commission ("CQC") and is consequently under duties imposed by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ("the CQC Regulations"). The clinical staff employed by the defendant are subject to professional obligations imposed by their regulators, the General Medical Council, the Nursing and Midwifery Council and the Health and Care Professions Council.

3. The claimant is a serving prisoner currently detained at prison in the north of England.

4. The claimant has many health-related issues. In particular, he is now quadriplegic: he is paralysed from the neck down and has lost function in all four limbs, although he is able to press a button to operate a television or to call staff. He has lost all of his teeth. He is in pain most of the time. He is, and will remain, severely disabled and dependent upon others. He requires 24 hour care and assistance with all activities of daily living, including elimination, bathing, administration of medication and feeding. The defendant's staff provide the claimant with the care and assistance he requires. In particular, the defendant's staff are responsible for feeding the claimant.

5. In his witness statement, the claimant explains that he is completely isolated from normal life. He claims that the only thing that varies in his life is the taste and experience of food. He states that being able to eat what he wants represents his last shred of humanity and dignity.

6. The claimant describes the difficulties he has had with food: because he cannot chew food with his teeth, he has had to adapt his diet. Previously, meals were sent to his cell and he would have to decide whether he could eat them. He states that the kitchens often provided him with food he could not chew and break down, so he would not eat it. Instead, he would supplement his diet with snacks bought from the prison canteen.

7. I permitted the claimant to adduce the witness statement of Mr Andrew Sperling which exhibits a digest of the claimant's very extensive medical notes. My attention was drawn to the following:

   (a) There were 2 occasions between 2016 and the present in which the claimant choked on something he had ingested; on 6 September 2016 (when the cause was medication) and on 9 July 2020 (when the cause was something he ate).

   (b) He choked for unspecified reasons on 8 June 2018.

(c) He choked possibly on phlegm on several occasions between April and October 2019.

(d) There were many occasions when the defendant's staff gave the claimant chocolates, biscuits and boiled sweets.

8. The claimant's witness statement states that after a period in hospital in 2019 where he was offered a soft diet, the claimant returned to prison and asked for a soft diet to be provided for him. He states that eventually, the staff insisted that he be assessed by a speech and language therapist before a soft diet would be provided. It appears that the involvement of the speech and language therapist may not have been so arbitrary as the claimant suggests in his witness statement. I note from the exhibit to Mr Sperling's witness statement that in around May 2020, the defendant's care team was expressing concerns that the claimant's consumption of boiled sweets and biscuits gave rise to a risk of choking. Even after the claimant agreed to accept responsibility for the decision to consume such items, the staff were uncomfortable about the issue. At length, the claimant was referred to the speech and language therapist on 21 April 2021. The reason for the referral was given as: "difficulties with eating, drinking or swallowing" and "recurrent chest infections/UTIs".

9. Kristina Croller-Baker, a speech and language therapist, undertook an assessment on 27 May 2021. The purpose of the assessment is recorded as being to develop a care plan "and for clarity for staff supporting him".

10. In her note under the heading "Nutrition," Ms Croller-Baker recorded that the claimant ate food compliant with IDDSI Level 6 food[1], but also hard boiled sweets, crisps and biscuits. Ms Croller-Baker expressed the view that hard boiled sweets "are considered high risk."

11. Under the heading "Analysis" Ms Croller-Baker said this:

> [JJ] has an okay cough which he could demonstrate in the session; however, whilst this may clear fluids from the airway, it is unlikely to clear any thicker residue due to its weakness in nature. [JJ] is at high risk of aspiration and choking due to his supine position and this will also make it difficult for any coughing to be effective in clearing the residue due to having to go against gravity. In addition [JJ] is showing signs of laryngopharyngeal reflux, which is likely to be a consequence of his positioning in combination with other physical health conditions.
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> [JJ} is presenting with mild to moderate oropharyngeal dysphagia characterised by poor oral control, positioning and reduced airway protection. While [JJ]'s chest remains clear and he has not experienced any choking episodes he is at high risk of this in the future. [JJ] appears to understand the consequences of this and accepts this risk.

[1] The Standardised Framework of the International Dysphagia Diet Standardisation Initiative ("IDDSI") defines food of Level 6 as soft and bite-sized which can be eaten with a fork, spoon or chopsticks but does not require a knife, does not require biting but does require chewing with pieces of food no larger than 1.5cm.

12. Under the heading "Plan", Ms Croller-Baker stated that the claimant had agreed that once the 10 hard boiled sweets in his box were gone, he would trial 2 weeks without them to see if they supported reducing the production of phlegm. She advised "Level 6 Soft and Bite-Sized Diet to be given."

13. The defendant acted upon Ms Croller-Baker's recommendations. However, the claimant was dissatisfied with Mr Croller-Baker's assessment and her recommendations. From about 7 June 2021, he went on hunger strike. He stated that he had capacity to make a decision about what he wanted to eat and drink, he was aware of the risks and he therefore had the right to eat the food of his choice.

