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IN THE HIGH COURT OF JUSTICE
FAMILY DIVISION
AND IN THE COURT OF PROTECTION

Case No. 14082797

Royal Courts of Justice
Strand, London, WC2A 2LL

Thursday, 29 June 2023

Before:

MR JUSTICE FRANCIS

(In Public, subject to a Reporting Restrictions Order)

BETWEEN:

GLOUCESTERSHIRE HEALTH & CARE NHS FOUNDATION TRUST
Applicant

- and -

(1) FD
(by her litigation friend the Official Solicitor)
(2) ED
(3) RD
(4) PD
(5) TD
Respondents

REPORTING RESTRICTIONS AND ANONYMISATION APPLIES

MISS E SUTTON KC and MR J RYLATT (instructed by DAC Beachcroft LLP) appeared on behalf of the Applicant.

MISS N GREANEY KC (instructed by the Official Solicitor) appeared on behalf of the First Respondent.

THE SECOND, THIRD, FOURTH and FIFTH RESPONDENTS appeared In Person.

JUDGMENT

(Transcript prepared without the aid of documentation)

MR JUSTICE FRANCIS:

1 This case concerns FD, who was born in February 1994 and is, therefore, now aged 29. FD recalls that her earliest memory of anorexia was when she was about four or five years old. FD's first involvement with child and adolescent mental health services was when she was 12 years old. Before she had reached her 13th birthday, in 2007, FD had been admitted to X Hospital for naso-gastric ('NG') feeding after she had stopped eating and drinking completely. FD has been in one medical institution or another suffering from anorexia nervosa since that time. This means that she has missed all of the usual adolescent and young adult experiences in life; she has missed the things that make life pleasurable for us as human beings.

2 This case has come before me, as a judge sitting in both the Court of Protection and the Family Division of the High Court, for a series of orders sought by the Gloucestershire Health & Care NHS Foundation Trust ("the Foundation Trust"). FD describes her current situation as "torture".

3 It is agreed that the issues which I now have to determine are the following four:

1. Whether FD has capacity to conduct these proceedings and whether FD has capacity to make decisions regarding her nutrition and hydration arising from the diagnosis of anorexia nervosa.

2. Whether it is in FD's best interests for active treatment against her wishes for her anorexia nervosa, in the form of nutrition and hydration and/or treatment to address

the mental and physical health consequences of her anorexia, to be withheld.

3. Whether declaratory relief under the inherent jurisdiction of the High Court should be granted regarding the legality of FD's treating clinicians not taking steps towards providing FD with nutrition and hydration by force, under the Mental Health Act 1983, whether by use of restraint or sedation, against her wishes.

4. Whether the reporting restrictions order should continue.

I would, I think, add to that list of four things, which are summarised in the very helpful joint note prepared by counsel, that I need to consider my views in relation to FD's current detention under a section pursuant to the Mental Health Act, although I understand that that is, in part at least, covered by what I have just referred to.

4 The Foundation Trust has been represented by Miss Emma Sutton KC and Mr Jake Rylatt. Because of the issue of capacity, FD has been represented by the Official Solicitor, who, in turn, has instructed Natasha Lukies of Reeds Solicitors as her agent to visit FD and attempt to establish her wishes and feelings. FD is represented in court in these proceedings by Miss Greaney KC. FD's parents are ED and TD. They are divorced, but I have seen nothing but cooperation and family unity in my court and I am grateful to them for that. ED was accompanied at the hearing by FD's twin sister, RD. TD was accompanied at the hearing by FD's younger sister, PD. All of the family appeared online through the CVP link, with my consent, of course, rather than attending in person at court. This was their choice and I am satisfied that through the CVP, they were able to join the proceedings and fully take part in them.

5 It is, I suggest, impossible for anyone to imagine the emotion and the anguish which the family must be suffering, knowing that a possible (if not likely) consequence of acceding to the hospital's application could be FD's untimely death. Unfortunately, neither TD nor ED have been represented and I say something about the issue of Legal Aid at the end of this judgment. However, I am confident that the family have, at all times, been able to put questions to the relevant witnesses and they have said everything that could possibly have been said had they been represented. RD and PD have put questions to the medical witnesses, as have each of their parents.

6 I discussed with counsel and with the family whether they would prefer to receive my decision at the outset of this judgment. It must be almost impossible for a family in a situation such as this to listen to a judge laboriously going through the relevant legal principles, the competing arguments and only to receive his decision at the end of what is bound to be a fairly lengthy judgment. Everyone has agreed that they would like to receive my decision at the outset of my judgment. The Official Solicitor, on FD's behalf, and all of the family now wish me to make the order which is sought by the Foundation Trust. I met with FD last week and will say more about that meeting later in this judgment. FD was anxious to convey to me her desperate wish to be allowed to make decisions about her own future, acknowledging, as she did, that that might even lead to her death.

7 Accordingly, in these most tragic of circumstances, everyone agrees that I should make the order sought by the Foundation Trust. It seems to me that it would be wrong, in the circumstances, for me to do anything other than to make the orders which are sought. I make it clear now that I propose to make the order in the terms which have been requested by the Foundation Trust. I am going to set out, obviously, in full my reasons for doing that, which cannot, of course, simply be that that is what everybody wants me to do. I have come to the fully independent conclusion that it is the right thing to do.

8 I make this order knowing that it may have fatal consequences for FD, but also knowing that she regards her present existence as simply, to use her words, “torture”. In other words, continuing with forced treatment is to subject her to a life of “torture”. It is impossible for any of us to imagine how difficult it has been for the family to come to this decision. The fact is, however, that, for 17 years, FD has been treated, often unwillingly, for her condition. Before I do pause in a moment, I wish to say this. I do not see this as a one-way street, with FD headed only towards an untimely end as her system shuts down through lack of nutrition. Those who know her best, her family and those who have treated her for a significant period of time, particularly Dr A, hope and see a future for FD. In this regard I was moved to hear, and I use this merely by way of what I regarded as an important example of hope, that Ms B at X Care Home where FD now lives has interested FD in English Literature and FD now even has her sights on the possibility of a GCSE in the subject. Having read and seen what I have, I would see this as a triumph for FD and just possibly something that would give her the hope and the inspiration which has for so long been absent from her life.

