Neutral Citation: [2022] EWCOP 44

Case No: 13236134

IN THE COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 7 October 2022

Before :

MR JUSTICE POOLE

- -

Re A (Covert Medication: Closed Proceedings)

Between :

A Council

Applicant

- and -

(1) A (By her Litigation Friend, The Official Solicitor)
(2) B (A's Mother)
(3) An NHS Trust

Respondents

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- -

Jodie James-Stadden (instructed by) for the Applicant
Sam Karim KC (instructed by the Official Solicitor) for the First Respondent
Michael O'Brien KC (instructed by) for the Second Respondent
Joseph O'Brien KC instructed by the Third Respondent

Hearing dates: 15 September 2022 (Closed Proceedings); 20-22 September (Open Proceedings)

- -

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.

.....

A Transparency Order is in force which prevents any publication or communication which identifies or is likely to identify the subject of these proceedings, members of her family, the place where she lives other than as being in the North of England, or the expert witness, Dr X. The Order provides that the Third Respondent Trust must be referred to only as an NHS Trust and the Applicant as a Local Authority. Identification of those involved with A's care and treatment would be likely to identify where she is living and so they have been anonymised within the judgment. The judge has given leave for this version of the judgment to be published on condition that (irrespective of what is contained in the judgment) in any published version of the judgment the anonymity of A, the subject of proceedings and members of their family must be strictly preserved and the Transparency Order shall be complied with. 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.

Mr Justice Poole :

1. This case concerns closed proceedings at which the Court of Protection has authorised the covert administration of hormone treatment to a young woman without the knowledge of her family. A is the subject of these proceedings. B is her mother. This judgment is published as a single judgment but Part One follows a closed hearing on 15 September 2022, to which B was not a party, on the Trust's application in relation to the covert medication of A. Part Two follows an open hearing involving all parties on 20-22 September 2022. Given my decisions (i) to approve the continuation of covert medication but (ii) to end the closed proceedings and to inform B of the covert treatment of A, I circulated my draft judgment in Part One to all parties' representatives during the open hearing. B was then made a party to the Trust's application and the closed proceedings bundle of documents was disclosed to her. At the open hearing I gave oral rulings on the next steps in the proceedings, contact, and reporting restrictions, and informed the parties that I would prepare a written judgment on those issues. I then circulated my full draft judgment. This judgment, approved for publication in anonymised form, includes both the closed and open judgments. The paragraph numbering is consecutive over the two parts.

Part One – Judgment in Closed Proceedings

2. Part One of this judgment follows closed proceedings in the Court of Protection concerning the covert administration of hormone treatment to A, a 23 year old woman, soon to be 24, who has been found to lack capacity to conduct this litigation or to make decisions about her residence, care, contact with others, and her medical treatment for epilepsy, primary ovarian failure, and vitamin D deficiency. Until 2019, A lived at home with her mother, B. By a series of orders in the Court of Protection, to which B was a party and A was represented by the Official Solicitor as her Litigation Friend, A has been removed from her mother's care against the wishes of both of them, and now resides in Placement A and has only indirect, telephone contact with her mother. The reasons for those orders are set out in judgments of HHJ Moir, the Circuit Judge who has conducted all previous hearings in this case, dated 18 June 2019 and 17 June 2020. Those judgments have not previously been published but the parties have had copies of them and I rely on those judgments in full. I have taken steps to have the judgment of 18 June 2019, a copy of which HHJ Moir approved for publication, anonymised and published. Its neutral citation number is [2019] EWCOP 68 and it is being published simultaneously with this judgment. A summary cannot do justice to the detail and nuance within her judgments, but the Judge found that:

   (i) A has a diagnoses of mild learning disability and Asperger's syndrome, epilepsy, primary ovarian failure, and a vitamin D deficiency.

   (ii) A lacks capacity in relation to the conduct of this litigation and the decision-making referred to above.

   (iii) A's primary ovarian failure had not been referred to or investigated by healthcare professionals and had remained untreated whilst she had been living with her mother. As a result A had not undergone puberty. She was aged 20 years 8 months at the time of the Judge's first judgment. The Judge accepted

expert evidence from Dr X, an endocrinologist who told the court that it was exceptionally unusual for a young woman with absent periods not to be brought to medical attention and that he had never had experience of a woman of A's age having avoided investigation. The advised treatment was by way of hormone medication which was straightforward, guaranteed to succeed, and would transform A from a child to a woman. Without treatment she would have an "extremely bleak" prognosis with significant risks to her physical and mental health as set out in the judgments. The Judge recorded that Dr X became "quite emotional" giving evidence to the court, saying to the Judge that it was "unthinkable" that A should not receive the treatment and that it was the "basic human right of every girl to blossom into a woman".

(iv) B had not sought any medical help or advice for her daughter's ovarian failure. A consistently said that she was opposed to taking the medication but her reasons such as they were did not withstand scrutiny. The Judge found that A and B had an "enmeshed" relationship. A was home-schooled and isolated from the wider community. The Judge found that whilst B said that she would encourage A to take the medication for her primary ovarian failure, she had conspicuously failed to do so, and concluded that,

> [84] I have listened very carefully to [A]. Whilst I accept that she is now saying that she accepts that treatment should be undertaken, I have no confidence that she will encourage or support [A] to take medication or keep hospital appointments. [B] continues to assert [A] has capacity, that it is [A's] distrust of medical professionals arising from her admission to hospital in September 2017, which has prompted [B's] own approach. [B] continues to reiterate that the doctors have lied to them and that a second opinion was required because she had no trust in Dr X or his team. [B] continues to say [A] can make up her own mind and her decisions should be respected.
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> …
>
> [87] The advantages of undertaking the treatment are significant and fundamental. It is 100 percent effective without risk. It ensures a normal life expectancy and no death by a serious fracture or cardiovascular disease by 30 to 40 years of age. The disadvantage is that it is against [A's] expressed wishes. However, I am not satisfied that she has been able to form an independent and informed opinion. It is difficult to see how it can be said not to be in [A's] best interest for the treatment to be undertaken or any potential disadvantage to it being undertaken even if it is against [A's] wishes.
>
> …
>
> [88] The prospect that [B] will in the future support her daughter and positively encourage her to engage with the treatment must be extremely limited. Sadly, it is difficult to reach any conclusion other than [B] would prefer [A] not to "grow up" for want of a

> better description, that she would prefer [A] to remain the same, dependent upon her mother, and isolated within her mother's sphere without any outside influence or influences."

(v) It was in A's best interests to live at Placement A, apart from her mother, with restricted contact with her, and for her to receive treatment there for her epilepsy, primary ovarian failure, and vitamin D deficiency.

3. Following a period of time at Placement A, the Court was so concerned about the continuing adverse effects of B exerting an adverse influence over A that it held that it was in A's best interests to suspend contact between them (judgment of 17 June 2020).

4. On 25 September 2020, the HHJ Moir held a closed hearing on the Trust's application for A to be covertly administered hormone treatment for her primary ovarian failure, no notice having been given to B or her legal representatives. B was not made a party to the application. At that hearing the Judge approved a covert medication plan in respect of the hormone treatment. A had been refusing such medication. The Judge found, again, that A lacked capacity to make decisions about such treatment and remained very concerned that B's influence was causing A to refuse the medication. The court received further expert evidence from the Consultant Endocrinologist, Dr X.

5. Under the covert medication plan A was to be offered her hormone treatment in tablet form each time a tablet was due but, if she refused it, it would be covertly administered to her. The plan would be known only to a limited number of healthcare professionals and carers. A did refuse to accept the hormone treatment and so covert medication began to be administered at the end of 2020. A has continued to refuse the treatment and so covert hormone treatment medication has continued since then. The plan has been reviewed by the court on a number of occasions since then, most recently by the Circuit Judge on 4 March 2022. Continued attempts have been made to engage A in education about her health, recently with some success. The continuation of the covert medication plan and attempts to encourage A to elect to accept the medication have also been given considerable attention by the Trust, the Local Authority and the relevant staff at placement A.

6. In the meantime contact between A and B had been reinstated but limited to telephone contact only, now twice a week for 30 minutes, supervised so that B does not raise various matters she has been ordered by the court not to speak about in her conversations with A.