14. Dr Foud Bassa made a psychiatric assessment of the claimant on 23 September 2021. Dr Bassa found that there was nothing to suggest that the claimant was suffering from depression or any mental health issues and that he had capacity to make his own decisions to accept or refuse the food offered to him.

15. The claimant was further assessed by Bernadette Clifford, a speech and language therapist, on 24 November 2021, whilst he was still on hunger strike.

16. Ms Clifford records that the claimant was clear that he understood that anything placed in his mouth posed a risk, but he did not understand the difference between aspiration and choking. She recorded:

> "As [JJ] is in the supine position and has paralysis of his body, it would be very difficult if not impossible to be able to administer first aid to support the choking episode."

She continued:

> "We discussed that for the recommendations to be changed a re-assessment would be required and this would include observations of [JJ] having some food. As [JJ] has not been eating for some time, I advised that his ability to eat, drink and swallow may have changed as he has not been using the muscles. We discussed that this may have deteriorated, and the skills do not return even when re-introducing eating. To consider a reassessment, he would need to re-commence eating on a plan as advised by a dietitian (due to high risk of re-feeding syndrome) and speech and language therapist in relation to the management of textures. He would also require a physiotherapy assessment to support his posture and establish if he is able to be elevated more than he is currently… This is a process that would take several months and would require collaborative working to be able to establish recommendations that would keep [JJ] safe, the staff team safe and support quality of life. [JJ] felt that for him to start this process he would want a letter writing stating that it's his choice and he and the staff could at any point choose to ignore the recommendations…"

17. The evidence of Dr Thomas shows that re-feeding syndrome occurs when food is introduced too quickly after a period of malnourishment. Variations in electrolyte levels can cause serious or even fatal health complications. Dr Thomas believes that the claimant would be at considerable risk of dying if provided with solid foodstuffs introduced in an unplanned manner.

18. The claimant continued to refuse food after he had been examined by Ms Clifford. On 22 December 2021, he made an Advance Decision to Refuse Treatment ("ADRT") which confirmed that he would not take food even if his life were at risk or might be shortened as a result. He gave directions as to what care he was to be given should he lose the capacity to make decisions about his health care.

19. On 17 May 2022, the claimant was found unresponsive and was transferred to Aintree University Hospital. The hospital staff found that there was no treatment that could be administered consistent with the claimant's ADRT. The claimant was transferred to St Joseph's Hospice for end of life care. Whilst he was at the hospice, the claimant ate some cake, custard and ice cream. His condition improved and he was returned to prison. I understand that he has resumed his hunger strike.

20. The claimant states that he is aware that he "may need to go through a re-feeding process to be able to eat properly again." He states: "I would be willing to do this, but only provided that, when I am capable of eating again, I can exercise my basic freedom of choice to decide what I will eat, being fully aware of the risks."

21. The defendant summarised its position in a letter dated 23 May 2022, as follows:

> "The issue is that [JJ] wants to be fed at risk contrary to the SALT advice. Because of the severe disability afflicting [JJ], his prone position, and the length of his hunger strike it is a recognised risk that re introduction of foods/feeding can lead to death. [JJ] is quadriplegic and has an established diagnosis of X-linked hypophosphatemia (XLH). SALT specialists responsible for [JJ] 's care have recommended that [JJ] be given a 'Level 6' soft diet, and in particular should not be given boiled sweets.
>
> He cannot feed himself and therefore staff would have to feed him contrary to SALT advice. Were he to die as a result of the introduction of solids, boiled sweets, or anything other than a 'Level 6' soft diet, the relevant individual could be at risk of both criminal proceedings and disciplinary proceedings.
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> [JJ] cannot consent to the serious harm that might occur as a consequence of the staff acting contrary to the SALT advice. Furthermore there could be organisational risk associated with the decision to acquiesce to this.
>
> So [JJ] is free to articulate his choice in the matter but in view of the above it is not an option available to him."

22. On 27 May 2022 the claimant sent a pre-action letter to the defendant challenging the defendant's refusal to permit the claimant to choose his diet. The defendant responded on 6 June 2022, maintaining the position but indicating that it would take a neutral position and "not actively oppose" a claim for judicial review and declaratory relief.

Evidential issues

23. It is convenient to address some evidential issues at this stage.

24. The claimant submits that the defendant places undue weight on the views expressed by Ms Croller-Baker and Ms Clifford. He points to the long history of his consuming sweets, biscuits and snacks as demonstrated in the exhibit to Mr Sperling's witness statement. He emphasises that there have been only 2 occasions when choking has occurred when swallowing food or medication. The claimant's witness statement implies that Ms Croller-Baker's opinion is deficient because she did not observe him eating. He submits that there is a significant lack of evidence supporting key elements of the defendant's submission in relation to the imminence and seriousness of the risk to the claimant from ingesting the food of his choice.

