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Case No: 12554134

COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 08/10/2014

Before :

MR JUSTICE COBB

- -

Between :

A NHS FOUNDATION TRUST	**Applicant**
- and -	
Ms X	**Respondent**
(By her Litigation Friend, the Official Solicitor)	

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- -

Michael Mylonas QC (instructed by **DAC Beachcroft**) for the Applicant
Conrad Hallin (instructed by **Official Solicitor**) for the Respondent

Hearing dates: 11-12 September 2014

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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.

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MR JUSTICE COBB

This judgment was delivered in public.

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 the incapacitated person and members of their family must be strictly preserved. All persons, including representatives of the media, must ensure that this condition is strictly complied with. Failure to do so will be a contempt of court.

The Honourable Mr Justice Cobb :

Introduction & Overview

1. Ms X is a young woman; she lives alone in a private rented bed-sit. She is suffering from an enduring and severe form of the eating disorder, anorexia nervosa; this condition has, it appears, dominated her life for the last 14 years. Ms X also suffers an alcohol dependence syndrome (psychological dependence on alcohol) which has caused chronic and now "*end-stage*" and irreversible liver disease, cirrhosis; this follows many years of abuse of alcohol. The combination of anorexia nervosa and alcohol dependence syndrome is unusual, and has been (and continues to be) medically acutely difficult to manage.

2. For many years Ms X has been trapped in an increasingly destructive revolving door of treatment and recurrent illness. She has required repeated specialist in-patient hospital admissions, when she has been force-fed in an attempt to arrest and reverse the effects of her anorexia; these admissions have brought about only short-term benefits given that, when discharged into the community, she has invariably sought refuge in alcohol on which she has binged increasingly excessively to blunt her distress. The causes of her distress are multi-factorial but include the treatment for her anorexia itself and the removal of her personal autonomy when treated, superimposed upon a background of harmful childhood experiences. Furthermore, when free to make choices, she consciously acts to undo the weight gains achieved in hospital, to the point that her weight falls to a critical level and re-admission to hospital for re-feeding treatment becomes once again necessary. Thus the increasingly predictable and immensely damaging cycle repeats, as it has many times over recent years.

3. Ms X is currently in extremely poor health. She is extraordinarily malnourished, with a body mass index ("BMI") assessed to be in the region of 12.3-12.6 kg/m². She is continuing to consume alcohol to excess; although she does so covertly, it is believed that her consumption is in the region of half a bottle (375mls) of vodka per day, sometimes more. Her current weight and BMI would, in ordinary circumstances, now provoke a further admission to a hospital unit specialising in eating disorders for treatment. The doctors who have treated her in recent years however regard it as "*clinically inappropriate, counter-productive and increasingly unethical*" (Dr. A – see below) to cause her to be admitted for compulsory feeding; their experience reveals that on each recent admission, she has been more and more unwell (as a result of her intervening bingeing on alcohol), and they confidently predict that she will be yet more poorly and fragile now than on previous admissions. Ms X has been on an 'end of life pathway' twice in recent months; indeed, it is said that her physical condition is now so fragile that her life is in imminent danger.

4. The purpose of re-feeding an anorexic patient is to keep that patient alive whilst psychotherapy, talking therapies, can be facilitated in an endeavour to investigate and treat the underlying anorexia; this has been shown over many years not to work for Ms X. So it is that the medical professionals firmly believe that not only would in-patient treatment once again involve painful, invasive and wholly unwelcome procedures for Ms X, but it would be pointless in terms of achieving long-term treatment, and would be likely in their view to intensify her consumption of alcohol

on discharge from hospital, thereby actually increasing her mortality, and accelerating her demise. As it is, the doctors opine that her life expectancy is measured in months.

5. It is against that background, summarised above and more fully discussed below, that application was made on 29 August 2014 by the A NHS Foundation Trust ("the Trust") for declarations that:

   i) It is not in Ms X's best interests to be subject to further compulsory detention and treatment of her anorexia nervosa, whether under the *Mental Health Act 1983* or otherwise, notwithstanding that such treatment may prolong her life.

   ii) It is in her best interests, and shall be lawful, for her treating clinicians not to provide Ms X with nutrition and hydration with which she does not comply.

6. Those declarations are sought in the context of the Trust's contention that Ms X lacks capacity to make a decision as to whether it would be in her best interests to receive treatment for her anorexia.

7. I emphasise that the doctors do not seek authorisation to withhold treatment. Treatment remains on offer for Ms X should she wish to avail herself of it; the doctors hope that she will. This case, tragic in so many ways, is about the lawfulness of not compelling treatment.