7. On 5 April 2022, B applied for A to be returned home either to live with B or to live at the home alone (with support) with B living nearby and/or extended contact including direct contact between them. On 25 April 2022, the Judge adjourned that application and transferred it to me. That hearing, before me, will begin on 20 September 2022.

8. The Open Justice Court of Protection Project published an online blog about this case on 2 May 2022 entitled, "Medical treatment, undue influence and delayed puberty: A baffling case." One observer had seen the hearing on 26 May 2020, another the hearing on 25 and 29 April 2022 . When comparing the hearings, both observers were "dismayed" and "baffled" because over a two year period of separation from her home

and her mother - a separation that appeared to be for the primary purpose of administering endocrine treatment that A was not likely to receive at home - A had still not received endocrine treatment and there was an application for her to return home "in the hope that (after all this!) her mother will then be able to persuade her to have it." The observers were wrong – A had been covertly administered the medication – but they were not to know that having only observed the open hearings in this case and, like A and members of A's family, being unaware that covert medication was being administered and that A was benefiting from it.

9. A further closed hearing to review the covert medication plan was heard by me on 15 September 2022. This judgment follows that hearing, the first hearing before me in this case. It had been listed earlier in the summer but due to administrative reasons had to be vacated and could only be relisted shortly before the open hearing. As at previous closed hearings, the Local Authority, the Trust, and A (through the Official Solicitor) were represented but neither B nor her legal representatives were aware of the hearing. The hearing was not included in the open list and so no observers or journalists were present. It was necessary to conduct a closed hearing in order to determine whether closed hearings should continue. Given the unique circumstances of this case due to A having not entered puberty by her early twenties and her separation from her mother by court order, any reporting or commentary on the case would be very likely to identify A to her mother, family members, and carers. Even the listing of the case number (which is the same as the case number in the open proceedings) would be likely to alert B to the happening of the closed hearing. It is common for Court of Protection hearings listed at the Royal Courts of Justice before a Tier 3 High Court Judge to be tweeted in advance of the hearing so that those interested may choose to attend the hearing to observe. Should B or her legal advisers have seen such a communication then the closed hearing would be discovered. In those circumstances I considered that it was not possible to list the case publicly. In retrospect it might have been possible to list the case without a case number or with a new case number created for the specific hearing, without any identifying names or initials to enable the listing to be linked to any previous open proceedings, and to make a reporting restrictions order at the hearing to prevent any communication or publication about the hearing (at least not until further order).

10. It was very evident from the representations to me at the closed hearing and the documents within the closed hearing bundle, that the most anxious consideration has been given to this very difficult and troubling case by all the parties to the closed proceedings and the Circuit Judge. At all times A's best interests were the foremost consideration. The Trust, the Council and the Official Solicitor and the court were faced with a situation where, as the court had found, due to A and B's enmeshed relationship A was refusing medication she needed to prevent serious harm to her physical and mental health and which would not give risk to any foreseeable adverse complications.

11. At the hearing I received written expert evidence from Dr X and he gave brief oral evidence at the hearing. I also received written evidence from A's social worker, Ms Y.

12. The primary issues which I considered required determination at the closed hearing were:

(i) Did A continue to lack capacity to conduct this litigation and to make decisions about her medical treatment for epilepsy, primary ovarian failure, and vitamin D deficiency?

(ii) Was it in A's best interests that she should receive hormone treatment for her primary ovarian failure?

(iii) Was it in A's best interests that such treatment should be administered covertly in the event that she continues to refuse to accept the treatment?

(iv) Should B be informed of the past and ongoing covert administration of medication for A's primary ovarian failure?

(v) Should publication of the fact that A has been and is being covertly administered medication be prevented by a Reporting Restrictions Order?

The Current Treatment

13. Every day A is offered her hormone treatment tablet and every day so far she has declined to take it. She is then given the tablet covertly in accordance with a detailed covert medication plan. Only a very limited number of personnel at Care Home 1 are aware of the plan, so, some of A's carers are unaware of it.

14. The evidence I received was that the covert medication plan had been effective in that (i) A had achieved puberty and was progressing well on the hormone treatment medication. The medication had changed in June 2022 to maintenance therapy; (ii) The covert plan had remained covert. No-one had disclosed it and no-one who was not deliberately made aware of the plan had discovered it.

15. A has developed breasts and has recently acquired a bra. She has not experienced menstrual bleeding which is due to the maintenance treatment she is receiving. Her bodily habitus has changed to that of a woman rather than a girl. She has a normal body hair distribution. Dr X reported that he most recently visited A at Care Home 1 on 7 September 2022. He met with two senior managers one of whom had recently returned from a 12 month secondment elsewhere and had been struck by how much more socialised A was on her return, interacting with staff and residents. Nevertheless, the common view was that there were no indications of her having regained capacity. A would not converse with Dr X but, unlike on previous visits, she did not bury her head beneath her bedding clothes. She has enjoyed some outings with staff, including to the beach. She is showing interest in health promotional materials.

16. The treatment plan has succeeded so far. A has not had any reported side-effects or complications from the treatment. Dr X's strong recommendation is that the maintenance hormone treatment should continue for as long as possible. A will benefit permanently from having gone through puberty, but without continued maintenance medication she will be at a higher risk of early osteoporosis, fractures and cardiovascular complications. She would not be able to carry pregnancy using donor

eggs (albeit it is unlikely A will ever be able to consent to fertility treatment). Were her treatment to cease now she is likely to suffer from significant decreased bone density with complications from osteoporosis some twenty years earlier than would be the case should maintenance treatment continue.

17. A does now consent to receiving vitamin D treatment and treatment for epilepsy. However, the fact that she is now making "wise" decisions about such treatment does not mean that she is able to understand, retain, or weigh or use the information relevant to making decisions about such treatment. It means that when assessing her best interests in relation to those treatments, her consent to them is a factor to be taken into account.

Capacity

18. I have seen no evidence to suggest that A might have regained capacity in relation to the conduct of litigation, and decisions about treatment. Indeed, the evidence shows that she continues to lack capacity in relation to such decision-making. I have regard to all the evidence and the findings previously made as to A's capacity by the Circuit Judge. All parties to the closed hearing agree that A continues to lack capacity in all the relevant respects. Applying sections 1 to 3 of the Mental Capacity Act 2005, I am satisfied to the requisite standard that A continues to lack capacity to conduct this litigation and to make decisions about treatment for epilepsy, primary ovarian failure, and vitamin D deficiency.

Is it in A's Best Interests to Receive Hormone Treatment for Primary Ovarian Failure

19. In relation to all questions concerning A's best interests, I apply the principles and provisions set out at sections 1 and 4 of the Mental Capacity Act 2005.

> Best interests
>
> (1) In determining for the purposes of this Act what is in a person's best interests, the person making the determination must not make it merely on the basis of—
>
> (a) the person's age or appearance, or
>
> (b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about what might be in his best interests.
>
> (2) The person making the determination must consider all the relevant circumstances and, in particular, take the following steps.
>
> (3) He must consider—

> (a) whether it is likely that the person will at some time have capacity in relation to the matter in question, and
>
> (b) if it appears likely that he will, when that is likely to be.
>
> (4) He must, so far as reasonably practicable, permit and encourage the person to participate, or to improve his ability to participate, as fully as possible in any act done for him and any decision affecting him.
>
> (5) Where the determination relates to life-sustaining treatment he must not, in considering whether the treatment is in the best interests of the person concerned, be motivated by a desire to bring about his death.
>
> (6) He 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 him when he had capacity),
>
> (b) the beliefs and values that would be likely to influence his decision if he had capacity, and
>
> (c) the other factors that he would be likely to consider if he were able to do so.
>
> (7) He 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 his 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 in subsection (6).

20. The evidence demonstrates that A is clearly benefiting from her residence at Placement A, both as a result of the support and care she is receiving, and the medication administered to her. She is enjoying benefits for her physical and mental health. Dr X reports that her socialisation and behaviour have improved “gratifyingly”. Some of the benefits of the medication that has been covertly administered have already been

achieved and could not be reversed, but there remains the potential for substantial benefits from continuing the maintenance hormone treatment. Dr X advises that,

> "If, for whatever reason, the treatment ceases … then [A] will have significantly improved her bone density and achieved completion of her full adult physical and neurocognitive maturation potential, subject to limitations imposed by genetic potential and/or adverse socio-environmental factors in childhood and adolescence. The longer the treatment continues, the greater the benefit to her bones and cardiovascular system.
>
> …
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> "[Cessation of treatment, in the future] will still leave her exposed to an increased risk of osteoporosis, fractures and cardiovascular disease in middle/old-age, but still far better than if she had never been treated in the first place."