9 A care plan has been put together for FD. I have heard evidence from a number of witnesses, to which I shall, of course, return shortly, that there are very many options for FD should she choose to avail herself of them. FD will be in the same place tomorrow, now that I have made this decision, as she is today. She can stay at X Care Home. If she is no longer detained under the Mental Health Act, as I believe will now be the case, she will have the autonomy to make the decisions now and not have them forced upon her. In addressing the court, FD’s mother poignantly observed that it was not until FD was in the care and comfort of X Care Home that this application could really have been made. FD will continue to receive nutrition through the NG tube. FD was adamant when we met that she needs to be in charge of her own life. There is no doubt that this wish of hers is shared by

her twin sister RD, who said that FD was desperate to be treated as a person and not "as a piece of paper". This is also shared, as I have said, by her younger sister PD and by her parents. The phrase about being a piece of paper was used by FD herself. It has had an important impact on my impression of this case. Whilst under compulsion of treatment and whilst under section, FD sees no hope for the future and only sees herself as being controlled, subject to unwelcome and inhumane treatment and allowed no opinion of her own and no control of her own destiny.

10 I also propose to continue the reporting restrictions order. This case has been heard in open court, as is usual now in these Court of Protection cases, so that interested persons, people who follow legal cases, legal bloggers, and so forth, can observe the process. However, in my judgement it is essential that the privacy of FD and her family is preserved. I am also determined to preserve the privacy of the treating clinicians and the wonderful staff at X Care Home who are looking after FD. Social media, these days, can produce unwanted attention, trolls and people who are determined to see bad where they should see good and to make mischief. In my judgement, those people who work in this exceptionally difficult area of medicine, making incredibly hard decisions about young people suffering from extreme mental and psychological conditions, are entitled to have their privacy protected. Unusually, therefore, I am going to make the reporting restrictions order in this case to be a permanent order. I must, of course, give liberty to an interested person to apply to vary or discharge my order and I will ask for it to be provided in the order that they may do so, giving at least seven days' written notice. Whilst I concede that there may be some public or legal interest in this case, there can be no public interest in identifying this particular family or this particular hospital or these particular treating clinicians and hard-working other medical staff. Even if there were any public interest in revealing any of those identities, in my judgment, that public interest would be substantially outweighed by the family's right to a private life and family life. In particular, I bear in mind the impact that

identification could have on FD and also on all of her family were there to be any identification.

11 As it happens, we do not have anybody here from the media. But if, in due course, Mr Farmer, who is well-known in these courts, asks for a transcript of this judgment, he will be provided with an anonymised transcript, and I accept the very kind offer of Miss Sutton's junior, Mr Rylatt, to have a first go at anonymisation. Obviously, then that will have to be approved by both leading counsel and then, in due course, by me. But I am, however, completely satisfied with Mr Farmer's integrity. He is very well-known in these courts and if he is given a copy of the unanonymised transcript with a copy of the reporting restrictions order, I know that he will, of course, abide by it.

12 I also make clear that I accede to the request made by the Foundation Trust and I express the strong view that FD should be discharged from detention under the Mental Health Act. I am going to deal with this later in my judgment. Miss Sutton KC tells me, and of course I accept, that the section can and will be removed almost immediately following my decision. Although I make it clear that I do not consider myself to have the power to order removal of the section, but my strong invitation that it should be removed is likely to be followed.

13 To make things absolutely clear then, at this stage, for FD and her family, as I know they are listening carefully to what I am saying, I am acceding to the Foundation Trust's application and although, as I shall set out, I am finding that FD lacks capacity to make decisions in relation to her nutrition and hydration, I also find that it is in FD's best interests for me now to hand FD control over her own destiny, all decisions in relation to nutrition and hydration and any necessary medical treatment. I do this, having heard very carefully presented arguments, out of respect for FD's request for autonomy, out of respect for the wishes of her twin, her younger sister and her parents. I do this because I have been persuaded that any

further compulsory treatment and force-feeding and/or hydration would be futile, such a process having failed for some 17 years.

14 I have had to recognise, as has every member of FD's family, that the decision which I have made is replete with risk. It carries the risk that FD will, to use her own words, "honour" the anorexia and allow it to kill her. However, the correlative feature of this is that it offers FD, possibly for the first time ever, but certainly for the first time for a long time, autonomy, control and hope. FD has attended the majority of this hearing remotely by CVP from the home where she is staying, and I venture to suggest and to say to her that she will have seen and witnessed the love that is shown to her by all those who have been involved in this process: people who want the very best for her. But these people do not only include her loving family, but the caring medical team, including, if I may say, in particular, Dr A and Ms B.

15 I invited Miss Greaney to take instructions from Mr Edwards, from the Official Solicitor's office, as to whether he might be willing to continue to make himself available to FD after this case concludes today. I also asked the same question in respect of Natasha Lukies of Reeds Solicitors, who was instructed by the Official Solicitor to meet FD and to ascertain her wishes and feelings. When I met with FD, Miss Lukies attended, and it is clear to me that she and FD have been able to build a bond of trust and friendship. Mr Edwards and Miss Lukies have both unhesitatingly agreed to continue to be available to answer any requests that FD may have and even to follow up whether the promised facilities of the care plan are being delivered. I recognise that this is a big ask, not least because I anticipate that, once this case has concluded, these kind people will not be remunerated. I am extremely grateful to each of them for their offer to do this. It is a question which I have rarely asked in Court of Protection cases. I recognise the central importance to FD of being able to access people that she knows and has come to trust. When I talk of the hope for FD's future

as well as the risks, I firmly believe that that hope will be strengthened by the kind and generous offers of the people to whom I have just referred to make themselves available to assist FD. I have also expressed the sincere offer that if it is felt, for example, by Mr Edwards or anyone from the Official Solicitor's office, that further judicial input may help hasten any facilities that FD has requested or agreed to use, then I would be more than happy to be involved, provided, of course, that the various protocols are complied with. I want FD to feel not only loved as she is by her family, but supported by all of the professionals who have engaged with her in this case.