8. The only respondent to the application is Ms X herself. She has made known her views (which I have set out below [48]-[51]); in short, she supports the application. Given the expert assessment of incapacity to litigate, she has been represented in the proceedings by her litigation friend, the Official Solicitor, who, having heard and tested the evidence, now does not oppose the application sought.

9. The absence of real opposition to the grant of relief sought by the Trust does not relieve me of the onerous obligation to satisfy myself that I can and should exercise jurisdiction in relation to Ms. X, and to make orders which protect and advance her best interests.

10. For the purposes of determining this case, I received written and oral evidence from:

   i) Dr. A, a consultant psychiatrist and psychotherapist (with specialism in a range of therapies) employed by the Trust, with particular expertise in eating disorders; she has been treating Ms X since 2009;

   ii) Dr. B, a consultant gastroenterologist with a special interest in nutrition and eating disorders, employed by an acute Trust which has also been responsible for providing care to Ms X for several years. Dr. B has cared for Ms X and treated her liver disease since 2010;

   iii) Dr. Tyrone Glover, an expert in eating disorders who has met with the medical and lay protagonists, and has reviewed the majority of the estimated 25-30,000 pages of medical notes (I may add, within a very short space of time, for which I am grateful) in order to advise the court;

   iv) Ms Y, a friend of Ms X – said to be her "*best friend*".

I further received a letter from Ms X herself, which I reproduce in full at [51] of this judgment.

11. The hearing of oral evidence occupied one full day of court time. I took the opportunity overnight to reflect on the material before delivering my decision and an abbreviated form of this judgment. The particular tragedy of the case is that there is a possibility even now that Ms X could live a long and happy life, but that chance is very small indeed – less than 5%. Moreover, I am satisfied that she does not want to die.

Background

12. The outline sketch of Ms X's early life contained in the evidence before me reveals a range of harmful childhood experiences which she suffered while in the care of her parents; she has spoken to professionals and others (although not in detail) of these experiences. It is unnecessary, and I believe unhelpful to Ms X, for me to elaborate further on this aspect of her life here. Her narrative accounts of the highly disordered relationship with her parents is corroborated not just by the descriptions of Ms X's terror (Ms Y described her as 'hysterical') when she has more recently encountered her father, but more significantly – it is thought – by the development of her current illnesses, and her deeply engrained and highly injurious self-harming behaviours. There is little doubt in my mind, as in the minds of the experts, that the traumas of her childhood have left deep wounds which continue to manifest themselves through her psychological disturbance.

13. Ms X first displayed symptoms of anorexia nervosa some 14 years ago. In October 2003 she was referred to secondary services for treatment by her GP, though was prevented from attending by her mother. In the years since then, she has had over 45 admissions to hospital, sometimes for many weeks or even months at a time; she has received treatment (under the provisions of the *Mental Health Act 1983*) at some of the most specialised eating disorder units in the country. She has spent most of the last two years, and five of the first six months of 2014, in hospital.

14. Dr. A describes Ms X thus:

> "*[Ms X] has clear attachment and abandonment related issues from childhood, physical and emotional trauma experience and other suspected but as yet undisclosed trauma. She has poor effective positive coping strategies, has no self-compassion, feels herself unworthy and likely has highly negative core schema (though these have not been formally identified with her). She is intolerant of any emotional experience with active action to avoid the same either through her starvation and/or alcohol use. Her eating disorder and alcohol dependence are in effect barriers to her experiencing emotional experience and without them she is overwhelmed with both activation of these beliefs, thoughts, feelings and emotions and also remembered and re-experienced traumatic material (imagery, physical and sensory, emotional) for which she has no other strategies. If she is unable to use her Eating Disorder to cope or this behaviour is challenged then her alcohol use escalates*."

15. Significantly throughout the last fourteen years she has barely engaged in any psychological counselling (Dr. Glover thought that of the 25,000 pages of notes less

than 20 contained records of any talking therapies). Her opposition to such intervention appears to be entrenched, and long-standing. Ms X told Dr Glover:

> *"I don't like talking about these things. I don't do talking. I have never opened up to therapists and I never will. I don't like it."*

leading him to conclude that:

> *"[Ms X] has repeatedly proved unable or unwilling to engage in such treatment and continues to express the view that she will not engage in "talking treatment". No one can be coerced into psychotherapy and so this avenue is closed and most likely the time for such treatment has long since passed."*

16. He added in oral evidence that Ms X:

> "*…is absolutely clear in her refusal to engage in talking treatment; she says this to everyone; she has no wish for treatment of any nature…. She wants to be left to her own devices.*"

17. Her friend, Ms Y, told me that there is "*not a glimmer of hope*" that she would find the strength or will to open up in therapy.