21. In oral evidence Dr X told the court that on cessation of treatment now or in the near future, A will be likely to suffer from the adverse effects of osteoporosis and fractures two decades earlier than would be the case were she to continue with the treatment. He did say that fractures in the elderly are associated with earlier mortality, but accepted that continuing hormone treatment for A now could not be regarded as "life-saving" in any way. When the covert medication plan was instigated, there were far more serious concerns about A's physical health and the dire consequences for her if she did not undergo hormone treatment.

22. The benefits of continuing hormone treatment for A's neuro-development and mental health are difficult to quantify, but evident to those caring for her and to Dr X. In her pre-pubescent state A would have thought about herself, and interacted with the world, as a girl. Now she is seen by others as a woman and her relationship with others will change. Hormonal changes also affect brain development. Significant gains have been made – Dr X advises that "full neuro-cognitive maturation potential" has been achieved. Nevertheless, as I understood his oral evidence, there are continuing benefits from continued treatment in relation to neuro-functioning and mental health, albeit those benefits will be more marginal than the benefits already achieved.

23. The medical evidence and the evidence that I have from the social worker as to A's socialisation and behaviour, demonstrate that hormone treatment has been very successful and that continued hormone treatment will bring benefits to A's physical health and her general wellbeing. On the evidence I have received, there are virtually no risks of adverse side-effects from the treatment and none have been experienced to date.

24. However, A continues to decline hormone treatment demonstrating a wish not to receive it. I do not have evidence from B of her own views because she is excluded from the hearing. The evidence available suggests that B wishes A to return home but states that she would encourage A to take her hormone treatment tablets if she was caring for her. Ostensibly therefore she supports the administration of hormone

treatment but only with A's consent which she has previously said she believes A is capable of giving or refusing. Not only has the court found that A lacks such capacity, but the court has previously found B's assertions about encouraging A to take hormone treatment to be hollow and unreliable. Moreover, it is reported to the court that during supervised telephone contact, B has not taken the opportunity to encourage A to accept hormone treatment.

25. In respect of the weight to be given to A's wishes, I have to take into account that, even now, A's own expressed wishes about medication are strongly influenced, over many years, by her mother. That was the clear finding of the Circuit Judge in her judgments. B has very restricted contact with A, and gradually her influence may wane, but it continues to exert a strong hold on A's beliefs, wishes and feelings. Nevertheless, I do take into account A's consistently expressed wish is not to receive hormone treatment and B's views that it is in A's interests to take the medication but that A has a right to choose for herself whether or not to do so. The views of those caring for A at Placement A and the healthcare professionals involved in her treatment are strongly in favour of A continuing to receive hormone treatment.

26. The law on the weight to be given to an incapacitous person's wishes and feelings was reviewed by Hayden J, Vice President, in *Barnsley Hospital NHS Foundation Trust v MSP* [2020] EWCOP 26. In this case the degree of A's lack of capacity is demonstrated by the striking fact that she has not once commented on the bodily changes she has undergone over the past 18 months.

27. Having regard to all the evidence I conclude that it is in A's best interests to continue to receive hormone treatment for her primary ovarian failure. Continued treatment is clearly beneficial to her health and wellbeing and is supported by those caring for her and, ostensibly, by her mother. A's wish not to accept the treatment has less weight because she has so little understanding of the risks and benefits of the medication and has been influenced by her mother over a number of years, as has been found by the judge who has previously conducted these proceedings.

Is it in A's Best Interests for Hormone Treatment to be Covertly Administered?

28. A continues to refuse hormone treatment for her primary ovarian failure. I have determined that it is in her best interests to receive such treatment. The ongoing benefits from the medication are not as significant as they were during the first year or so of treatment because the treatment has successfully brought A to puberty and through puberty. The gains from A having achieved puberty will not now be lost if the treatment were to cease.

29. On the one hand, covert administration of hormone treatment appears to be the only way in which such treatment, which it is in A's best interests for her to receive, can be given. She continues to refuse the treatment when offered to her. On the other hand, the continued implementation of the covert medication plan is fraught with risk. My concerns are (i) that A will discover the fact that she has been and/or continues to be medicated covertly; and (ii) that the discovery will have harmful repercussions in that she will lose trust in those caring for and treating her, perhaps even to the extent of losing trust in all professional carers and healthcare professionals, refusing food

prepared for her at her current or other residential homes, and suffering physical and mental harm as a consequence. In the past, at placement A, A has refused food. She has learned to distrust healthcare professionals and if she finds out that they have been secretly medicating her against her will, her fragile residual trust may well disappear.

30. As to the risk of discovery of the covert administration of medication, it is surprising that it has not already happened. A has undergone marked physical changes. She has developed breasts and body hair. She sometimes wears a bra. Dr X told the court that A looks very different facially – she looks like a woman not a pre-pubescent girl. Yet, A herself has not commented on these changes or asked questions about them. As already noted, that indicates the degree to which she falls short of having capacity to make decisions about her care and treatment. A has asked staff why they keep offering her the hormone treatment tablets since she always refuses them, but she has not extended her questioning any further. B has not seen A for over three years – the only contact she has is by telephone. But, A's grandparents do see her and last saw her in June 2022. It is remarkable that they have not asked questions about A's changed appearance. They have commented on her weight gain but not in the context of pubertal changes: they suggested that she should exercise more. Some care staff at Placement A are not aware of A's covert medication plan, but it appears that no-one has inadvertently said something to A to lead her to question why she has undergone the physical changes she has been through.

31. Both of A's maternal grandparents, with whom she has occasional contact, including face to face contact, are seriously unwell. Her grandfather is in his mid-90's. It is therefore foreseeable that one or other of them could deteriorate further or die in the next few months. Unless A were to be prevented from having any contact with her grandparents that allowed her to see them, and/or were prevented from attending their respective funerals, she would be visible to them (when alive) or other family members and the changes in her appearance would be obvious. Whilst her grandparents have not made any inferences so far, they might do on the next occasion when they see A. So might other family members.

32. It seems to me that at any moment, A might inadvertently discover from someone else, that she must have covertly received hormone treatment. A casual comment by a carer or family member might cause the "penny to drop". The Open Justice blog to which I have referred asked the question why A was being kept in Placement A if she was not being treated. A reader of that blog, including a carer or B perhaps, might conclude that A must be being treated covertly. Were B to have direct contact with A, or even video contact, she would surely notice changes in A and realise that A had received hormone treatment.

33. Even if B and other members of A's family are not informed of the past use of covert medication and the ongoing covert medication plan, they are liable at some point to work out for themselves that covert medication has been and is being used.

34. In any event, A may very well work out for herself, or inadvertently discover from discussions with staff who are unaware of the covert medication plan, that she has gone through puberty and that she has done so due to receiving medication that she has consistently refused. She will work out that she has been given the medication covertly. If that happens then there will be a very difficult situation for those caring for and treating A to manage.

35. Whether A discovers that she is being covertly medicated with or without a court approved plan, difficult questions will arise as to the extent of what she should be told. Likewise, even if she were to consent to the medication at some point in the future, a question would arise about what she should be told, if anything, about the past use of covert medication.

36. In the judgment of DJ Bellamy in *AG v BMBC* [2016] EWCOP 37, he said,

> "Treatment without consent (covert medication in this case) is an interference with the right to respect for private life under Article 8 of the ECHR and such treatment must be administered in accordance with a law that guarantees proper safeguards against arbitrariness. Treatment without consent is also potentially a restriction contributing to the objective factors creating a DOL within the meaning of Article 5 of the Convention. Medication without consent and covert medication are aspects of continuous supervision and control that are relevant to the existence of a DOL. It must therefore attract the application of Section 1(6) of the Act and a consideration of the principle of less restriction and how that is to be achieved.
>
> "1(6) Before the act is done, or the decision made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action".
>
> "Such intervention must be proportionate to the circumstances of the case and accord with the principle of minimum intervention consistent with best interests."