16 Also, I want to say this. My task has been to consider all the background information and, crucially, to look forward to what steps should be taken for FD in the future. I have only had the briefest of opportunities to meet FD's mother and father and, as I said, this has only been online through the CVP link. I want to make clear that there is nothing at all that makes me criticise either of FD's parents: quite the reverse, for I have seen a family united in their sincere and profound desire to do everything they possibly can to help FD. Indeed, in her very private and frank note, FD said this:

> "My mum and dad are divorced and a lot of people think this is the reason for my anorexia. But they are wrong."

Everything that I have read and seen about this case currently persuades me that FD has a loving and supportive family, who have suffered so much emotional heartache as they have witnessed FD's decline. I pay tribute to all of them. They have had to come to terms with the most difficult decision that a parent could really ever have to make about their child and, as I shall set out in due course in this Judgment, they have made their decision based entirely on what they think is best for FD. But when I use the expression "their child", of course, FD is an adult of 29, but I do so, knowing that to a parent their child is in some respects always just that.

17 I want to convey to FD that, as a judge sitting in the Court of Protection, I expressed when I saw her and I repeat now the sincere hope that she will choose to accept the nutrition and the hydration which is being offered to her, in the knowledge that this is now something that she is in charge of rather than something that she is being subjected to. This, obviously, is a hope which everybody involved with this case shares.

18 As I shall set out in more detail below, at an earlier directions hearing I asked FD whether she would like to meet me as the judge making this huge decision about her. She indicated that she would like to meet me, not via a computer link but for me to visit her at the care home where she is being looked after. I found the visit invaluable as an opportunity to get to know FD, at least a bit. I made it very clear to FD, as is, of course, the case, that my visit was not about evidence gathering. I made sure that I complied with the guidance given recently by Hayden J in relation to judges visiting patients. I was accompanied by Miss Lukies of Reeds Solicitors and an attendance note was made and that has been circulated, of course, to all relevant people. I thanked FD for agreeing to meet me and I said to her then, and I repeat now, that it was a privilege for me to do so. I also offered then, and I repeat the offer now, that if she would like me to visit her again following this case, I will do so, of course complying with the appropriate guidance and protocols and ensuring that I am accompanied again and that an attendance note is taken. I will only, of course, do such a thing with the full knowledge and agreement of all parties, but I am sure that if this is something that FD wanted, that is cooperation and participation that would be accepted by everybody.

19 FD also made it clear to me that she would find it very useful to have a close confidante, who could help to talk to her and guide her through the next phase of her life. Whilst everybody appreciates that FD's health is on something of a knife edge, I detected hope as

well as despair in my conversations with FD, and now that FD is going to be in charge of her own destiny, we must all express the hope that the optimism is rising not falling. I have been assured that as part of the care plan such a, what I am calling, close confidante, will be found for FD.

20 Counsel have very helpfully provided me with an agreed list of issues, chronology, suggested pre-reading, legal framework, witness template and draft final order. The agreed chronology has been particularly helpful and, with the agreement of counsel, I incorporate it as follows:

1994	FD born (now age 29).
May 2006	FD first involvement with Child and Adolescent Mental Health Services ("CAMHS") (age 12).
January 2007	Admission to X Hospital for NG feeding after she had stopped eating and drinking completely (informal status) (age 12).
April 2007	Transferred to a different hospital (CAMHS eating disorder unit) (informal status) (age 13).
November 2007	Discharged home. This was the last period FD lived in the family home (age 13). Diagnosis of Anorexia Nervosa by the point of discharge.
December 2007 – November 2009	Treated as an informal in-patient at several adolescent eating disorder units.
November 2009 – December 2009	**Detained under section 3 MHA 1983** In-patient at several intensive care units (age 15).
December 2009	Attendance at A&E due to severe headbanging. No fracture or

	injury (age 15).
December 2009	Transferred to adolescent eating disorders rehabilitation accommodation (age 15).
February 2010	Transferred to an intensive care unit (age 16).
September 2010	**Detention under section 3 MHA 1983 converted to Community Treatment Order under section 17A MHA 1983** Transferred to an eating disorder rehabilitation/stepdown unit), following gradual transition (age 16).
September 2011	Transferred to an adolescent eating disorders rehabilitation accommodation at a hospital (age 17).
September 2011	**Community Treatment Order under section 17A MHA 1983 revoked and detention continued under section 3 MHA 1983** (age 17).
September 2011 –February 2012	Resided at an intensive care unit and for a time at an adolescent eating disorders rehabilitation accommodation.
March 2012	**Detention under section 3 MHA 1983 converted to Community Treatment Order under section 17A MHA 1983. Transferred to an eating disorders rehabilitation/step-down unit**
January 2013	**Community Treatment Order under section 17A MHA 1983 revoked and detention continued under section 3 MHA 1983** Transferred to an eating disorder unit (age 18).
July 2015	Referral to Professor C for a Second Opinion. Professor C subsequently asked Mr A to refer to Dr B (instead) as she was not able to see FD at that time (age 21).

November 2015	Referral to Dr B for a Second Opinion (age 21).
January 2016	Second Opinion report provided by Dr B (age 21).
March 2018	**Discharged from detention under the MHA 1983** Informal admission to acute psychiatric inpatient unit) (age 24).
June 2018	Transferred and informally admitted to a psychiatric rehabilitation unit. (age 24).
November 2018	**Detention under section 3 MHA 1983** Admitted to a Hospital for medical refeeding (age 24).
December 2018	**Transfer under Scottish equivalent of Mental Health Act 1983** Admitted to Eating Disorder Unit in Scotland (age 24).
March 2020	**Transfer under warrant from Scotland back to England, with detention continuing under section 3 MHA 1983** Admitted to a hospital (age 26).
June 2020	Transferred to a psychiatric rehabilitation unit (age 26).
August 2020	Transferred to X Hospital to be assessed in the Acute Medical Assessment Centre (age 26).
August 2020	Family and professionals meeting.
August 2020	Transferred to a hospital (age 26).
September 2020	Mental Capacity Assessment.
October 2020	Family and professionals meeting.
October 2020	Family and professionals meeting.
November 2020	Transferred to PICU as a planned respite admission for four weeks