Anorexia and Alcohol Dependence Syndrome

18. As indicated above, Ms X has suffered from anorexia nervosa for 14 years; it is of a high severity and the symptoms include a morbid fear of being fat, body dysmorphism and an absolute fear of weight gain. For some considerable time, Ms X has engaged in weight reducing behaviours mainly through restricting her dietary intake, regular vomiting and purging. This has inevitably caused physical and metabolic complications due to severe starvation; her strong anorexic drive has made it difficult to engage her therapeutically. More than once her BMI has fallen as low as 11.8kg/m².

19. Dr. Glover is of the view that the roots of Ms X's emotional and psychological disturbance lie buried within her traumatic childhood. He believes that starvation numbs her emotions, and re-feeding arouses them. During periods of re-feeding (and afterwards) Ms X finds her emotional state increasingly unbearable and seeks solace in alcoholic anaesthesia.

20. The *Mental Health Act 1983* has been deployed by the Trust on multiple occasions in the past to authorise compulsory treatment of Ms X for her "*mental disorder*" (anorexia nervosa is considered to be per *section 1(*2*)* a "*disorder or disability of the mind*"). However her treatment for alcohol-related complications has usually only been achieved in response to situations of acute (sometimes life-threatening) crisis, the *Mental Health Act 1983* offering no mechanism for in-patient treatment in this regard (note that "*[d]ependence on alcohol or drugs is not considered to be a disorder of the mind for the purposes of subsection 2 above*": *section 1(3)*).

21. While nutrition is important to address the starvation in one who suffers anorexia (thereby ensuring physical and medical stability), the experts strongly opine that the only effective long-term treatment for anorexia is psychotherapy, to which (if it were

to be effective) Ms X would need to make an urgent, firm and enduring commitment. In the course of such talking therapies, she would, I am advised, need first to resource coping and life skills, and engage with focused work on attachment, compassion and emotion tolerance. In the course of this, she would need to devise strategies for daily life experiences which divert her away from her eating disorder, alcohol, or indeed more drastic forms of self-harm. Once this first stage is complete, she could then progress to specific therapies to address her underlying experiences and traumas; this would then be followed by "*life after chronic illness development work*" (Dr. A). For many years, Ms X has used her eating disorder and alcohol as props to enable her to function; they now are not just props, but represent the very essence of her life. It is apparent to me that lengthy and psychologically challenging work would be required to displace them. The difficulty of this work for a patient with such engrained behaviours, and the personal strength required to complete it, cannot be under-estimated.

22. Periods of 'medical rescue' (i.e. in-patient treatment and re-feeding) do not address the underlying causes of her anorexia, though they have kept Ms X alive and less medically at risk, so providing a window of opportunity for her to engage in therapy. However, history reveals in this case that treatment for her eating disorder causes her to increase her alcohol consumption, thereby raising the risk of an accelerated death from liver failure.

23. Ms X started drinking as a young teenager, and has abused alcohol (and been alcohol dependent) for most of the last nine years. Inevitably, Ms X's abuse of alcohol has taken a considerable toll on her; nearly six years ago, she was admitted to hospital with acute renal failure and liver failure relating to alcohol consumption. In the following year she again suffered liver failure which became multi-organ failure, and caused her to descend into a coma. Two years later again she developed severe liver failure with ascites, jaundice, abnormal clotting of blood, encephalopathy and a variceal haemorrhage. Dr. B has advised that as a consequence of her heavy alcohol intake: "*she has developed cirrhosis of the liver (permanent irreversible liver damage)*" and that this: "*is likely to cause her death*". He says that she has previously developed several complications of the liver disease, although none is said on their own to have been life-threatening, including:

    (a) Bleeding of oesophageal varices;

    (b) Recurrent episodes of encephalopathy, confusion and delirium due to liver failure, which is usually due to alcohol causing inflammation of the liver, or infections;

    (c) Clotting abnormalities

    (d) Fluid retention in her ankles and abdomen;

    (e) Persistent deranged synthetic liver function.