37. In *A Local Authority v P* [2018]EWCOP 10, Baker J said at [55],

> "Covert medical treatment is a serious interference with an individual's right to respect for private life under Article 8. In An NHS Trust v The Patient [2014] EWCOP 54, Holman J observed (at paragraph 22):
>
> "My own view is that even in the case of incapacitous or very incapacitous patients (leaving aside those who lack consciousness), it remains extremely important in any civilised society that they are not subjected to anaesthesia or invasive surgery without, as a minimum, being informed in sensitive and appropriate language as to what is about to be done to them before it is done."
>
> …

> [56] The covert provision of medication to an incapacitated adult is always an interference with personal autonomy and thus a very significant step.
>
> …
>
> [63] … Covert treatment should only be countenanced in exceptional circumstances."

38. The balance of risks and benefits from covertly medicating A has changed since the original court decision to authorise the covert medication plan. The benefits of the medication continue but they are not as significant as they were for the first year or so of the operation of the covert medication plan. As A's body has visibly changed due to puberty, so the risks of discovery of the covert administration of medication, and the potentially harmful consequences of that discovery, have increased. On the other hand, the questions of cessation and what, if anything, A should be told about the changes to her body and the medication she has had, requires anxious consideration. The conclusion I have reached is that the long term continuation of covert medication is unsustainable but that its immediate cessation would not be in A's best interests. A's best interests are served by exploring the most effective way of transitioning from covert to open medication and/or ending covert medication in a way that is likely to cause the least harm to A. This needs to be a controlled process, if possible. The reasons why the covert medication plan was authorised in 2020 were sound but the very success of the covert hormone treatment plan has created the problem of how to end it with the least harm to A.

<u>Should A's mother be informed of the past and ongoing covert administration of medication for A's primary ovarian failure?</u>

39. The Court of Protection Rues provide extensive case management powers which empower the court to exclude any person from attending a hearing or part of it where there is good reason for making the order – rules 4.1(3)(b), 4.3(1)(c), and 4.4(1)(a) – see *In the matter of P (Discharge of Party)* [2021] EWCA Civ 512 in which Peter Jackson LJ also reviewed the authorities on excluding a party from proceedings, or a part of proceedings, and/or withholding documents from a party, including *Re D (Minors) (Adoption Reports: Confidentiality)* [1996] AC 593; *Re B (Disclosure to Other Parties)* [2001] 2 FLR 1017, *Re D* [2016] EWCOP 35, and *KK v Leeds CC* [2020] EWCOP 64. In *KK,* Cobb J concluded that a judge faced with an application for party status, which have close application to the issue in the present case:

> "i) The general obligation of open justice applies in the Court of Protection as in other jurisdictions …;

ii) A judge faced with a request to withhold relevant but sensitive information/evidence from an aspirant for party status, must satisfy him/herself that the request is validly made …;

iii) The best interests of P, alternatively the "interests and position" of P, should occupy a central place in any decision to provide or withhold sensitive information/evidence to an applicant (section 4 MCA 2005 when read with rule 1.1(3)(b) COPR 2017); the greater the risk of harm or adverse consequences to P (and/or the legal process, and specifically P's participation in that process) by disclosure of the sensitive information, the stronger the imperative for withholding the same …;

iv) The expectation of an "equal footing" (rule 1.1(3)(d) COPR 2017) for the parties should be considered as one of the factors …;

v) While the principles of natural justice are always engaged, the obligation to give full disclosure of all information (including sensitive information) to someone who is not a party is unlikely to be as great as it would be to an existing party …;

vi) Any decision to withhold information from an aspirant for party status can only be justified on the grounds of necessity …;

vii) In such a situation the Article 6 and Article 8 rights of P and the aspirant for party status are engaged; where they conflict, the rights of P must prevail …;

viii) The judge should always consider whether a step can be taken … to acquaint the aspirant with the essence of sensitive/withheld material; by providing a 'gist' of the material, or disclosing it to the applicant's lawyers; I suggest that a closed material hearing would rarely be appropriate in these circumstances."

40. The decision taken to exclude B from the Trust's application to use covert medication was an exceptional course which engages B's Convention rights under Arts 6 and 8 as well as A's Convention rights. Such exclusion requires regular review and scrutiny of changing circumstances to ensure that it remains justified.

41. The parties to the closed proceedings are united in their view that there is a significant risk that if B is informed of the use of covert medication she will find a way to reveal it to A. In the past B has given notes to A during face to face contact with messages designed to encourage her not to submit to the advice of those wanting to treat her. The adverse consequences to A from discovering that she has been and is being covertly administered medication could be very harmful to her, as set out above. Accordingly, there was no written submission to me prior to the hearing that B should be told. On the other hand, the parties to the closed proceedings were all anxious about how the open hearing of B's applications in respect of residence and contact could be managed whilst the use of covert medication was withheld from B and her legal advisers. Although there are a number of reasons other than the benefits of continued covert medication why the parties to the closed proceedings will oppose the application that A should return home, the fact is that B will argue for a return home in large part because she believes that A has not had any benefit from medication for her primary ovarian failure whilst at Placement A. Further, the primary ground for opposing face to face contact between A and B, or even indirect contact by video, is to avoid B seeing the physical changes in A and realising that she must have been administered hormone treatment without her knowledge.

42. The medical advice is that the best health benefits to A are from lifelong maintenance hormone treatment but, in my judgement, it would be extremely difficult, if not impossible, to sustain the covert medication plan in the long term. However, it would be even more difficult to continue the plan without the fully informed co-operation of B. If B were to discover the use of covert medication inadvertently, then, given her past conduct and views, as set out in the Circuit Judge's judgments, B would be likely to find a way to inform A. That could have very harmful consequences for A as I have set out above.

43. I am also concerned that B continues to be unable to make her views known about continuing medication and the covert administration of that medication, especially as there are no other family members available to give their views. A proper consideration of A's best interests ought to take into account the views of A's family if that is at all possible. Further, at the open hearing of B's applications, it is very difficult to see how the hearing could be held, and a judgment given without actively misleading B and observers if the use of covert medication and the benefits it has brought, remains secret.

44. I raised with the parties to the closed proceedings the possibility of disclosing only the gist of the withheld information and material to B but they agreed that a full disclosure of the fact and history of the use of covert medication was preferable. If B were told simply that there had been closed hearings about A's treatment, she would be bound to infer that the treatment in question was hormone treatment and that the hearings had been closed because covert administration of that treatment had been considered. It was not possible in this case to provide a gist of the withheld information and material without in effect alerting B to the covert medication.

45. I am satisfied that,

(i) There is a substantial ongoing risk that A will discover that she has been and is being covertly medicated even if the fact of the covert medication plan is withheld from B by the court.

(ii) The health risks to A from the medication ceasing are not as significant as they were when the covert medication plan was first implemented. She would suffer harmful consequences, in particular in future decades, but they would not be life threatening.

(iii) Injunctive orders can be made to prevent B from informing A of the use of covert medication. There is of course a risk that they will be breached but they offer some safeguards against disclosure by B to A.

(iv) B purports to support the use of hormone treatment medication. Although there continues to be considerable scepticism about her genuine intentions, if B is in support of the treatment being given then it is more likely that a plan to transition to open use of hormone treatment and to minimise the harm to A from ending the covert medication plan will succeed with B's co-operation than without it.

(v) Informing B of the past and continuing covert administration of hormone treatment will protect her Article 6 rights at the open hearing of her application for a transfer of residence and/or increased contact with A. It would be difficult to have anything resembling a fair hearing of B's applications whilst B and her representatives remain unaware of the use of covert medication.

(vi) One cost of withholding information about the use of covert medication from B is, or may well be, the continued restriction of her contact with A. They have not had face to face contact for over three years. That is a significant interference with their Art 8 rights and, now that A's puberty has been achieved, may well be contrary to her best interests. It is at least arguable that it is in A's interests to see her mother in person or by video but that level of contact would be highly problematic whilst the use of covert medication is withheld from B.

46. This issue is not an easy one to determine but balancing all the relevant factors I have concluded that the continued use of closed proceedings can no longer be justified. The balance of rights and A's best interests now weigh in favour of openness with B about the past and ongoing use of covert medication. Accordingly, B and her legal advisers should now be informed that A has been, and continues to be, covertly administered hormone treatment for her primary ovarian failure. B should be informed that the treatment has been successful and that A has now gone through puberty with the associated physical changes, that A appears not to have recognised those changes, or the significance of those changes, and that her socialisation and behaviour have improved. Given the limited time before the open hearing begins, and the need to impart the previously withheld information in an orderly manner, the information will be given to B and her legal representatives by me at the opening of the hearing on 20 September 2022.