25. I cannot accept the claimant's submission for a number of reasons.

26. The first reason is that even though the claimant had been consuming boiled sweets and biscuits without choking for a long time, the defendant's staff had long been concerned that this gave rise to an elevated risk of choking: the risk had been perceived, even though it had not resulted in serious harm to the claimant. In May 2020, the general practitioner employed by the defendant was sufficiently concerned about the issue that he issued a direction that the claimant should not be given whole biscuits. In April 2021, the defendant commissioned a review by a speech and language therapist in order to devise a care plan and to provide clarity for the staff supporting the claimant. The defendant engaged an appropriate professional to advise upon the care plan; the fact that the defendant then relied upon it as identifying the relevant risks cannot in my view be criticised.

27. The second reason is that Ms Croller-Baker took into account the matters relied on by the claimant when she expressed her opinion. She took into account that the claimant had a history of eating boiled sweets, crisps and biscuits (even though the claimant had concealed this from her, despite repeated questioning: she found out about these items through the staff). She advised on the basis that the claimant had suffered no previous choking episodes, but nevertheless considered that he was at high risk. In my view, Ms Croller-Baker's views were formed after an apparently appropriate consideration of the claimant's history. It is not

for this court in an application for judicial review to substitute for the informed and considered view of a professional its own view of the medical risks involved.

28. The third reason is that I reject the implication that Ms Croller-Baker's report is deficient because she did not observe the claimant eating. She observed the claimant drinking and made a careful analysis of the swallowing action. If it were to be alleged that Mr Croller-Baker could not produce a reliable report unless she had observed the claimant eating, I would require cogent evidence to that effect from a recognised expert, supported by appropriate learned material. There is none. I note that Ms Hirst did not press this criticism in her submissions.

29. The fourth reason is that the facts demonstrate that the situation is dynamic and the claimant's condition has changed significantly since the time when he was eating sweets and biscuits without incident. Whatever the position may have been in May 2021, the claimant has since been on a long hunger strike with the consequences that he may have impaired or lost altogether his ability to eat, drink and swallow and he runs the risk that he may develop re-feeding syndrome. Ms Clifford's note provides clear evidence about the risks in the now-changed situation; in my judgment, the defendant cannot be criticised for relying upon it. Further, the defendant's medically qualified director, Dr Thomas, has expressed her view about the current risk: there is no hint that Dr Thomas is not expressing a genuinely-held and rational professional opinion.

30. For the avoidance of doubt, I reject the proposition that the food the claimant consumed when at St Joseph's Hospice has significance to the outcome of this case. The evidence about precisely what was eaten, over what period and in what circumstances is exiguous and does not, in my judgment, provide a sufficient evidential basis to discredit the opinions expressed by Ms Croller-Baker or Ms Clifford.

31. The claimant submits that there is no evidence before the court to support the defendant's assertions as to potential criminal or regulatory liability should the claimant suffer harm as a result of staff giving effect to his food choices. I accept that, as a matter of fact, this submission is well-founded: there is no such evidence. I consider later in this judgment whether any such evidence is required or could be produced.

32. However, it is pertinent, I believe, to consider what would happen should the claimant suffer fatal harm as a result of staff giving effect to his food choices. I bear in mind that the claimant requires 24 hour care: it will be inevitable, therefore, that one or more of the defendant's staff will witness the claimant's demise, probably by choking. It would be surprising if the staff

members could treat such an event with equanimity; it is likely to be a harrowing and stressful experience, even for seasoned medical professionals. There will inevitably be an independent and thorough investigation that is capable of leading to the identification and punishment of any person or company that may have been criminally responsible for the death: this follows from the state's duty of investigation inherent in Article 2 of the European Convention on Human Rights ("ECHR"). Any such investigation is likely to have regard to the advice the defendant received from the experts who expressed views upon what the claimant should eat, whether the defendant's staff complied with the experts' views and if not, why not. Although it is entirely proper that the conduct of medical professionals should be subjected to careful scrutiny in the event that a patient under their care dies, I do not minimise the stress placed on the person whose actions are being investigated. It is necessary to bear in mind that the claimant's choices may exact a toll upon his carers.

The grounds

33. Having dealt with these preliminary matters, I turn to consider the Grounds.

Ground 1: Autonomy

34. The claimant submits that his right to eat what he chooses is one of the few remaining areas in which he can exercise autonomy. The defendant's refusal to allow him to exercise that choice is, he submits, unlawful.

Legal Framework.

35. In *Montgomery v Lanarkshire Health Board* [2015] UKHL 15 at paragraph 108, Lady Hale defined a person's autonomy as "their freedom to decide what shall and shall not be done with their body." In *Airedale NHS Trust v Bland* [1993] AC 789, at 826F, Hoffman LJ defined a man's autonomy as "his right to choose how he should live his own life." Autonomy is a fundamental principle of the common law.