24. Although Ms X has inflicted enormous damage to her liver, Dr B clarified (in a note prepared for the parties in response to specific questions posed jointly by the Official Solicitor and the Trust), that Ms X's liver disease has not progressed past the point of no return; there is potential for recovery such that if she stopped drinking and resumed a proper diet, she might have "*a near normal life expectation*". Each admission to

hospital for treatment of her malnutrition has imposed periods of abstinence, with which there has been associated a level of recovery of liver function; however with each admission over the last year, this level of recovery has been achieved to a lower level. She is now at a higher risk of liver cancer and is likely to have a slightly reduced life expectation from this alone. The chances of her surviving are said to be "*significantly and adversely affected*" by a combination of two significant factors, in Dr. B's opinion:

i) The fact that even amongst those who indicate a desire to stop drinking and engage with all support services, only 10-20% would remain abstinent at the end of the year; and

ii) A good prognostic indicator for recovery from liver disease is good nutrition: "*if she maintains very poor levels of nutrition then she will not be giving her liver the best chance to recover*".

There is, sadly, every reason to believe that Ms X would fail to achieve abstinence, and is highly unlikely to achieve good levels of nutrition.

25. Dr B further gloomily opined:

> "*the 'best' level of liver function we can achieve after each protracted admission (with feed, alcohol abstinence) has lessened indicating her underlying cirrhosis is progressing. This progression will one day lead to a situation where her liver will not recover even with best medical care. At this point she will die.*"

Adding:

> "*It is my belief that if [Ms X] did not have anorexia nervosa she would already have died from a complication of cirrhosis. She is alive today because the Mental Health Act has provided us with an option to treat her anorexia when her BMI drops to a dangerous level. The intermittent admissions have allowed us period of time to break the inexorable cycle of heavy drinking that would otherwise have led to end stage liver failure.*"

Capacity

26. I determine Ms X's capacity to participate in the litigation and make decisions in relation to the subject matter in issue (i.e. the treatment decisions in relation to anorexia) in accordance with the established principles set out in *section 1* of the *Mental Capacity Act 2005*. I approach the issue from the proposition that Ms X "*must be assumed to have capacity unless it is established that [she] lacks capacity*".

27. In this respect, I heard evidence from Dr. A and Dr. Glover. Dr. A (who has regular experience of assessing capacity decisions around nutritional treatment) has been Ms X's clinician for most of the last five years, and has first-hand knowledge of Ms X's symptom-based experiences; she has performed repeated assessments of Ms X in relation to the same, and for the purposes of her report to the court has conducted a detailed assessment of Ms X specifically in relation to her understanding of the issues around her anorexia nervosa. She opined

> "*[Ms X] is able to understand the information provided and on my assessment of her cognitive sate on the 28th August 2014 she was able to retain and feedback to me the information provided to her about the same evidencing both retention and understanding. However due to ongoing severe body dysmorphia, false beliefs about her weight shape and nutritional state and absolute fear of weight gain from her anorexia, she was and is unable to apply the information to herself or believe in the need for it. In addition the absolute fear of weight gain and anxiety induced around the same over rides any loose connection she might have to the information pertaining to herself. The reality and importance of the associated risks including death of her malnourished state are therefore not truly appraised which means she is unable to weigh up the information provided in the decision making process.*
>
> *On this basis [Ms X] is unable to make decisions regarding her nutrition and treatment of her eating disorder, whilst she is able to understand the information around treatment and risks*" (emphasis by underlining added).

28. Dr. Glover went further. Although initially considering that Ms X had the capacity to understand and retain the relevant information, when giving oral evidence he retreated a little from that position, doubting Ms X's ability to 'understand' all of the salient information relevant to the decision. Because Ms X is body dysmorphic she believes she is larger than she is and is unlikely therefore to understand how ill she in fact is. In any event, he was firmly of the view that Ms X was unable to weigh the relevant information (see *section 3(1)(c)*):

> "*…her ability to weigh the decision in the balance is significantly disturbed by her fear of weight gain. This disturbance is sufficient to render [Ms X] incapacitous with respect to these decisions*."

29. Experienced and expert professionals who have assessed her have had no hesitation in reaching that conclusion. On the evidence which I have heard, I am entirely satisfied that Ms X lacks capacity to litigate and to make decisions about her eating disorder.