Should publication of the fact that A has been and is being covertly administered medication be prevented by a Reporting Restrictions Order?

47. The possibly unique circumstances of this case, namely that A remained pre-pubescent at the age of 20, has been removed from her mother's care at home, and has been administered hormone treatment covertly such that she has now gone through puberty, mean that any person familiar with A who was to read only those facts about this case, even anonymised, would be highly likely to recognise her. The extent of any risk of that happening and of A then learning of the use of covert medication as a result, needs careful consideration, but there are grounds to believe that publication or communication of the fact that covert medication has been given to A, would be likely to lead to her identification. There are no observers, legal bloggers or journalists present at the closed hearing because no notice has been given and the case has not been included in the open list. The open hearing on 20 September will be listed and journalists or others may attend. There is a Transparency Order in force, made in 2020, which prevents the publication or communication of information that would or would be likely to identify A, members of her family including B, and where she lives (Placement A). A Reporting Restrictions Order preventing publication or communication of the covert administration of medication to A would provide additional protection against A discovering inadvertently, directly or indirectly, about the use of covert medication, a discovery that could well have very harmful consequences for her. It appears to me to be necessary and proportionate having regard to the balance of Article 10 rights and Article 8 rights, to make a Reporting Restrictions Order in respect of the issue of covert medication to hold the position at the beginning of the hearing on 20 September 2022 when the existence of closed proceedings and the use of covert medication is revealed to B and her legal advisers. However, I shall then review the justification for continuing the order, following any representations from the news media, bloggers, and the parties, including B, either during or at the conclusion of the open hearing.

Conclusions

48. In my judgement:

(i) B must be informed of the past and continuing covert administration of hormone treatment and of the fact that covert medication has been authorised at closed hearings from which she has been excluded.

(ii) An injunctive order will be made to prevent B from informing A or anyone else about the past or ongoing use of covert medication, or to discuss with A any matters, including puberty or medication, which could lead to A becoming aware of the use of covert medication. The precise terms of the injunctive order will be the subject of submissions.

(iii) Given the imminence of the open hearing of B's applications and the necessity to control the information given to B, I shall inform her and her legal representatives at the opening of the hearing on 20 September 2022 of the fact that covert medication has been administered, that a covert medication plan remains in place, of the fact that there have been closed proceedings in relation

to the use of covert medication, and of the injunctive order I shall make against B. I shall also make a Reporting Restrictions Order to prevent publication of the fact that A has been covertly administered medication for her primary ovarian failure and continues to be covertly medicated. I shall consider the continuation of the RRO, and the publication of an anonymised version of this judgment, at the hearing beginning on 20 September 2022 having informed the national news media of the reporting restrictions order, in accordance with Practice Direction 4A of the Court of Protection Rules 2017.

(iv) It is in A's best interests that covert administration of medication for her primary ovarian failure should continue for the time being but that it is unsustainable in the long run and that a treatment plan should be devised, for review by the court, for how to exit the covert medication regime with the least possible harm being caused to A. A fresh look at the A's medication plan will be required in the light of the disclosure of information about covert medication to B. The plan will cover the question of imparting information to A about the past use of covert medication – should that be done and if so, when, where and by whom, including the extent of the involvement of B. That will be tied in with the issue of contact with B. In devising and implementing any plan everything must be done in A's best interests.

(v) At the hearing beginning on 20 September I shall consider, with the assistance of submissions, the following further matters, and any other issues that arise after B has been told of the closed hearings and the covert medication, namely

a) The continuation of the hormone treatment and the covert medication plan in the light of any representations on behalf of B.

b) Whether other members of A's family, including her grandparents, should be told of the covert medication and, if so, whether injunctions should be made against them in similar terms to that to be made against the mother.

c) Whether the note of the judgment of the Circuit Judge authorising the use of covert medication and any other documents within the closed hearing bundle should be disclosed to B and her legal advisers unredacted, redacted, or at all.

d) Whether the hearing of B's applications in relation to residence and contact can proceed or whether they should be adjourned and what, if any, further evidence may be required before they can be determined.

e) The continuation of the reporting restrictions order, the terms of the Transparency Order and the appropriateness of publishing this judgment in anonymised form.

Part Two – Judgment in Open Proceedings

49. At the closed hearing on 15 September 2022 I decided that the closed proceedings should end and that B should be informed of the past and ongoing use of covert medication for her daughter, A.

50. I gave that information to B and her legal representatives at the outset of the open hearing which began on 20 September 2022 and which is a hearing of B's applications for A to be moved back home and/or for extended contact between A and B.

51. I gave B and her Counsel, Mr M O'Brien KC, time to reflect on the new information and its ramifications. Mr M O'Brien KC had understandably prepared written submissions on the issue of residence and contact on the basis that the main anticipated benefit of placement A, namely that A would receive medication, had not materialised and so the balance of benefits and risks was now in favour of A leaving placement A and being looked after at home. During the open proceedings it was agreed that B and her legal representatives should have full access to the closed hearing bundle. B has the judgment of the Circuit Judge, HHJ Moir, who heard all the previous applications, dated 18 June 2019, and I directed that B be provided with a note of the Judge's decision of 25 September 2020 when she approved the covert medication plan in closed proceedings from which B and her legal representatives were excluded.

Next Steps

52. After some time to reflect, and after he and B had seen some but not the majority of the documents in the closed proceedings, Mr M O'Brien KC informed the court that B was pleased that A had gone through puberty, that she would like to encourage A to take the maintenance hormone treatment by speaking to her in person and that she still wanted A to return home immediately. She did not want to lie to B. On the second day of the hearing, Mr M O'Brien KC told the court that B had reflected further and did not wish to pursue her application for a change of residence at this hearing – that application is adjourned. However, she does seek extended contact and she proposes a medication plan which would involve her speaking directly to A to encourage her to take the hormone treatment. B proposes that once A begins taking the treatment she should be able to go home. Her compliance with the treatment at home could be monitored, for example by blood tests. A's birthday is imminent and B proposes face to face contact between her and A on that occasion, and continuing thereafter. B remains pleased that A has gone through puberty, will encourage her to take the maintenance medication, but does not want to lie to A. She does not think it advisable, and she would not choose, to inform A that she has been covertly medicated.

53. I made it clear to Mr M O'Brien KC during his submissions that there can be no question of A being told that if she takes the hormone medication she can return home. No such promise can be made to her. The question of residence is separate from that of medication or covert medication. The other parties might yet oppose A's return home even if she begins voluntarily to take her medication. The perceived advantages of her remaining at placement A go beyond the opportunity to administer medication to her.

54. The other parties oppose B's current proposal. They each accept that a medication plan which contemplates a transition from covert to open administration of the hormone treatment is required. For the Trust, Mr J O'Brien KC says that the medication plan has been under constant review, that attempts to educate A in relation to her health and to encourage her to take the hormone treatment have been made throughout her time at placement A. The previous findings of the court, and B's blithe assumption that A would now accept B's encouragement to take the medication and would continue to do so in the long term whilst at home in her mother's care, should give the court no confidence at all that B's proposal is realistic or in A's best interests. A staged process is required with contingency planning in the event that there are setbacks. Ms James-Stadden for the Local Authority and Mr J O'Brien KC for the Trust both suggested that the process could take many months.

55. As I set out in Part One of this judgment, the covert medication plan has been successful. A has gone through puberty and this will bring irreversible advantages to her physical and mental health and her neuro-development. However, there would be harm to her health, in particular in later life, were she to cease what is now maintenance treatment with hormones. Ideally, she should continue to take the treatment for the rest of her life. Certainly, the longer she takes the medication, the better for her. However, A has undergone noticeable physical changes – she now has fully developed breasts, normal bodily hair distribution and her bodily habitus has changed from that of a girl to that of a woman. She has not had any menstrual bleeding which is due to the maintenance medication she is receiving, but the physical changes are obvious. I found that there are very significant risks that A could discover at any time that these changes are due to medication given to her secretly and that if A discovers that she has been and is being covertly medicated there are very significant risks that she could respond negatively, refusing to eat or drink food prepared for her - as she has done in the past - and could lose the carefully built but fragile trust she has in carers and healthcare professionals. That would be very damaging to her.