	(age 26).
December 2020	Transferred back to the ward (age 26).
December 2020	Mental Capacity Assessment.
December 2020	Best interests meeting scheduled but converted to a meeting to discuss future care plans following FD being assessed as having capacity.
February 2021	Referral to Professor C for second opinion.
March 2021	Mental Capacity Assessment.
May 2021	Transferred to X Hospital to have PEG refitted (age 27).
May 2021	Transferred back to previous hospital (age 27).
July 2021	Transferred to X Hospital after removing PEG on 11 July 2021 (age 27).
March 2022	Family and professionals meeting.
March 2022	Mental Capacity Assessment.
May 2022	Family and professionals meeting.
June 2022	Family and professionals meeting.
July 2022	FD supported by MHLT in a 2.5 hour meeting with Dr B (age 28).
August 2022	Family and professionals meeting.
September 2022	Family and professionals meeting.
November 2022	Family and professionals meeting.
February 2023	Extended section 17 MHA 1983 leave commenced for FD at X Care Home, following increasing periods of leave to the placement

	from January 2023 (age 29).
April 2023	Admitted to V Hospital for tests following an overdose of Amisulpride, which came back normal. Agency nurse left a drugs trolley unlocked at the care home (age 29).
April 2023	Discharged back to X Care Home. Present residence under section 3 MHA 1983 with extended section 17 MHA 1983 leave.
April 2023	Mental Capacity Assessment (COP3) completed by Dr A.
May 2023	COP1 issued by Court of Protection.
19 May 2023	Directions order of Francis J following hearing of same date Reporting restrictions order of Francis J.
7 June 2023	Directions order of Francis J following hearing of same date Amended reporting restrictions order of Francis J.
20 June 2023	Independent Psychiatric Report of Dr B.
26 June 2023	Roundtable meeting in advance of final hearing.
28-29 June 2023	Final hearing before Francis J.

The chronology shows that FD was first admitted to hospital shortly before her 13th birthday, after she had stopped eating and drinking completely. After that, she spent time at Y Hospital; following a period at home she was admitted to Unit A, Z Hospital until transfer to A House (an eating disorder rehabilitation/stepdown unit) at the age of 15.

21 It is plain from what FD has said that her time at Z Hospital was extremely unfortunate and tragically unhappy. But there is no benefit in me saying more about that now and, in any

event, I do not have enough factual information or evidence to be able to make findings about her time at that institution.

22 The first time that FD was detained under the Mental Health Act was when she was 15. In 2009, she was variously at Unit B (Z Hospital), Unit C (Z Hospital), A&E at S Hospital, and other institutions. The following year, FD was again detained under the Mental Health Act. This was converted to a Community Treatment Order. The Community Treatment Order was revoked in September 2011, and then FD was variously at all the institutions referred to above. In March 2012, a further Community Treatment Order was granted, which was then revoked in January 2013. FD was then transferred to Y Hospital, though shortly thereafter transferred to Unit C, Z Hospital, as Y Hospital was not offering NG feeding at that point. She was then transferred to C House, before being transferred back to Unit C, Z Hospital. It was in November 2015 that FD was first referred to Dr B. Dr B gave compelling evidence by video link yesterday. It was, in my judgment, expert evidence of the highest quality and has been central to the determinations that I have had to make.

23 The chronology shows that, from 2018 right through until the present time, FD has been attending hospitals, eating disorder units and clinics. I do not want to distress FD or her parents any further than these proceedings must obviously be distressing them by reciting many of the unfortunate incidents that have taken place. But, just by way of example, FD has repeatedly removed her PEG tube. I mention it really in the context of a description by FD of her life as being “torture”. I found her use of that phrase to me compelling. And for her, sitting in a relatively small room, with nothing to do except have voices in her head and feeling tortured, no access to social media or television because she avoids those, it is not a life that she regards as worth living; and I understand that.

24 FD moved to X Care Home in early 2023 and that is where she is now. It is where I visited her and it is where she plainly is loved by the staff and where she has made genuine friends. Based on what I saw, but more particularly on what I have read in the papers in this case and the evidence that I have heard, I cannot commend highly enough the care and love that I saw and that I have read about that FD receives at X Care Home. It seems clear to me, and I think to everybody who knows and loves FD, that the existence FD currently enjoys is not an existence which is bearable for her. I say this as an observation of what FD subjectively feels, and also what I understand objectively for her, being in the circumstances that I have described. I must emphasise strongly this is not in any sense at all a criticism of anybody in the house where she is. As I have said, that house appears to be full of love and care and I have no doubt it is a place which offers, at the moment, the best possible care in the circumstances that FD is in.

25 X Care Home also seems to me to be somewhere that offers FD the greatest hope. If FD is no longer being forced to be fed or, indeed, subject to anything at all against her will and if FD is given the power of control over her own decision-making, which I am now giving her, then there is, as I have said, some possibility, some hope that FD will decide to see if she can move her life into a happier situation. All of the services which she now enjoys will be available to her. In one sense, therefore, nothing has changed, but in another sense there has been a seismic shift, for it is FD that now has the control.

26 I refer to the importance of Dr B in this case. Dr B has said in her reports to this court that FD's identity is "totally tied up with anorexia". She reports that FD has an extremely poor self-image. FD believes that she is worthless and that she deserves to die from her illness. She has almost no interests at the moment. She describes unrelenting internal voices telling her that she is fat and that she is ugly. Dr B gave compelling evidence to the court on the CVP link and was asked questions by both counsel and also by both of FD's parents and by

both of FD's sisters. Some time was spent on definitions about FD's capacity to make decisions in relation to her nutrition and her fluid intake. Dr B sought to draw a distinction between FD taking fluids with no calories (such as water, black coffee and Pepsi Max) and fluids containing sugar and dextrose which would provide nutrition, which FD would regard as unacceptable because they contain calories. The doctor described the issue as "enormously complicated" and that FD wanted to drive herself to take fewer calories, and this was driven by FD's immense fear. Dr B described that FD regards the anorexia as something that is unbeatable and, therefore, something that she has to "honour". She said that FD has a compulsion to lose weight and fears gaining weight. She said that one could argue the case that FD has capacity to make decisions through her experiences over many years and that these give her what Dr B referred to as "a great experiential insight". Dr B said, and I accept, that FD does have an understanding of nutrition and energy and that she regards these forms of nutrition as suitable for other people but not herself.