30. Both Dr. A and Dr. Glover were clear in drawing a distinction between Ms X's capacity to make decisions around her eating disorder (anorexia) and her use of alcohol. They both considered that Ms X was able to understand, retain, and crucially weigh up, the decision around drinking; they felt that her drinking was responsive to events – she appeared to be making choices about when to drink, when to drink more, and when to drink less. In particular, Dr. Glover was of the view that Ms X was able to weigh information such as the calorific content of alcohol, and appeared to be aware of the consequences for her liver functioning of continued abusive drinking, including the prospect that it could kill her; Dr. Glover considered that she may limit her alcohol consumption on occasion for this reason. In short, both doctors considered that she had capacity to make decisions about alcohol and I accept these opinions.

31. It follows that my jurisdiction is limited to making best interests decisions only in relation to the treatment of anorexia nervosa and not in relation to the management or treatment of her alcohol dependence disorder.

Advance Decision to refuse treatment

32. Ms X has made an Advance Decision in relation to future treatment of her liver disease; it is dated 18 June 2014. She has made clear in that document that in relation to liver disease she wishes to refuse the following treatments:

    i) admission to hospital where

        a) she is found unconscious;

        b) acutely confused;

        c) vomiting blood or passing blood per rectum;

        d) intoxicated;

        e) ascites and fluid retention from liver disease.

    ii) cardiopulmonary resuscitation where she has suffered cardiopulmonary arrest "*even if my life is at risk as a result*";

    iii) calling an ambulance in relation to (i) and (ii) "*even if my life is at risk*".

33. This Advance Decision was made in accordance with *section 24* of the *Mental Capacity Act 2005*, and I am satisfied on the evidence is a "*decision made by a person ("P"), after [she] has reached 18 and when [she] has capacity to do so*". It follows that "*at a later time and in such circumstances as [she] may specify, a specified treatment is proposed to be carried out or continued by a person providing health care for him, and at that time [she] lacks capacity to consent to the carrying out or continuation of the treatment, the specified treatment is not to be carried out or continued*".

34. There is no doubt on the evidence that Ms X had mental capacity to make this Advance Decision when she did so; indeed as indicated above ([30]-[31]) she still does have capacity in relation to the matters reflected by the Advance Decision (per *section 25(3) MCA 2005*). This Advance Decision is therefore entitled to the fullest respect: as Lord Goff observed in *Airedale NHS Trust v. Bland* [1993] AC 789 ("*Bland*") at page 864:

> *"…the principle of self-determination requires that respect must be given to the wishes of the patient, so that if an adult patient of sound mind refuses, however unreasonably, to consent to treatment or care by which his life would or might be prolonged, the doctors responsible for his care must give effect to his wishes, even though they do not consider it to be in his best interests to do so."*

35. The Advance Decision is relevant to the issues before me in this limited but not unimportant respect; management of Ms X's inter-related conditions become yet more complex when she has capacity to decide on the treatment (or refusal of treatment) for some, but not, crucially, others. As Dr. A observed:

> "*Treatment of complications related to her liver disease would need to be in line with her current Advance Decision, which we believe was made with capacity,*

> *which notably states she does not wish medical hospital treatment for the same. It will also be extremely difficult to establish which of her physical presentation is related to her liver disease and which to her malnutrition potentially leading to an inadvertent contravention of her capacitous wishes around the treatment of her liver disease in the process.*"

Best interests

36. I am naturally steered to exercise my judgment in this case in a manner which attaches the highest (even if not absolute) priority to the preservation and sanctity of life; this approach corresponds with the obligation imposed on me by common law (see [39] below), by the provisions of *Article 2* of the *European Convention on Human Rights* ("*ECHR*"), and accords with the directive in *section 4(5)* of the *MCA 2005*. I approach the issue conscious of the importance of protecting Ms X's valuable, and I am satisfied in her case a valued, right to life so far as I am able to do so. In applying this principle, I further adopt the guidance set out in the *Mental Capacity Code of Practice paras 5.29–5.36* which confirms that "*all reasonable steps which are in the person's best interests should be taken to prolong their life*" and that there will only be "*a limited number of cases where treatment is futile, overly burdensome to the patient or where there is no prospect of recovery*".

37. Unsurprisingly, therefore, prominent among the arguments marshalled and advanced in this case, in considering Ms X's best interests, has been the contention that I should resist taking any step which would have the effect of foreshortening that life. This is not just a theoretical argument, even though there is in fact no material opposition to the outcome contended for by the applicants (which authorises the Trust not to offer treatment). I was encouraged by Mr. Hallin, through his cross-examination of the medical witnesses, to consider the potential benefits to Ms X of long term in-patient treatment for her anorexia (running into years) with the associated advantage that Ms X would have reduced access to alcohol for such period of treatment, thereby ameliorating her alcohol dependence syndrome. While the medical professionals accepted Mr. Hallin's propositions to some extent, they could not accept that in-patient re-feeding treatment would bring real benefits to Ms X in the long-term unless within that period of treatment she could come to see (for the first time) the benefit of talking therapies. Each regarded that prospect as vanishingly low.