56. The most obvious route by which A might learn of the use of covert medication, given past actions, would be through contact with B. I have made injunctive orders against B to prevent her communicating any matters to A which might cause A to discover that she has been covertly medicated. I have evidence from A's social worker that A does not watch or read the news, and she uses social media only for her own particular interests. She has outings from placement A but always with staff.

57. Remarkably, A has not raised questions about her physical changes, nor have her grandparents who have had face to face contact with her, most recently in June 2022. Likewise, her Aunt R has visited her and has not commented on the physical changes or asked questions about them. There is an Uncle S who is married to Aunt R who has visited with her and there is an Uncle T who has not visited A, as I understand it, but who is showing a great interest in this case in discussions with B who would find it helpful to have someone to talk to.

58. The question of contact appears to me to be linked to the devising and implementation of the future medication plan. It needs to be made clear that the restriction on contact and the change in residence have not been authorised by the court only in order to administer medication covertly. There have been a number of factors leading to the decisions to remove A from home, and then to restrict contact with B. There appear to

be a number of advantages to A from being at placement A other than the opportunity to administer covert medication.

59. Covert medication is an interference with A's article 8 rights which, although I consider it to be presently justified, necessary and proportionate, ought not to continue longer than is necessary. The least interventionist approach should be taken. Likewise, if the use of covert medication is a barrier to options for residence and contact then it should be removed as soon as possible if that can be achieved without creating an unacceptable risk of harm to A.

60. I have had close regard to the previous judgments of HHJ Moir. I have not been asked to hear any oral evidence at this hearing and have not considered it necessary to do so. HHJ Moir did hear oral evidence and was very familiar with the case. The salient points from previous judgments of HHJ Moir which I take into account are:

    (i) Contrary to the compelling evidence and clear findings of the Court, B considered that A did have capacity to make decisions about her treatment.

    (ii) B considered that A's wish not to have the treatment should be respected.

    (iii) The court recorded that A and B lacked trust in the expert opinion of Dr X that A should undergo hormone treatment for her primary ovarian failure but that the court accepted the expert evidence without reservation.

    (iv) The expert evidence was that there were considerable benefits from the proposed hormone treatment, negligible, if any, risks and that if the treatment were not given there would be dire consequences for A.

    (v) The court accepted expert evidence from Dr X that if A's primary ovarian failure remained untreated "the long term prognosis for A is extremely bleak with outcomes becoming correspondingly less good the longer she goes untreated." The risks of the condition being untreated included early vertebral fractures before her 50's with an associated fifty per cent increased relative risk of death. HHJ Moir wrongly recorded Dr X's evidence that "Spine crush fractures are around 10 percent more common than fractured neck or femur in patients with osteoporosis." [80]. His evidence was that spinal crush fractures were around ten times more common than fractured neck of femur in such patients. Left untreated, A would have been at a significant risk of a spinal crush fracture by the age of 50-60. She would have a significantly increased risk of coronary heart disease and stroke. A would look very young for her age for a decade or two but would then look much older than her age because of having oestrogen deprived skin. In addition, there would be adverse effects on A's mental health and neuro-cognitive development were she to remain untreated.

    (vi) Even though B accepted at the hearing in 2019 that it was "unthinkable" that A should not proceed with a course of medication, she still supported her daughter's refusal to accept the treatment "without a second opinion."

    (vii) HHJ Moir found that there was no realistic prospect of B ever supporting A to undergo the course of treatment even though the benefits of it for A were so obvious that it was "unthinkable" that A should not have the treatment: "I find

that B has been so obsessed with her own wishes, views, and fears that she has been blinded to the obvious and risk-free advantages to her daughter of encouraging her to undergo the treatment…" A and B had an "enmeshed" relationship such that A adopted B's views and wishes.

(viii) In deciding that B should not be informed of the covert medication plan, HHJ Moir balanced the Convention rights of A and B, and relied on the Official Solicitor, acting on A's behalf, to provide a "balance sheet", accepting also that the Trust and Local Authority as public bodies took very seriously the rights of persons with whom they are concerned, their medical needs and interests. She had the advantage of having heard evidence from B at previous open hearings and was very familiar with the case. The Trust's application regarding the covert medication plan was supported by the Local Authority and by the Official Solicitor acting as A's Litigation Friend. The Judge concluded that

> "the court finds uncomfortable the prospect of dealing with such significant and long reaching issues in the absence of B … [but] throughout these proceedings B has demonstrated a reluctance to support A to receive the treatment that I have already found her best interests require … I am satisfied that if B was made aware then she would seek to subvert the covert treatment plan."

(ix) The court's view was that such were the benefits of the treatment that it was "unthinkable" that A should not receive it, and such was the risk that B would subvert the treatment if she were aware of it, that it was appropriate to conduct closed proceedings, excluding B and her legal representatives, so that A could receive the treatment in her best interests.

61. I do not sit as an appellate court and, as I reminded Counsel at the hearing, it is not my role to conduct a forensic post-mortem into the previous decisions of HHJ Moir, but it is evident that great care was taken over the decision-making, the decisions were supported by the Official Solicitor acting on A's behalf, and the reasons for making the decisions were set out in detail. HHJ Moir approved her open judgment of 18 June 2019 for publication but it has not previously been published. I have taken steps to ensure that it is published, suitably anonymised, simultaneously with the publication of this judgment. Her open judgment of 17 June 2020 was not approved for publication but all parties have a transcript. The court and the parties have a note of the closed judgment, authorising covert medication and the exclusion of B from the closed proceedings, and a recording of the hearing, but no transcript of the judgment or written judgment has been prepared.

62. It is important to have regard to HHJ Moir's judgments not least because they assist this court in approaching B's assertion, through her Counsel, that she will now encourage A to take the hormone treatment. A has gone through puberty and so the current and future treatment is for maintenance. It has a different purpose from the medication plan under consideration in 2019 and 2020, which was to ensure A went through puberty. There has been a material change in that A has now gone through puberty and B now knows that for the first time. There has also been a considerable passage of time from when B gave evidence to HHJ Moir. Therefore, it is feasible that B could have genuinely changed her attitudes and intentions. However, the benefits of the proposed treatment were even more striking in 2019/2020 than the benefits of the

ongoing treatment are now. If B would not or, on her case, could not then persuade A to take the medication, is it credible that she would or could do so now? Although I have not heard evidence from B and I have not heard her assertions tested in cross-examination, given the previous findings, I treat with considerable caution B's assurance that she would encourage A to take the hormone treatment and would ensure that it was taken if she were to look after A at home. Further, the evidence shows that during telephone contact B has never once made encouraging remarks to A to listen to those giving her healthcare advice or to take the hormone treatment. The lack of encouragement noted by HHJ Moir appears to have continued. Even if B genuinely tried to encourage A to take the medication, A might not necessarily be persuaded. The issue of what information and advice is given to A, by whom and in what circumstances, requires careful and skilled planning. It may be that B has a role to play in that planning and in a transition to open medication, if that is feasible, but she needs to demonstrate by her actions that she will play a positive role and will not create a risk of harm to A, as she has done in the past, in relation to the issue of her health and treatment.

63. Having considered all the circumstances, the views of B and of those caring for and treating A, and the provisions of s.1 and s.4 of the MCA 2005, in my judgement it is in A's best interests that:

(i) She should continue to be administered hormone treatment. I addressed this in Part One of the judgment. Although she does not consent to the treatment, it is in A's best interests to receive it.

(ii) The covert administration of hormone treatment in accordance with the current covert medication plan should continue. Again I have addressed this in Part One of the judgment. Nothing I have heard in the open proceedings has caused me to change my view.

(iii) A medication plan should be drawn up by the Local Authority and the Trust, having liaised with B, to address:

a) The transition to open medication with A's consent and how that can be most effectively and safely achieved.

b) The imparting of information to A about her pubertal development.

c) The imparting of information to A about the risks and benefits of maintenance hormone treatment.

d) The imparting of information to A about the use of covert medication.

The plan will include consideration of whether, when, where and by whom any such information should be given to A, and the involvement of B in the implementation of the plan given that she now knows of the use of covert medication and expresses a wish to help to encourage A to take the maintenance hormone treatment. By directing that the issues set out above should be addressed I am not, at this stage, directing what the contents of the plan should be.