27 The Court has also been enormously helped in this case by the evidence of Dr A. Dr A has known FD for a long time and, although I agreed yesterday that she could be released from these proceedings so that she could go and see other patients, who I am sure need her time, I note, in fact, that she has been present throughout the whole of this hearing, including the second day. I see that, even as I am talking now, she is still shown on the screen as attending even though it is 4.30pm in the afternoon on the second day. I have no doubt that Dr A's attendance over this time, which was something which she volunteered and was not required to do, is because Dr A profoundly wants to help FD in this next phase of her life. Dr A, sadly, will only be able to remain with FD's case for a few more weeks now that I have made the orders that I have. Whilst this is regrettable, I completely understand that her professional duties are mainly connected with other hospital trusts and that the various different trusts operating in different areas prevent Dr A from being closely connected with FD in the future. Having said that, and as an example of the care that I have referred to Dr

A having for FD, Dr A has offered that she can remain, from time to time, available for FD. I want to express the immense gratitude of this court to Dr A for the enormous care and help that she has given to FD and which she will continue to give to FD.

28 Dr A probably knows FD better than most, if not all, of the various treating medical professionals, certainly in recent years. Dr A was less supportive of the distinction drawn by Dr B between calorific fluids and non-calorific fluids. I am persuaded that it is neither necessary nor appropriate in this case for me to seek to draw such a fine distinction. This is not in any way to criticise Dr B, to whom, as I have already said, the court is extremely grateful. As counsel have pointed out to me in the authorities to which I have been taken, the Court of Appeal has discouraged judges from making these fine distinctions and I do not know of any case where a distinction has been made in such a way as this about the difference between calorific fluids and non-calorific fluids. But if I was in any doubt at all about the correctness of my decision not to draw that distinction, that doubt is firmly resolved in favour of not drawing such a distinction when I remind myself of FD's words in her own note that:

> "Water is a huge trigger for me. When I was 12, I was sat in my conservatory drinking a glass of water and the voice in my head went, 'You're going to get fat from that.'"

Whilst I accept that FD's recollection of events, which was almost 17 years ago when she was only 12, could be flawed, given the comment that FD made about water, I cannot accede to the distinction between calorific fluids and non-calorific fluids. I have been told, and I accept, that there have been occasions when FD would take substantial quantities of water shortly before being weighed in order to create the misleading impression that she had gained weight when in fact it was just the fluid that had just been put into her system.

29 Dealing briefly with FD's weight and current circumstances, and I do this without wishing to cause any distress to anybody, but these are numbers that I was given quite properly by Miss Sutton KC when the case commenced yesterday. On 20 June, FD weighed 5 st 7 lbs/36.1 kg. This was a decrease from 5 st 8 lbs/36.8 kg on 13 June. I was told yesterday that FD's weight then was 5 st 6 lbs/ 34.47 kg and that her body mass index is now 12.3. This is regarded as dangerously close to starvation. I was told that FD's current calorific intake is 1,116 calories a day, but that she has not agreed to increase this through the nasogastric tube.

30 As I have said, counsel have produced an extremely helpful document which is called an Agreed List of Issues, Chronology, Suggested Pre-reading, Legal Framework, Witness Template and Draft Final Order. I am not going to run through all of the authorities to which I have been referred. To do so will, I fear, be tedious and would take a long time. In any event, I regard it as unnecessary. What I do need to do is to refer to the headline guideline cases from the higher courts rather than a large number of cases where more or less the same thing has been said. And, of course, I must always bear in mind that these cases are very fact-specific and two cases, even dealing with people of the same gender, of the same age, with the same condition, can still be factually very different.

31 As is well-known to those of us who practise in the Court of Protection, the overarching principle begins with the clear statement that there is no obligation on a patient with decision-making capacity to accept life-saving treatment and doctors are neither entitled nor obliged to give it. As I have said, I have found, following the compelling evidence that I have referred to, that FD lacks capacity to make decisions in relation to her nutrition. This is the central issue for, of course, without nutrition FD will not survive. It is this issue in relation to which FD most of all wants to have control. I have referred above to the risks which are inherent in giving FD autonomy and control in relation to this issue. I have set

out above the hopes and the aspirations which balance these risks. Only FD now will be able to decide which path to take, although, as I have set out, she will be enormously supported on whichever path she chooses. I recognise that this will not be a linear path, but that, whatever route FD chooses, there will be anguish, moments of despair, but I hope also, moments of optimism and achievement. When I met with FD last week, I discussed with her the possibility that she might look back, say, to go one week back, two weeks back, three weeks back and say, overall, one, two or three weeks later: "Am I a tiny bit better than I was?" And if she sees even the smallest improvement, maybe she will find that that difficult path to recovery is one that she will want to follow.

32 Dealing with the law in relation to capacity, a person must be assumed to have capacity unless it is established that they lack capacity, as set out in section 1(2) of the Mental Capacity Act. The burden of proof, of course, lies on the person asserting a lack of capacity and the standard of proof is the ordinary balance of probabilities. Determination of capacity is decision-specific, having regard to the clear structure provided by sections 1 to 3 of the Mental Capacity Act. Capacity must be assessed in relation to the specific decision at the time the decision is to be made and not to a person's capacity to make decisions generally. The draft order which has been agreed between counsel, respectively, with the Foundation Trust and the Official Solicitor reads as follows in relation to capacity:

> "FD lacks capacity to conduct these proceedings and to make decisions regarding her nutrition and hydration and consequential treatment of the medical complications which may arise from her diagnosis of anorexia nervosa."