36. The principle of autonomy means that a person may lawfully decide to take his own life. Thus, in *Reeves v Commissioner of Police* [2000] 1 AC 360, Lord Hoffman accepted (at p 369 B) that if a prisoner went on hunger strike, the police would not be entitled to administer forcible feeding. Likewise, a person can refuse medical treatment or choose between treatments even if the consequence of the decision may be the patient's death: see *Sidaway v Board of Governors of the Bethlehem Royal Hospital and the Maudsley Hospital* [1985] AC. 871 *per* Lord Templeman at p 904; *Airedale NHS Trust v Bland per* Lord Mustill at p 892 H; *R(Burke) v General Medical Council* [2005] EWCA Civ 1003 *per* Lord Phillips MR at [30].

37. There are limits to the principle of autonomy; for example, the principle of autonomy does not apply where a patient invites another person to end the patient's life by active means: mercy-killing remains unlawful in this jurisdiction and the patient's autonomy does not permit him to confer upon the killer the right to comply with the patient's wishes: see *per* Lord Goff in *Bland* at p. 864; *per* Lord Mustill at p 893 A; *Pretty v UK* (2002) 35 EHRR 1. Fundamental principles can come into conflict and "may therefore require a painful compromise to be made" per Hoffman LJ in *Bland* at p 827.

38. The reason that this case gives rise to particular difficulty is the claimant's disability. An able-bodied person, having chosen how to live their own life, can set about doing so. An adventurous able-bodied person can attempt the ascent of K2, knowing that the enterprise involves a significant risk of death. However, this claimant relies on others for almost all of his activities. Although the claimant can express his choice about (for example) what to eat, another person ("the carer") is required to execute his wishes. The decisions the claimant makes about his own life are likely to affect the life of his carer. If the claimant wished to attempt K2, he would put at risk not only his own life but also that of his carer. It is self-evident that the carer has autonomy, and the way in which the carer chooses to live their life may conflict with the claimant's. Is the court required to consider only the claimant's autonomy and ignore that of the carer, or does the conflict between the humanity and dignity of the claimant and that of the carer require a painful compromise to be made?

39. The issue has been addressed (at least in part) in the context of medical treatment. (It is common ground that when feeding the claimant, the defendant is providing him with medical treatment.) I derive the following propositions from the authorities to which my attention has been drawn:

(1) Once a patient is accepted for treatment, the medical staff come under a positive duty at common law to care for the patient: *R(Burke) v General Medical Council* [2005] EWCA Civ 1003 para. [32].

(2) A fundamental aspect of this positive duty of care is a duty to take such steps as are reasonable to keep the patient alive: See *R(Burke) v General Medical Council* [2005] EWCA Civ 1003 at para. [32]. The duty compels a medical professional to provide the patient with treatment so long as it prolongs the patient's life: *Burke* at para. [40].

(3) This duty will not, however, override the wish of a competent patient to refuse treatment: see the cases cited in paragraph above.

(4) Autonomy and the right of self-determination do not entitle the patient to insist on receiving a particular medical treatment regardless of the nature of the treatment: *Burke* para. [31].

(5) If a medical professional concludes that a course of treatment is not clinically indicated, he is not required (i e he is under no legal obligation) to provide it to the patient: *Re J(A minor)* [1993] Fam 15 at p. 26 H; *Burke* para. [50]. A patient cannot demand that a medical professional administer a treatment which the medical professional considers is adverse to the patient's clinical needs: *A National Health Trust v D* [2000] 2 F.L.R. 677 para. [51]; *Burke* para. [55].

40. Ms Hirst referred me to guidelines offered in *Ms B v An NHS Hospital Trust* at para. [100] by Dame Elizabeth Butler-Sloss P, in particular to guideline (viii). She submitted that a doctor who could not carry out the wishes of the patient is under a duty to find another doctor who will do so. This issue was also addressed in *Burke* at para. [40]. Under the heading *The doctor with care of Mr Burke must either comply with his wish to be given [treatment] or arrange for another doctor to do so*, the Court of Appeal implied that the problem ought not to arise because the doctor with care of the patient would himself be obliged, *so long as the treatment was prolonging the patient's life*, to provide it in accordance with his expressed wish (my emphasis).

41. I was referred to the General Medical Council's *Good Medical Practice*, which provides professional guidelines for doctors. Similar guidance is provided for nursing, midwifery and other healthcare professionals. The General Medical Council expects doctors who have a conscientious objection to a particular course of treatment to refer the patient to another doctor (see paragraph 52 of *Good Medical Practice*). However, if a doctor considers that a colleague is endangering a patient, he should seek advice and, if necessary, report the doctor concerned (see paragraph 25). It is plain that a doctor may not refer a patient to another whom the doctor believes might endanger the patient.