38. None of that takes away from the fact, as I learned from Ms Y in particular, that Ms X retains an interest in life, and has plans for her future – including "*visiting places*", spending time with her beloved grandfather, distance learning, and enjoying music. Moreover, it is apparent from a number of sources that although she does not want to be compelled to receive treatment, Ms X has no wish to die.

39. Consistent with my judicial instinct (described in the first sentence of [36] above), I was of course referred by counsel to dicta from a number of the relevant cases in this field, including, but not limited to, the *Bland* case (above), and the decision of the Supreme Court in *Aintree University Hospital NHS Foundation Trust –v- James* [2013] UKSC 67, [2013] 3 WLR 1299 ("*Aintree*"). In *Aintree*, Baroness Hale interpreted the *Bland* decision thus:

> "*… the focus is on whether it is in the patient's best interests to give the treatment, rather than on whether it is in his best interests to withhold or*

> *withdraw it. If the treatment is not in his best interests, the court will not be able to give its consent on his behalf and it will follow that it will be lawful to withhold or withdraw it. Indeed, it will follow that it will not be lawful to give it. It also follows that (provided of course that they have acted reasonably and without negligence) the clinical team will not be in breach of any duty towards the patient if they withhold or withdraw it.*" (emphasis added by underlining).

40. In the context of the issue of withholding further life sustaining treatment in the context of a patient lacking capacity, Baroness Hale observed that while:

> "*… the starting point is a strong presumption that it is in a person's best interests to stay alive … this is not absolute. There are cases where it will not be in a patient's best interests to receive life-sustaining treatment*" (paragraph 35).

Adding later (paragraph 39):

> *"The most that can be said, therefore, is that in considering the best interests of this particular patient at this particular time, decision-makers must look at his welfare in the widest sense, not just medical but social and psychological; they must consider the nature of the medical treatment in question, what it involves and its prospects of success; they must consider what the outcome of that treatment for the patient is likely to be; they must try and put themselves in the place of the individual patient and ask what his attitude to the treatment is or would be likely to be; and they must consult others who are looking after him or interested in his welfare, in particular for their view of what his attitude would be."*

41. As indicated at [4] above, the medical experts speak with one voice in indicating that the purpose of the re-feeding treatment is to enable Ms X:

i) to gain weight,

ii) more importantly to gain insight into the benefits of psychotherapeutic interventions to address the causes of her illnesses, and then

iii) yet more crucially still, to avail herself of those psychotherapeutic interventions.

Such a hospital admission would impose a considerable restriction on Ms X's liberty, interference with her *Article 8 ECHR* rights, and reduce her quality of life considerably – removing her from the society of the people she holds dear (her friend Ms Y, and her grandfather in particular) to reside in a specialist clinical hospital setting. Relief from the undoubted distress which she would experience in such a setting would not readily be achieved through alcohol (although she has been known to be sufficiently resourceful to obtain alcohol on the ward in hospital in the past), raising a much more grim and real prospect that she would, in that situation, turn to more drastic relief from her torment by attempting to take, or worse still in taking, her own life. This risk is not merely conjectural; the medical records are littered with references to previous overdoses and suicide attempts at times when she has found her situation intolerable. Dr. A, who has known Ms X well for many years, described the

threat of suicide in this situation as "*phenomenal*" adding "*the risk of other behaviours, cutting or hanging, would escalate considerably*".

42. Medical treatment is invariably designed to achieve the protection and preservation of life. But there is a paradox in this case: that if I were to compel treatment, I may (and the doctors argue strongly that I would) be doing no more than facilitating or accelerating the termination of her life. I have no jurisdiction to make 'best interests' decisions about Ms X's drinking; that remains wholly within her power. Any treatment for her anorexia (particularly if that is in-patient and compelled) is likely – on past experience – to provoke subsequent increased, sustained and dangerous alcohol consumption which will (in the medical view) hasten Ms X's death.

43. Any re-feeding treatment would not now, as it never has, address the cause of the anorexia; it would merely serve to prolong life. Dr. A told me (evidence in chief) that:

> "*… bringing her back for treatment keeps her alive but does not treat her; every time we bring her in we distress her, and this then increases her alcohol use; this will shorten her life by increasing her liver disease*"

As indicated above, I am satisfied on the evidence that Ms X has no intention now, as indeed she never has, of accessing – let alone benefiting from - talking therapies.