(iv) The medication plan and any evidence in support shall be served on the Official Solicitor and on B by no later than 4pm on 27 October 2022. Their responses by no later than 4pm on 10 November 2022. I shall review the plan and hear and consider further directions on 15 November 2022 at the Royal Courts of Justice, in person.

(v) Contact with A's maternal grandparents should be on the same terms as already ordered by the court. It will be a matter for those caring for A as to the best arrangements for A to have contact with her grandparents on her birthday for example, given that they have mobility problems.

(vi) Contact with B shall continue to be by telephone for a further four weeks, twice weekly with an extended one hour contact on A's birthday, supervised as now, thereafter face to face contact can take place once a fortnight for the duration of one hour between 10 and 3pm supervised by staff at placement A, in addition to the two supervised telephone calls. All contact will be subject to ongoing monitoring and review. I am satisfied that face to face contact as set out above can take place given the injunction in place preventing B from discussing with A any matters that might trigger her to believe she has been covertly medicated. However, more extensive contact at this time would not be in A's best interests. B has to demonstrate that she can be trusted not to act to A's detriment as face to face contact begins and before any more extensive contact and involvement can be contemplated.

(vii) There is no challenge to A's continued residence at placement A at least until the next hearing and I am satisfied that it is in her best interests to do so and to receive care there in accordance with the current care plan.

Reporting Restrictions and Sharing Information

64. The previous open proceedings in this case have been the subject of blogs on the Open Justice Court of Protection Project website. Open Justice also alerted its readers to the listing of the open hearing before me, linking the hearing to the previous hearings and re-posting the blog piece originally posted on 2 May 2022 to which I have already referred and which observed that the case was "baffling" because A was not receiving medication for her condition when the need for her to be treated was a key reason why she was removed from her mother's care.

65. Bloggers with an interest in the justice system and Court of Protection cases have attended the open hearing. Given the need to protect A from learning about the covert medication, or to learn about it in an uncontrolled way, which risks causing her significant harm as I have described, given the unpredictability of what might happen when the court informed B and her legal representatives of the use of covert medication and the closed proceedings, and given the likelihood of reporting of the case including the use of covert medication, I imposed a reporting restrictions order ("RRO") at the outset of the open hearing, preventing the publication or communication of material or information that would or would be likely to identify that A has been and continues to be in receipt of medication which is being administered covertly.

66. That RRO was made to prevent immediate publication or communication that might alert A to the covert medication plan but I indicated when making the RRO at approximately 12.00 hrs on 20 September 2022 that I would review it during or at the conclusion of the hearing of the open proceedings. I ensured that the fact of the RRO and its review was made known to the national news media through the Copy Direct scheme in accordance with PD 4A of the Court of Protection Rules Rules 2017. The RRO and brief summary was sent during the lunch adjournment on 20 September 2022 to Copy Direct. No representative of the national news media attended the open hearing but I received written and oral representations from three bloggers/observers about the continuation of the RRO. In addition, Counsel for the parties made submissions. Mr J O'Brien KC for the Trust and Mr Karim KC for the Official Solicitor proposed that the RRO should not be continued. There was considerable public interest in the workings of the Court of Protection and, in particular, decisions that had been made in closed proceedings about covert medication. It was important however that the use of covert medication and closed proceedings was fully understood. At all times the steps taken were decided to be in A's best interests. Ms James-Stadden for the Local Authority expressed concerns that the use of covert medication could leak out and reach A causing irreparable harm.

67. Mr M O'Brien KC for B said that she had no concerns about the proposed order. He took the opportunity to complain that B's exclusion from the closed proceeding concerning covert medication meant that she and her legal representatives were induced to believe that no medication was being given. That understandable misapprehension was at the heart of B's application in respect of residence and formed the basis of the written submissions made on her behalf. Hence, time and resources were wasted, and B was deprived of the opportunity to engage meaningfully in the proceedings. Her Art 6 rights were significantly compromised (as the court has recognised). Although Mr M O'Brien KC did not say so, it may be considered to be material to the decision about continuing the RRO that B's exclusion should be reported. If there is a prohibition on reporting on the covert medication, in effect there would be a prohibition on reporting on use of closed proceedings. Further, there would be a risk that B's true position could be misrepresented.

68. The helpful representations from the observers/bloggers supported discharge of the RRO. One matter of concern was that due to there having been open and closed proceedings running in parallel, the blog authors for Open Justice had inadvertently misled their readers. One blogger wrote after the April 2022 open hearing before HHJ Moir:

> "I think that P is still unhappy living in the care home and that she has still not been receiving the medical treatment deemed in her best interests at the previous hearings, and she remains at high risk of medical complications as a result. The reason I say 'I think' is because I deduced this from the hearing, rather than it being stated explicitly."

I have referred to the authors as "bloggers" or "observers" but it should be recorded that the author of that piece is a Consultant Clinical Psychologist and the Open Justice Court of Protection Project is an important project that makes a significant contribution to transparency and public understanding of the workings of the Court of Protection. They feel that the proceedings in this case have undermined their work.

69. Articles 8 and 10 of the European Convention on Human Rights and Fundamental Freedoms are engaged.

> Article 8
>
> Right to respect for private and family life
>
> 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.
>
> Article 10
>
> Freedom of expression
>
> 1. Everyone has the right to freedom of expression. This right shall include freedom to hold opinions and to receive and impart information and ideas without interference by public authority and regardless of frontiers. This Article shall not prevent States from requiring the licensing of broadcasting, television or cinema enterprises.
>
> 2. The exercise of these freedoms, since it carries with it duties and responsibilities, may be subject to such formalities, conditions restrictions or penalties as are prescribed by law and are necessary in a democratic society, in the interests of national security, territorial integrity or public safety, for the prevention of disorder or crime, for the protection of health or morals, for the protection of the reputation or rights of others, for preventing the disclosure of information received in confidence or for maintaining the authority and impartiality of the judiciary.

Section 12 (4) of the Human Rights Act 1998 provides that:

> The court must have particular regard to the importance of the Convention right to freedom of expression and, where the proceedings relate to material which the respondent claims, or which appear to the court, to be journalistic, literary or artistic material (or to conduct connected with such material) to (a) the extent to which (i) the material has, or is about to, become available to the public, or (ii) it is, or would be, in the public

> interest for the material to be published, [and] (b) any relevant privacy code.

70. The leading case on the approach to be adopted is the decision of the House of Lords in *Re S (a child) (Identifications: Restriction on Publication)* [2005] 1 AC 593. It was held that an intense focus on the comparative importance of competing rights under Articles 8 and 10 was required. Neither Article has presumptive weight over the other; the proportionality test must be applied to each. The court should always ask whether there is any less restrictive or more acceptable alternative to a RRO – see also *JIH v News Group Newspapers Ltd* [2011] 1 WLR 1645.

71. Here, the principal reason an RRO was made and might be continued was to protect the physical and mental health of A – that is a protection of her Art 8 rights. One might even say that her Art 2 rights are engaged given the risks to her. She is a vulnerable young woman who might well respond to any discovery that she has been covertly medicated by losing trust in those caring for her, those treating her, and, more broadly, with all professional carers and healthcare professionals. It is possible - and this I not a fanciful suggestion - that she might refuse to eat or drink. She has done so in the past. That might be her response because she may believe that the medication is a form of poison.

72. The use of covert medication and its continued use enhances her Art 8 rights to develop physically and mentally in a healthy manner. The use of covert medication is on the face of it contrary to the exercise of her autonomy since she refuses the medication but it is a means of overcoming the detrimental influence of her mother and it is considered to be in her best interests. It therefore empowers her and so arguably enhances her autonomy and her Art 8 rights.

73. I take into account that this case has previously been the subject of publication through a blog which referred to A as P. The current hearings are obviously linked to the previously reported open proceedings and so A will be identifiable as P. The blog raised questions, publicly, about why A was not being medicated, leading readers to doubt, on false information, the rationale for the court continuing to direct that it was in A's best interests to reside at placement A and to not see her mother face to face. That is not to criticise the blog authors in any way – they were not to know of the closed proceedings and clearly did not contemplate the possibility that medication might have been administered covertly. However, as the blog authors have pointed out to this court, the misleading impression will stand uncorrected if the RRO remains in force.