42. I take the law to be that a medical professional is obliged to provide life-sustaining treatment if the patient wishes it, and if the medical professional cannot or will not do so, he must find another who will do so. But I do not accept that a medical professional who has reached the conclusion that a treatment is adverse to the patient's needs is required to find another medical professional who will administer that treatment. My view is, I believe, consistent with *Burke* and *Re J(A minor)* and is also consistent with the professional guidance offered to doctors by the General Medical Council. It is not clear to me what argument was offered on

guideline (viii) in *Ms B*. If the President was urging that a professional is obliged to find another who will administer treatment which the professional believes is adverse to the patient's needs, then I must, with the greatest of respect, disagree.

43. For completeness, I deal with the submission of Mr Lock KC that *Reeves v Commissioner of Police* [2000] 1 AC 360 is authority for the proposition that the state (and by extension in this case, the defendant) owed the claimant a duty to take care to prevent him from killing or harming himself, to that extent curtailing the claimant's autonomy to choose activities that might harm him. I do not accept that this is what *Reeves* decided. In *Reeves*, counsel for the appellant conceded that because the appellant was aware that the deceased was a suicide risk there was a duty on the part of the officers at the police station to take reasonable care to prevent the deceased from committing suicide (not, be it noted, a duty to prevent a prisoner from harming himself in a more general sense). Lord Hoffman observed (at p. 369 A) that the duty

> "is a very unusual one, arising from the complete control which the police or prison authorities have over the prisoner, combined with *the special danger of people in prison taking their own lives.*" (my emphasis)

Reeves is concerned only with the risk that a prisoner who has capacity might deliberately end his life. No authority was cited to me that supports the proposition for which Mr Lock KC contends. I do not think that the state has a duty to take care to prevent a prisoner from voluntarily undertaking an activity which *might* harm him (even fatally) and which the prisoner might undertake when at liberty: such a duty is in my judgment too wide. For example, such a duty might require the prison staff to prevent prisoners from smoking, an activity which it is widely accepted carries with it the risk of fatal disease.

44. A civil court should not make declarations about criminal liability save in the most exceptional circumstances: see *Imperial Tobacco Limited v Attorney-General* [1981] AC 718 at p. 742 C, p. 746 F; *R(Bus and Coach Association) v Secretary of State for Transport* [2019] EWHC 3319 at para. [47].

Submissions

45. Mr Lock KC submitted that the defendant had formed the view that feeding the claimant foods of the type he had previously demanded was adverse to the claimant's clinical needs because it represented a serious risk to the claimant's health. Such a view about the risks was justified by the reports of Ms Croller-Baker and Ms Clifford. Mr Lock KC submitted that the defendant could not lawfully administer food to the claimant which was known to constitute an elevated risk to his life. He submitted that if the defendant complied with the claimant's

wishes and as a result the claimant suffered serious injury or death (for example, by choking, re-feeding syndrome or aspiration leading to pneumonia), the defendant and its staff would be vulnerable to criminal and regulatory sanctions. He identified the following risks: prosecution for manslaughter, infractions of the CQC Regulations, liability for Health and Safety offences and regulatory sanctions by the professional regulators of the defendant's staff.

46. Ms Hirst submitted that the claimant had full capacity and was entitled to eat what he chose. She submitted that the defendant was required to demonstrate that the risk of prosecution or regulatory action was so great that it justified depriving the claimant of his autonomy to choose what he eats. She submitted that the ingredients of the offence of gross negligence manslaughter were so strict that it was extremely unlikely that the defendant or its employees would be prosecuted. She submitted that no offence contrary to the CQC Regulations would be committed or at any rate prosecuted. She urged me to reject the proposition that any offence contrary to section 4 of the Health and Safety at Work Act 1974 could be committed in the context of the care of the claimant. As recorded earlier in this judgment, she made the point that the defendant had not adduced any evidence about the attitude of prosecuting or regulatory authorities.

Discussion

47. I accept that the claimant is of full age and capacity. He is entitled to express a choice about what he eats. The issue is whether the defendant is obliged to give effect to his wishes, or whether it may refuse to do so.

48. For the reasons given earlier in this judgment, I consider that the defendant was entitled to rely upon the notes prepared by Ms Croller-Baker and Ms Clifford in assessing the risk to the claimant. At present, the claimant has not consumed food for many months and is vulnerable to the several and serious risks that Ms Clifford identified in her note in November 2021. As Dr Thomas points out, he is at "considerable risk of dying if he is provided with solid foodstuffs".

49. In accordance with the authorities referred to above, I conclude that the defendant is not required to comply with the claimant's wishes because it has formed the conclusion, rationally, that such is contra-indicated and adverse to his clinical needs. The defendant's decision is not unlawful. This is sufficient to dispose of this Ground.