44. The paradox extends further; all the medical professionals and Ms Y consider that provided Ms X retains her autonomy, she may well access some medical help – even if it is simply of a palliative nature. I accept their view that Ms X is not apparently choosing to seek help for the palliation of her physical symptoms of her liver disease at the moment due to concerns that these be taken as further signs of malnutrition, and so result in her detention in hospital. If Ms X were to be reassured that she would not be force-fed, she would (it is hoped) be more likely to engage in the palliative care process. Dr. A opined (in cross-examination) that:

> "*if left to her own devices, there is some opportunity for engagement. I think it allows for the possibility … if we enforce, we remove the opportunity.*"

I accept this proposition.

45. There are other factors ranged against the compulsion of medical treatment at this stage for Ms X. The very process of admitting Ms X and compelling her re-feeding would be highly traumatic to her; if she were resistant (and there is reason to believe that she would be) this would inevitably require a degree of restraint which would, as it has in the past, cause her considerable distress. Dr. A told me that Ms X remains distressed for hours and days after insertion of the naso-gastric tube. Ms Y reported as follows:

> "*Inserting the naso-gastric tube is a very traumatic experience for [Ms X]. It causes her nose to bleed and it has become infected and sore. I have witnessed occasions whereby [Ms X] has had to be sedated with medication to have the tube inserted. She has also required having her arms held away from her face to prevent her from interfering with the process. Even once the tube has been fitted [Ms X] manages to manipulate the bags of food and the internal end of the tube,*

> *which I understand is dangerous to her health. Other than the physical impact, she is of course emotionally traumatised throughout this process. Once out of hospital, [Ms X] goes over and above her usual means of losing weight to counteract whatever gain she has made in hospital, often resulting in her weight becoming lower than when she was admitted.*"

46. In this respect, *Articles 3* and *8* of the *ECHR* are particularly prominently engaged; repeated forcible feeding over a long period of time against her clearly expressed wishes, most especially with the use of physical restraint, is likely in my judgment to amount to inhuman or degrading treatment, certainly it would amount to a severe interference with her private life and personal autonomy

47. There are additional hazards too. For example, by the combination of liver disease and previous naso-gastric feeding treatments, Ms X now suffers oesophageal varices (varicose veins in the throat). The procedure for inserting the naso-gastric tube to re-feed her now would have to be undertaken in a district hospital, given the potential complications. The chance of rupturing one of the vessels is of the order of 5%; if this were to occur there would need to be urgent treatment to stem the bleeding.

48. In considering Ms. X's best interests, I must (per *section 4(6) MCA 2005*, and so far as "*reasonably ascertainable*") take account of her own wishes and feelings; these have been elicited by a number of professionals in different contexts. Dr. A reports that:

> "*[Ms X] fully agrees with [the application] and has repeatedly requested that we do not detain or forcibly feed her. She informed me that she has in the past contacted a solicitor to enquire about the prospect of making such an application herself. Specifically she does not want assessment or detention under the MHA 1983 in relation to treatment for her anorexia nervosa or any associated enforced nutritional refeeding or weight gain. She is very clear that in her experience the use of the MHA to enforce nutritional treatment serves only to make the situation and experience worse for her, not better. [Ms X] feels that not having the continued threat of MHA detention and treatment will also allow her control and the ability to make decisions about her care plan. Agreeing any medical monitoring and engagement with the team. As stated above she recognises the increased risks this places her at in terms of morbidity and increased mortality, in particular the likely increased progression of her liver disease. She is aware that all aspects of treatment, including admission for re-feeding will continue to be available to her to opt into as she wishes.*"

49. Dr. A ascertained (helpfully for the purposes of *section 4(4) MCA 2005*) that Ms X did not want to instruct her own solicitor. Moreover, she did not wish to be in contact with me, even by telephone, or be part of the process.