74. As a result of orders I have made, B has been informed that medication has been covertly administered and continues to be so. I have made injunctive orders to prevent her communicating with A about the covert medication or about her puberty. That is one protection against A learning of the use of covert medication in an uncontrolled manner.

75. I also take into account the Transparency Order which remains in force and which, upon my amendment, directs that any publication or communication about the case shall refer to the person who is the subject of these proceedings as A, her mother as B, and shall not identify the Local Authority, the Trust or the geographical area where any of them is based other than to refer to the North of England. It prevents identification of placement A and the expert witness Dr X. The Transparency Order therefore affords

considerable protection against the identification of A as the subject of these proceedings.

76. The added protection of the RRO would be provided by excluding any possibility that A or anyone she knows would learn through a report of the proceedings that she has been covertly medicated. However, it is relevant to question whether A herself would ever discover the use of covert medication through a publication about her case.

77. On the one hand, A's case is possibly unique. The expert witness Dr X told the court that he had never come across a young woman of A's then age – 20 who had not been treated for primary ovarian failure. Exceptionally, A was still a pre-pubescent girl at the age of 20. Accounts of this case, even anonymised, may well obviously refer to A to any reader who knows her or of her. There are neighbours of B for example who do not know about A's covert medication plan.

78. On the other hand, A lives at Placement A away from most people who know or know of her, and with limited contact with a few family members. They are B, her maternal grandparents, two uncles and an aunt. A does not watch or read the news according to the social worker whose evidence I have considered. She does now enjoy a number of outings - a measure of her progress at placement A - but otherwise has very limited contact with the outside world. Furthermore, she is supervised on outings and her contact with family members is also supervised. It seems to me that it is unnecessary and not in A's best interests for any family members other than B to be informed of the covert medication. None of them have asked any questions about A's physical changes so far. If they do so, then a holding answer will have to be given before consideration of whether they should be told and, if so, whether any injunctive order is necessary to prevent them telling A. One uncle has been pressing B for information about this hearing. B is injuncted from revealing the use of covert medication to him. However, it would be permissible for B's solicitor, an experienced Court of Protection practitioner, to speak to this uncle to inform him that there is information within the proceedings that cannot be disclosed to him by B or anyone else and that if he wants to know what it is, consideration will have to be given to making him subject of an injunction. If that uncle or any other of the close family members were to work out from reading a report of the case that mentioned covert medication that A had been covertly medicated, it would remain unlikely, in my judgment that they would tell A about it. Again, consideration could be given to imposing injunctions against them to prevent them discussing the matter with A. B knows about the covert medication but she is the subject of an injunction not to disclose that knowledge. The existence of an RRO would not provide any further protection against her disclosing the covert medication to A.

79. I have decided that it is in A's best interests for the covert medication plan to continue. However, I take into account that at some point in the future, irrespective of the reporting of this case, it is very possible that A will learn that she has been covertly medicated and that that is why she has gone through puberty.

80. In terms of Article 10, it seems to me that it is of considerable public interest that a case in the Court of Protection has involved closed proceedings, from which P's mother and family members were excluded and in which the use of covert medication for the purpose of inducing puberty has been authorised. These are exceptional circumstances. It is a matter of public interest that the court can and does authorise the use of covert medication in exceptional cases, but it adds another layer of exceptionality and public

interest that family members were excluded from those decisions. I do not wish to imply that the court was wrong to proceed in that manner in A's best interests, but clearly the fact that it did so is a matter of public interest which is liable to attract comment and diverse opinions.

81. It would be virtually impossible to report or blog about this hearing in a meaningful way without reference to covert medication. It would be close to a reporting ban to restrict reporting of the issue of covert medication because that is at the heart of the proceedings now that it has been revealed to B and her legal representatives. The decisions about residence and contact depend in part on the benefits and risks to A of covert medication.

82. One possibility is that the RRO should remain in force until transition to open medication has been accomplished. The next few weeks will see the introduction of face to face contact with B and could be an unstable time for A. Would it be best to extend the RRO until A is taking medication openly and voluntarily? The problem with that option is that the implementation of a medication plan might take months, even if the plan is approved by the court in November. It may be that the plan will be not to reveal the use of covert medication to A in which case the justification for continuing the RRO for an interim period would continue for a further interim period until it continues in the long term.

83. The RRO concerns convention rights and A's best interests. There is considerable and understandable anxiety to remove any chance of A discovering that she has been and continues to be covertly medicated. An RRO might go some way towards preventing those who know A or know of her, from finding out about the use of covert medication, but there seems to me to be a very slim chance of anyone then conveying that information to A, and there is an even lower chance of A herself accessing a report of the case and realising that she has been covertly medicated. Weighing the risks of that happening against the importance of open justice, weighing the convention rights to which I have referred and scrutinising the comparative rights with an intense focus, in my judgement the RRO should be discharged. The protections of A's interests afforded by the Transparency Order and injunction, allow the RRO to be lifted.

84. As for the publication of this judgment (in both the closed and open proceedings), it seems to me that it can be published once corrected and checked for anonymisation. However, so that the full circumstances of the case are available, I shall lift the RRO simultaneously with publication of this judgment. There have already been reports of this case which were based on only partial information – through no fault of the authors – and I am anxious to avoid any repetition. The short time over which the RRO will therefore remain in force will also allow for reflection on the marked changes in the circumstances of these proceedings and some preparation for the difficulties that are liable to arise in the near future before any publicity about the case begins.

85. Sometimes it is the best interests of a person who lacks capacity to make decisions about their treatment, to administer their treatment covertly. DJ Bellamy in *AG v BMBC* [2016] EWCOP 37AG set out guidance in relation to covert medication decisions in the context of standard authorisations:

> "(a) Where there is a covert medication policy in place or indeed anything similar there must be full consultation with healthcare professionals and family.
>
> (b) The existence of such treatment must be clearly identified within the assessment and authorisation.
>
> (c) If the standard authorisation is to be for a period of longer than six months there should be a clear provision for regular, possibly monthly, reviews of the care and support plan.
>
> (d) There should at regular intervals be review involving family and healthcare professionals, all the more so if the standard authorisation is to be for the maximum twelve month period.
>
> (e) Each case must be determined on its facts but I cannot see that it would be sensible for there to be an absolute policy that, in circumstances similar to this, standard authorisation should be limited to six months. It may be perfectly practical and proportionate provided there is a provision for reviews(or conditions attached) for the standard authorisation to be for the maximum period.
>
> (f) Where appointed an RPR should be fully involved in those discussions and review so that if appropriate an application for part 8 review can be made.
>
> (g) Any change of medication or treatment regime should also trigger a review where such medication is covertly administered.
>
> (h) Such matters can be achieved by placing appropriate conditions to which the standard authorisation is subject and would of course accord with chapter 8 of the deprivation of liberty safeguard's code of practice.
>
> (i) I endorse and gratefully adopt the proposed written guidance from BMBC as detailed earlier in this judgment and, whilst recognising it may not be proportionate or indeed desirable in every case, the revised format of the most recent standard authorisation."

86. In the present case in 2020 the court was asked to approve a covert medication plan and to do so without the knowledge of the family of the person involved. This was an exceptionally unusual situation for the Court of Protection to consider. Further distinctive features of this case were that the covertly administered medication would bring about obvious physical changes in the person treated and that the treatment would ideally be required to be continued for the rest of her life. Aside from the difficulties that this combination of exceptional features has presented to those caring for A, it has made the management of hearings extremely problematic. Although the Official

Solicitor was involved in the closed proceedings representing A's interests, there was in fact no dissenting party and therefore no prospect of oversight by an appellate court. Open proceedings have been held in parallel with closed proceedings but information and material which was highly relevant in open proceedings was withheld from a party, B, and her legal representatives, who did not know that any information or material had been withheld. All this arose from fully reasoned decisions in A's best interests which were given the most anxious consideration. The court's role at these two most recent hearings, as set out in this judgment, has been to chart the best course forward rather than to hold a review into the proceedings to date.

87. This has been a difficult case to conduct and I am very grateful to the constructive and adaptable approach taken by all counsel and solicitors. I wish to record that B conducted herself with dignity during what must have been a very stressful hearing for her. I also wish to record that the social workers, carers and healthcare professionals who are involved with A continue to give the utmost care and attention to A's needs and best interests. I shall conduct a review in November 2022.