50. The claimant seeks a declaration that it is lawful for the defendant's staff to give effect to the claimant's food choices: this is the corollary of the declaration that the defendant's refusal to allow the claimant to choose his diet is unlawful. I note that the effect of the declarations, if

granted, would be to absolve the defendant's practitioners from exercising clinical judgment in relation to what the claimant eats. It seems that the intended effect is to relieve the defendant's staff from potential future criminal liability in connection with the feeding of the claimant.

51. In her skeleton argument, Ms Hirst stated that the claimant's claim was not directed towards his current status, but instead to the position he hoped to achieve after re-feeding therapy had been undertaken. There are several difficulties in Ms Hirst's way. The first is that the declarations she seeks make no distinction between the present position and some future in which it is hoped that he claimant may be at less serious risk. When I invited her to deal with this point during submissions, she did not offer an answer that I found convincing. The second difficulty is that, though the claimant says in his witness statement that he will sensibly follow a re-feeding regime, he told Ms Clifford that he required that he and the staff could at any point choose to ignore the recommendations. If the court were to declare that the defendant's refusal to allow the claimant to choose his diet is unlawful, the claimant could insist on eating food that carried with it the risks mentioned by Ms Clifford, without regard to the circumstance that the defendant's staff would have to administer such food despite the knowledge that its medical director and speech and language therapists identify significant risks. The third difficulty is that the claimant's condition has progressively deteriorated. It may be that the claimant's ability to tolerate foods is not recovered or indeed is further diminished. The relief the claimant seeks takes no account of the significant changes that have occurred in the past and may happen in the future.

52. In my view, if in the near future a member of the defendant's staff gave the claimant food which choked him or caused him to develop re-feeding syndrome without referring the claimant for a re-feeding programme assisted by a dietician, a physiotherapist and a speech and language therapist, it is not at all fanciful to postulate that the defendant and the member of staff may be subject to criminal and/or regulatory action if the claimant were to suffer serious or fatal injury as a consequence. I do not accept that the prospect of a prosecution for manslaughter is negligible. As I understand the evidence of Dr Thomas and the report of Ms Clifford, there is a serious and obvious risk of death to the claimant in giving him food of any type other than under the conditions of a strict re-feeding programme. The question of whether the claimant validly consented to eating such food is an evidential question that would have to be resolved by a jury, and would have to take into account the fact that though the claimant may have made a decision to eat something, the defendant's staff had to execute the decision. Such a jury might find that feeding the claimant in the teeth of the advice of Ms

Clifford is indeed so reprehensible as to justify a criminal sanction. Neither do I accept that the defendant is likely to be immune from a prosecution under regulation 12 of the CQC Regulations. In circumstances where a prosecution for manslaughter is a possibility, action by the professional regulator is not unlikely.

53. Even if the claimant successfully undertook a re-feeding programme but continued to be at the risk of choking and aspiration identified by Ms Croller-Baker, it seems to me that the defendant and its staff remain at risk of prosecution or regulatory action, though I accept that the risk is smaller.

54. The varying presentation of the claimant's condition means the court could not expect a prosecuting or regulatory authority to indicate whether and in what circumstances it would act against the defendant's staff in the event that the claimant suffered serious injury or death. I would expect any investigation to concentrate upon the claimant's condition at the time of the incident that gave rise to harm to him and upon the clinical judgment exercised by the medical professional under the circumstances obtaining at that time. It would be surprising – indeed, disturbing – if a prosecutor or regulator bound themselves to a course of action even though the possible circumstances of the potential offence are many and varied. In the circumstances, I reject Ms Hirst's criticism that the defendant has adduced no evidence about the extent of the risk of prosecution. In my judgment, all that can or need be said is that there is a risk of prosecution that is more than fanciful. I am satisfied that I cannot say that the possibility of prosecution or regulatory action is negligible.

55. It seems to me that the claimant invites the court to do what the prosecuting authorities will not do, namely, to determine that no offence would be committed if the claimant were to come to harm when the precise circumstances are unknown. In my view, it would not be an appropriate exercise of the court's discretion to make the declarations sought where the fact that the claimant's presentation may vary significantly makes it impossible to state whether a future act would or not be lawful. In my judgment, it would be quite improper of this court to seek to tie the hands of a future criminal court by making a declaration that purports to have effect notwithstanding what circumstances might surround the harm that comes to the claimant.

56. The facts of this case demonstrate the wisdom of the authorities that counsel a civil court against making declarations regarding criminal liability. I regard myself bound by those authorities. There are no exceptional circumstances in the present case that might derogate from the rule that the court should not grant such a declaration.

57. It follows that I reject Ground 1 for two reasons:

(1) It is not unlawful for the defendant to refuse the claimant treatment – the feeding of particular foods to the claimant – which it believes is contra-indicated and adverse to the claimant's clinical needs.