33 Dr B, in her evidence yesterday, compellingly told us that, when it comes to making a decision about nutrition or hydration, FD becomes overwhelmed by the anorexia and, I have referred to this phrase already, she has to "honour" it. Whilst it is clear that FD knows and accepts that without nutrition and hydration she will die, I accept that FD lacks the capacity

to make a decision on this subject because the anorexia overwhelms everything and she is therefore unable to use or weigh the relevant information to enable her to make a decision. As I have said above, I shall make this order, which is requested by the hospital trust, supported by FD's family and by the Official Solicitor and desperately wanted by FD herself.

34 A person is not to be treated as unable to make a decision unless all practical steps to help them do so have been taken without success, and a person is not to be treated as unable to make a decision merely because they make a decision that is unwise. I have been referred here not only to section 1(3) and 1(4) of the Mental Capacity Act, but also to the *Heart of England NHS Foundation Trust v JB* [2014] EWHC 342. Also, as said by Hayden J in *Avon & Wiltshire Mental Health Partnership v WA* [2020] EWCOP 37 at §29:

> "...The Act emphasises the right of the individual, in exercising his or her personal autonomy, to make bad decisions even extending to those with potentially catastrophic consequences."

35 Pursuant to section 2(1) of the Mental Capacity Act a person lacks capacity in relation to a matter if at the material time they are unable to make a decision for themselves in relation to the matter because of an impairment of, or a disturbance in, the functioning of the mind or brain, the so-called diagnostic test. It does not matter whether the impairment or disturbance in the functioning of the mind or the brain is permanent or temporary. I have been referred in that regard to section 2(2) of the Mental Capacity Act. The question for the court is not whether the person's ability to take the decision is impaired by the impairment of, or disturbance in, the functioning of the mind or brain, but, rather, whether the person is rendered unable to make the decision by reason thereof. I have been referred in that regard to *Re SB (A Patient: Capacity to Consent to Termination)* [2013] EWHC 1417 (COP).

36 Pursuant to section 3(1) of the Mental Capacity Act:

> “(1) …a person is unable to make a decision for himself if he is unable –
>
> (a) to understand the information relevant to the decision,
>
> (b) to retain that information
>
> (c) to use or weigh that information as part of the process of making the decision, or
>
> (d) to communicate his decision (whether by talking, using sign language or any other means)”,

This is the so-called functional test. An inability to undertake any one of these four aspects of the decision-making process as set out in section 3(1) of the Mental Capacity Act will be sufficient for a finding of incapacity provided the inability is because of an impairment of, or a disturbance in, the functioning of the mind or brain. There must be a causal connection.

37 Following that test, and for the very clear reasons that I have been given by Dr B and Dr A, and as elucidated carefully by both Miss Sutton KC and Miss Greaney KC, I am not in any doubt that FD does lack the capacity to make those decisions in relation to her nutrition and hydration.

38 I need to say something here about the apparent conflict between FD’s belief that she does have capacity to make those decisions and the case advocated on her behalf by Miss Greaney KC, instructed by the Official Solicitor, that she does not. I think it is right that I do explain this apparent conflict, but I want to say right away at this point, so that FD and her family hear me say it, that this distinction is one that may be of interest to lawyers, but in fact it makes no difference at all in this case, because although I have made the decision that FD does lack capacity in relation to this issue, as I have said, I have also determined that it is in her best interests that she has the autonomy and control that she wants. So, we get to the result that she and her family want, albeit that, in relation to this

rather legalistic issue of capacity, we do it by a slightly different route.

39 I am grateful to Miss Greaney KC, who, at my request, has prepared a note on the role of the litigation friend and I highlight the following from that note now. Pursuant to rule 17.1(1) of the Court of Protection Rules 2017, the litigation friend must fairly and competently conduct the proceedings for the party and have no adverse interest to the party. There is a duty under the Mental Capacity Act to act in the best interests of the protected party. The litigation friend must confirm that they will act in that party's best interests. The duty is not stated expressly in the Court of Protection Rules but is derived from the statutory scheme as a whole. If a litigation friend is not willing to confirm that they will act in that party's best interests, it would not be an appropriate appointment.

40 I have been referred to the decision of Charles J, when he was Vice-President of the Court of Protection, in *NRA & Ors.* [2015] EWCOP 59, where he said this:

> "145. ... The role of a litigation friend (which has a significant overlap with that of a legal representative appointed by a First-Tier Tribunal...in a case under the Mental Health Act 1983 when the patient lacks capacity to litigate...shows that a litigation friend can be faced with difficult decisions in respect of both the advocacy role (directly or by giving instructions) and the implementation role and thus that both roles are integral to his task. Indeed, by applying the best interests test the litigation friend may have to control all aspects of the proceedings and, in doing so, may have to take a position that is contrary to, or does not fully accord with the expressed wishes and feelings of a P."

By "P" we mean, of course, the patient; and in this case, of course, we mean by that FD.

41 I do not think that I need to go further than that in my reading from Miss Greaney's note. That is not any discourtesy to her for her hard work, but there is no point me citing other cases that really say the same thing all over again. I merely end by pointing to paragraph 6, the final paragraph of the Miss Greaney's note, which reads as follows:

> "Hence, in acting as litigation friend, the Official Solicitor must act in P's best interests. In so doing, the Official Solicitor will have careful regard to P's wishes and feelings, but ultimately she [the Official Solicitor] must act for P's benefit and in P's interests. She must consider and assess legal advice that she receives. In fulfilling her role she may sometimes have to take a position that is contrary to the wishes and feelings of P."

I am very grateful Miss Greaney KC for that and I hope that it goes some, if not all, of the way to explaining what I referred to as the apparent dichotomy between FD's wishes and what been advocated to me by the Official Solicitor on her behalf.