(2) The court will not declare that it is lawful for the defendant to comply with the claimant's wishes regarding diet. It would be wrong to make a declaration which purports to decide an issue of criminal liability for future events, the circumstances of which cannot yet be known.

Ground 2: Rationality

58. The claimant submits that analysis of the claimant's history does not justify the conclusion that there is a significant risk to the claimant's life or health; that the assessments of Ms Croller-Baker and Ms Clifford do not provide a rational basis for its decision and that the defendant's perception of the risk of criminal or regulatory enforcement is irrational.

59. It will be apparent from my treatment of the evidential issues earlier in this judgment that I am not persuaded that the defendant's assessment of the risk to the claimant is irrational. For the reasons given above, I hold that the defendant was entitled to rely upon Ms Croller-Baker's views at the time she expressed them. Since then, the claimant has been on hunger strike for many months. The defendant could not have relied upon empirical evidence about the claimant's current ability to take food, because he has eaten almost nothing: the defendant has acted rationally in relying upon the opinion of suitably qualified experts (namely, Ms Clifford and Dr Thomas) to assess the current risk.

60. In my judgment, the defendant is amply justified in its view that feeding the claimant the foods he wants carries with it a risk of criminal and regulatory action against the defendant and its employees. For the reasons given above, neither the relevant prosecuting or regulatory authorities nor the court can identify the magnitude of the risk: much depends on the precise circumstances in a situation where the claimant's condition is continuously changing.

61. It follows that I reject Ground 2.

Ground 3: Article 8 European Convention on Human Rights ("ECHR")

62. The claimant submits that the defendant's refusal to permit the claimant to control his diet is an interference with the claimant's rights under Article 8 which is disproportionate to the legitimate aim of protecting the claimant's health.

63. The defendant (rightly) concedes that it is discharging a public function and that accordingly, it is required to respect the rights vouchsafed to the claimant by the ECHR. The issues for determination are (a) whether the claimant's Article 8 rights are engaged and whether the defendant has breached them; (b) if so, whether the proviso to Article 8 applies.

64. Article 8 provides as follows:

> 1. Everyone has the right to respect for his private and family life, his home and his correspondence.
>
> 2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

65. The concept of respect for private life and home life in Article 8 requires respect for "physical and psychological development", "personal development and autonomy" (*Pretty v UK* (2346/02)), "physical and moral integrity" (*Raninen v Finland* (20972/92)), "mental stability", "integrity of a person's identity" (*R(Razgar) v SSHD (No 2)* [2004] UKHL 27), "protection of private sphere and private space" *R(Countryside Alliance) v AG* [2007] UKHL 52. Just as the Divisional Court in *R(G) v Nottinghamshire Healthcare NHS Trust* [2008] EWHC 1096 found that a smoking ban in secure hospitals did not constitute a breach of patient's Article 8 rights, so, it seems to me, limiting a person's food choices in prison does not generally involve such an adverse effect upon these principles as to constitute an interference with Article 8 rights.

66. The present case is, however, exceptional. Because the claimant is so grievously disabled, his autonomy is extremely limited. Choosing what he will eat is one of the few activities which he remains able to undertake; his autonomy about what to eat forms a significant proportion of his capability as a person. I am persuaded that, in the particular circumstances of this case, the claimant's right to make a choice from amongst the foods available to him in prison is one which engages Article 8.

67. There is presently controversy about the extent to which Article 8 imposes a positive obligation upon states to make Article 8 rights real and substantial; I heard submissions and was referred to authority on the issue. However, I am not convinced that this case raises the question whether the claimant's Article 8 right imposes a positive duty to give the claimant what he wants. This is because, in the highly unusual circumstances of the present case, the defendant has an obligation at common law to nourish the claimant in any event (see, for example, *R(Burke) v General Medical Council* [2005] EWCA Civ 1003 para. [32]). When it comes

to choosing *what* the defendant should feed the claimant it seems to me that he is entitled to "respect" for his food choices. In this context, it seems to me appropriate to characterise the defendant's conduct as preventing the claimant from doing what he would otherwise be entitled to do, rather than stating that the defendant has a positive duty to give him specific foods. I consider that, in refusing to comply with the claimant's food choices, the defendant is interfering with the right protected by Article 8, paragraph 1 of the ECHR.

68. The claimant's right is not absolute. The defendant submits that, in accordance with paragraph 2 of Article 8, it may interfere with the claimant's right to choose what he eats for two reasons: to protect the claimant's own health and to the protection of the rights and freedoms of others i.e. the defendant and its staff to practise without risk of prosecution or regulatory sanction and in accordance with their professional judgment.

69. I have already found that the defendant's conduct is "in accordance with the law."

70. The claimant's current condition is currently fragile, as described by Ms Clifford. I accept her view that he is at risk from choking, aspiration and re-feeding syndrome and that his ability to swallow safely may have been impaired, perhaps irretrievably, by his hunger strike. If the defendant complies with the claimant's food choices, he may die or suffer serious injury. The consequences for the claimant's health are potentially very grave. The course adopted by the defendant is, in my view, taken for the protection of health.