42 Dealing next with the capacity to conduct proceedings, I have been referred to the decision of Hayden J, then Vice-President of the Court of Protection, in the case of *Lancashire and South Cumbria NHS Foundation Trust v Q* [2022] EWCOP 6, where he said this:

> "24. It…remains that in *Masterman-Lister v Brutton & Co* [2002] EWCA Civ 1889; [2003] 1 WLR 1511, endorsed in *Dunhill v Burgin* [2014] UKSC 18; 1 WLR 933. The essence of those judgments is to confirm, unambiguously, that capacity to litigate is addressed by asking whether a party to proceedings is capable of instructing a legal adviser 'with sufficient clarity to unable P to understand the problem and to advise her appropriately' and can 'understand and make decisions based upon, or otherwise give effect to, such advice as she may receive'. It follows that the issue of litigation will always fall to be determined in the context of the particular proceedings: *Sheffield City Council v E* [2005] Fam 236. None of this requires P to instruct his advisers in a particular way. Like any other litigant, in any sphere of law, he may instruct his lawyers in a way which might, objectively assessed, be regarded as contrary to the weight of the evidence."

43 I have been referred to a number of other cases on the question of capacity to conduct proceedings. As I have said before in a different context, I do not think there is any benefit to the parties or to anyone for me to refer to other cases which really say the same thing. I am satisfied on everything I have heard that FD does not have the capacity to conduct proceedings and that is, of course, the reason why FD has the Official Solicitor as her litigation friend. I want to express the court's enormous gratitude to Mr Edwards for all he

has done in this case and, of course, to those at Reeds who were engaged as agent for the Official Solicitor.

44 A great deal of this case, as I have set out above, is about the desire to give FD autonomy. I have referred above to FD's twin RD's comment that "[FD] is not a piece of paper; she is a person"; and I have referred to FD's comment that "Bob down the road can do something, but I can't." I am anxious that FD understands that, although the Official Solicitor has put forward a case which is slightly differently nuanced in the way that I have just described, at the end of the day, I have listened and we have all listened to what FD has said. FD made it clear to me when I saw her that this was her most fervent hope. FD's mother, father, twin sister and younger sister have all agreed with that FD should have this autonomy and RD, in particular, has written concisely but passionately about this herself. And, as FD's twin, I am sure that RD knows her incredibly well.

45 I have already said that I have found it to be in FD's best interests to be given the autonomy and the control that she seeks, even though I have found that she lacks capacity to make decisions in relation to her nutrition and her hydration. Section 4 of the Mental Capacity Act 2005 sets out the essential framework for the determination of best interests. It says that:

> "(2) The person making the determination must consider all the relevant circumstances and, in particular, take the following steps."

I have gone through carefully in reaching this decision all of the points that are listed in that section of the Mental Capacity Act. In particular, section 4(6) says this:

> "(6) He [the Judge] 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 [her] when he [she] had capacity."

46 As a Tier 3 Judge in the Court of Protection, usually to ascertain wishes and feelings of the patient is difficult because in many of these cases the patient will be in a condition where it is not possible to have a conversation with them. Maybe cases like car accidents where somebody might be in a semi-comatic state or desperately ill for all sorts of other reasons. So, in those cases, we have had to look at other things to guide us as to wishes and feelings. Of course, particularly, living wills, if somebody has made one. But, here, I have not had to have that difficulty because by the doctors, by FD's family and by the Official Solicitor, I have been told what FD's wishes and feelings are. There is clarity about that, there is no disagreement about it and, of course, as I have said, FD made it very clear to me when I saw her last week what her wishes and feelings are.

47 I want to make it very clear that my decision is based on the evidence that I have had from the family and the doctors and not based on what I was told by FD last week, which, as I have said, is not strictly evidence. But, of course, hearing it from FD myself and hearing her say almost word for word what I had read about her before I met her was confirmation to me that there is absolute clarity about FD's wishes and feelings.

48 Lady Hale in the Supreme Court case of *P v Cheshire West* [2014] UKSC 19 said this:

> "45. ...it is axiomatic that people with disabilities, both mental and physical, have the same human rights as the rest of the human race. It may be that those rights have sometimes to be limited or restricted because of their disabilities, but the starting point should be the same as that for everyone else. This flows inexorably from the universal character of human rights, founded on the inherent dignity of all human beings, and is confirmed in the United Nations Convention on the Rights of Persons with Disabilities."

49 Sanctity of life is a fundamental principle in cases like this. Sir Thomas Bingham MR said in *Bland* [1993] AC 789 at 808E:

> "(1) A profound respect for the sanctity of human life is embedded in our law and our moral philosophy."

Again, I have been referred to a number of other cases in this subject and, again, I do not want laboriously to go through all of those. But I do refer to Part 5 of the Mental Capacity Act Code of Practice. This provides assistance in assessing best interests at paragraphs 5.29-5.36. Paragraph 5.31 says as follows:

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

50 As I have said, FD reports that, looking back, she first recognised the symptoms of anorexia at nursery school, before she was five. Whether or not this is a correct and accurate recollection, I see no reason to disbelieve what FD has said in the absence of anybody contradicting it. On the balance of probabilities, I accept it as correct. As I have said, FD has, since she was 12, been one way or another in an institution being treated for anorexia nervosa. That is some 17 years. It is fair to say I find that this treatment has failed. I do not criticise anybody in saying that. I do not criticise the very many hospitals, clinics and caring professionals who have treated her. We are now in the middle of 2023. All of FD's family and all of the clinicians who know her well believe that imposing further treatment on FD against her will would be futile. When I say "futile", I use it in the strict sense as in being hopeless, of no effect. I also, remembering the words in the Code of Practice, bear in mind

these words, “or overly burdensome to the patient”. I remind myself of FD’s use of the word “torture”. So, I have concluded clearly, although of course on a balance of probabilities, but I am quite sure that this is one of those cases where respect for FD’s autonomy, the futility of further compulsory treatment, and cognisance of all past attempts at treatment compel me to the conclusion that preserving life at any cost is not the lodestar in this case. FD cannot stand the prospect of being forced into treatment that she does not want. But, as I have said, every aspect of her care that exists today at X Care Home is on offer tomorrow and as long as it is needed. Armed with the care plan, the love, care and support of family and staff and treating clinicians, I am not prepared to accept the inevitability of FD’s death following this decision and I do not accept that inevitability.