71. For the reasons set out earlier, the risk is real that the defendant and its staff may face prosecution or regulatory action; it is not possible to say how great the risk is, because the issue is highly fact-sensitive. I remind myself that the court will not force a medical professional to administer treatment to a patient which he considers to be contra-indicated and adverse to the patient's clinical needs; in other words, the court will not interfere with his professional autonomy. The course taken by the defendant is, in my view, taken for the protection of the rights and freedoms of others, namely, the defendant and its staff.

72. The question whether the steps taken by the defendant are "necessary in a democratic society" invites a consideration of proportionality. I have explained that I consider the claimant's right to choose his diet is, by reason of the extraordinary circumstances of this case, sufficiently important to merit the protection of Article 8. However, in my view, the countervailing concerns of the defendant, as highlighted in the previous two paragraphs of this judgment, amply justify the defendant's interference with the claimant's right to choose.

Given the claimant's current condition, the justification for interference with the claimant's rights is all the stronger.

73. Accordingly, I reject Ground 3 on the basis that although, in the exceptional circumstances of this case, the claimant's right to choose what food he will eat is one that engages Article 8 of the ECHR, the defendant's interference with that right is lawful, proportionate and justified for the protection of health and for the protection of the rights and freedoms of others. In any event, I would have declined to make the declarations of lawfulness and unlawfulness sought for the reasons set out in my discussion of Ground 1.

Ground 4: Equality Act 2010.

74. The claimant submits that the defendant's refusal to enable him to choose his food, and/or the defendant's control of the claimant's diet, constitute unlawful discrimination on grounds of disability contrary to ss13, 20 and 21 Equality Act 2010.

75. As I understand the claimant's case, he submits that because he is disabled, the defendant has not properly assessed the risk posed to him by eating the food of his choice: his case appears to be that the defendant has over-estimated the risks of serious or fatal consequences owing to his disability. This appears to me to be the argument I considered and rejected earlier in this judgment about whether the reports of the speech and language therapists accurately represent the risk. For the reasons I gave earlier, I do not think that the defendant has mis-construed the evidence about risk. I am not persuaded that in assessing the risks, the defendant has treated the claimant less favourably that it would have treated a person with no disability but for whom eating the food the claimant wishes to eat represents the same risk of harm or death.

76. I accept that the defendant's practice of providing the claimant with a special diet puts him at a substantial disadvantage in comparison with persons who are not disabled; thus section 20(3) of the Act is engaged. The question is whether the defendant has not taken steps it is reasonable to take to avoid the disadvantage. The only steps for which the claimant contends are to feed him in accordance with his wishes. In my view, it is not reasonable for the defendant to take those steps because (a) they may cause the claimant serious or fatal harm; (b) they might result in the defendant or its employees being prosecuted or subject to regulatory sanction (c) they would require the defendant and its employees to administer treatment which they believed was contra-indicated and not in accordance with the claimant's clinical needs. The claimant has not persuaded me that the defendant has failed to make reasonable adjustments.

77. Ms Hirst's skeleton argument advances a further argument under section 15 of the Act. This claim is not referred to in the Grounds and the claimant has not had permission to advance it. The defendant objects, and points out that it has not had the opportunity to serve evidence designed to make good a defence under section 15(1)(b). I am not willing to grant permission to advance this claim. In any event, it seems to me highly likely that the defendant would make good the section 15(1)(b) defence along similar lines to those dealt with in other grounds.

78. Accordingly, I reject Ground 4.

Conclusion

79. The claimant's medical condition has rendered him reliant upon others to feed him. I have reached the conclusion that, even though the claimant has capacity to make choices – even unwise ones – about what he wishes to eat, the defendant is not required to execute those wishes, because it has reasonably formed the view that giving the claimant those foods is contraindicated and adverse to his clinical needs and because it is possible that, were the defendant to comply with the claimant's requests, the claimant might suffer serious or even fatal consequences and the defendant and its employees might be open to prosecution or regulatory action.

80. The declarations the claimant seeks should not be granted because it is not possible for a prosecuting authority, a regulator or a court to state now whether some unknown future conduct of the defendant or its staff will be lawful or whether it should or might be visited with criminal or regulatory sanctions. For a court to do so on the facts of the current case would be contrary to principle and authority.

81. In the extraordinary circumstances of this case, I think that the claimant's right to choose what food he will eat engages Article 8 of the ECHR. However, the defendant has demonstrated that its interference with the claimant's Article 8 rights in this case is lawful, proportionate and justified for the protection of health and for the protection of the rights and freedoms of others.

82. I reject the claim under the Equality Act 2010.

83. The consequence is that the claim must be dismissed.