51 I have also been very impressed with the evidence of Ms C. In a moment of slight levity, which I hope was not inappropriate given the gravity of the proceedings, I observed that I have never heard reference to salsa dancing in a Court of Protection case. That reference was in the context of the things that are available to FD through the NHS. I was, frankly, amazed at hearing the list of things that might be available. I am not going to say I encourage FD, but I just remind FD of the availability of all of these things. I am quite determined that anything that FD may want to access she should access and as soon as possible. As I have said, if there is any delay in the provision of those services, I would like to think that the Official Solicitor can help, or Reeds can help, or, ultimately, I can help. Given all that we hear about the troubles in the NHS (and there is nothing that I could say that people do not already know), I have been incredibly impressed that for two days we have had two eminent leading counsel, junior counsel, two eminent psychiatrists at the very top of their game, incredibly caring staff at X Care Home, all dedicated to FD’s well-being and best interests in this case. I do not for a second ask FD to be grateful for that, gratitude has got nothing to do with it. But I merely observe, as a judge in a legal system which is so

riddled with funding problems, that this case has been remarkably well run and I am very grateful to everybody for that.

52 I do want to say something briefly about the subject of legal aid. I have said this publicly in a number of cases and I am simply going to refer back to what I said in *Great Ormond Street v Gard* [2017] EWHC 1909 (Fam), some years ago now. I said this, and I repeat it:

> "17. ... It is not for judges to make political points and I do not now seek to do so. However, it does seem to me that when Parliament changed the law in relation to legal aid and significantly restricted the availability of legal aid, yet continued to make legal aid available in care cases where the state is seeking orders against parents, it cannot have intended that parents in the position that these parents have been in should have no access to legal advice or representation. To most like-minded people, a National Health Service trust is as much an arm of the state as is a local authority. I can think of few more profound cases than ones where a trust is applying to the court for a declaration that a life support machine should be switched off in respect of a child."

53 Well, obviously, mercifully, that is not this case. But here we have an NHS Foundation trust asking for the High Court's approval of a plan not to compel a patient to accept life-saving treatment in circumstances where the patient lacks capacity to make that decision. I just say again publicly and not in any way politically, please could a review be given? Because I have been involved in a number of very difficult cases, usually end-of-life cases, where parents have not had representation and they needed it. As it happened, in the *Gard* case, because of the publicity, the parents were represented by excellent counsel acting *pro bono*. Since hearing this case, I am aware that due to changes in the regulations (which commenced on 3 August 2023), legal aid "means testing" is no longer required for parents applying for legal representation for matters concerning the withdrawal or withholding of life sustaining treatment in respect of their child. I am very pleased about this obviously sensible development.

54 I am now going to deal with the issue of declaratory relief relating to the section which FD is under at the moment. I am going to refer to some very helpful passages in Miss Sutton's note in this regard. I should say straightaway that Miss Greaney KC agrees with what Miss Sutton KC has said about this and, therefore, did not need to make separate representations to me about the law:

> "The decision whether or not to detain under the Mental Health Act is not a best interests decision which the Court of Protection has power to make on behalf of an incapacitated person. It is ultimately a public law decision by application of section 13 of the Mental Health Act. Additionally, even if a consequence of the court decision under the Mental Capacity Act, which refutes forced feeding, means, in practical terms, compulsory treatment under the Mental Health Act would go against that decision, they are different statutory regimes."

As a High Court judge sitting in the Court of Protection, I do not have the power to discharge FD from detention under a section of the Mental Health Act.

55 Whilst compulsory treatment, including a specialist eating disorder unit, remains a potential option, Dr A, to whom I have already referred, and Dr B, to whom I have also referred, do not consider that detention for treatment pursuant to section 3 of the Mental Health Act would be appropriate as it would simply replicate treatment that FD has received in the past but was ineffective. It would, if I may say so, be plainly wrong if we had spent the last two days deciding whether I should give the hospital the authority not to compel FD to accept feeding if only to find that feeding would be imposed under the Mental Health Act instead. We would agree it would achieve very little at all if that was where we are.

56 All of the best interest factors outlined which underpin the conclusion that it is not in FD's best interests to compel treatment under the Mental Capacity Act are just as relevant to whether or not treatment should be compelled under the Mental Health Act. I cannot compel clinicians to act or not act. But it is apparent from Dr A's evidence that she would

not seek to continue to impose treatment under the Mental Health Act, notwithstanding her clear understanding that this may lead to FD's death.

57 I am told by Miss Sutton KC, and I accept, that, under the inherent jurisdiction of the High Court, declaratory relief not to impose treatment under the Mental Health Act is likely to be extremely helpful to FD in understanding that compulsory treatment has, on the basis of the current evidence, been taken off the table. A full merits review has been undertaken in the context of this Court of Protection case and there has been anxious scrutiny by all relevant professionals in coming to the difficult conclusion that compulsion should not be used.

58 Therefore, I am going to make the declarations sought. I am not going to order, because I cannot, but I am going to ask that immediate consideration be given to the removal of the section pursuant to the Mental Health Act. I accept what Miss Sutton KC has told me, and Miss Greaney KC agrees, that what I am saying now will have that effect. If for some reason it does not have that effect, then, although I do not have the power to order it, I would like that, please, to be brought to my attention right away, in a message to me via my clerk, so that we can consider what the next steps should be. But with all the experience that Miss Sutton KC and Miss Greaney KC have in this field of the law, if they tell me that is what will happen then I accept that it will. By way of update, on 30 June 2023 (shortly after the hearing), I was made aware that Dr A had completed the necessary section 23 paperwork and that FD was discharged from her section.

59 I am immensely grateful to both leading counsel and, of course, Mr Rylatt, who, although he has not said anything, I am sure has done an enormous amount of work behind the scenes. I am hugely grateful to counsel for their immense efforts and I know that before they came into court yesterday to start this case they will have spent a great deal of time discussing this

case together, narrowing the issues and preparing what I have referred to as that very important document.

60 I want to end really by thanking TD, ED, RD and PD for their humble and incredibly courteous cooperation in this case. As I have said, I cannot think of many things more difficult for a family to face. You have, at all times, been incredibly helpful to me and I know to FD. So, I simply end with those thanks and, obviously, with a hope that things will start to look better.

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