50. Dr Glover (the single joint expert) assessed her less than two weeks ago and reported that she:

> *"is aware that she is terminally ill and may die at any time. She does not want to commence re-feeding as she becomes so emotionally distressed that her alcohol consumption increases. This has occurred on every occasion that she has been re-fed.*"

51. On the eve of the hearing Ms X sent the Official Solicitor a letter articulating her views which had been written for my attention; I set it out here in full:

> "*For the attention of the Judge in charge of my case on 11th Sept 2014*
>
> *I [Ms X] (d.o.b.) am writing to express my wishes about my care in the future;*
>
> *I understand the professionals concerns and the effect that this has had on all of them and I do recognise that everyone wants for the best. However I now feel I have had enough of the continual pressure of mental health staff and services [for the last 14 years] and that rather than helping me, it is actually making me worse. It is hard for everyone but there is a lot I can't deal with concerning therapy - it's just not something I have found able to be involved in, it's just too hard. But I am also fully aware that there is support and treatment still available if ever I want it.*
>
> *I am fully aware of what is wrong with my health and the effects of my wish to refuse treatments will have upon it. Whatever time I have left I just want to live each day alongside my granddad and [siblings], who are my world. I want them to know 'me' rather than this illness and to have some nice memories of our time together. I want to be able to look forward each day to doing 'nice' things like some of my hobbies […] and socialising with my friends.*
>
> *This whole journey is mentally and emotionally horrible for everyone. I've got support from my nearest and dearest and that is really all the support I want now and in the future. I can only hope that you really hear what I am saying and what I truly hope can happen.*"

52. I heard evidence from Ms Y, given by telephone from Ms X's home, though (I was told) away from Ms X's earshot. No one in the courtroom, I apprehend, will have been unaffected by what Ms. Y told us, bringing extraordinary wisdom, compassion, objectivity and insight into the current dreadful situation affecting her closest friend. I give weight to this evidence in the best interests determination, pursuant to *section 4(7)* of the *MCA 2005*. Ms Y confirmed her real concern that Ms X:

> "*…may spend the last period of her life detained in hospital under a force-feeding treatment plan that is going to cause her a great deal of physical and emotional stress."*

53. She told me that Ms X would "*in no way*" be agreeable to admission for treatment: "*she cannot cope with it… and is more and more distressed and unable to cope with the admissions*", adding poignantly "*in all honesty, I think she would kill herself.*"

54. Ms Y had spoken separately to other professionals. She had told the Official Solicitor's representative that when Ms X has been admitted to hospital in the past she "*recoils and won't speak or have anything to do with anyone*"; she described how Ms X tolerates what is necessary simply long enough to be discharged.

Best interests: conclusion

55. The medical advice marshalled in this case was in the end unanimous – namely that the relief sought by the Trust would be in Ms X's best interests. I was re-assured by the fact that this view was informed not just by those who know Ms X well (including Dr. A, who had herself discussed the case with a regional consultant and mental health colleagues) but by the independent and jointly instructed expert Dr. Glover who had in turn consulted with a professional colleague at the specialist eating disorder unit at Vincent Square. Dr. Glover's opinion can be summarised in the following extract from his report:

> *"[Ms X] finds her emotional state increasingly unbearable and seeks solace in "alcoholic anaesthesia." This pattern of behaviour has occurred repeatedly and has become entrenched. It is amenable to treatment in psychotherapy which would be of significant duration (1-2 years) and is often a deeply traumatic experience, notwithstanding its beneficial goal. [Ms X] has repeatedly proven unable or unwilling to engage in such treatment and continues to express the view that she will not engage in "talking treatment". No one can be coerced into psychotherapy and so this avenue is closed and, most likely, the time for such treatment has long since passed. [Ms X] has a long established maladaptive, coping strategy involving starvation and alcohol consumption. She has reached the point where her physical condition is so fragile that her life is in imminent danger. I do not believe it is in her best interests to enforce treatment as it is highly unlikely to be beneficial in the long term. Furthermore, there is little chance it will improve her physical condition sufficiently to prolong her life significantly and there is a real possibility that such action could lead to an increase in her alcohol consumption and thus perhaps precipitate a life threatening deterioration."*

56. Dr. Glover comes to this case having previously advised the courts in *A Local Authority v E and Others* [2012] EWHC 1639 (COP) [2012] COPLR 441 ("*Re E*") (Peter Jackson J), and *The NHS Trust v L and Others* [2012] EWHC 2741 (COP) [2013] COPLR 139 ("*Re L*") (Eleanor King J). Inevitably, given the superficial similarities between this case and *Re E* (to a lesser extent *Re L*), Dr. Glover was asked to explain why Ms X's case was different; while emphasising (and I unreservedly accept) that each case is fact and situation-specific he nonetheless drew attention to the following key points, among others:

i) In the case of *Re E*, the chance of successful treatment for E (and "*full recovery*") was considered to be in the region of 20% to 30% (see §72 and 90 of Peter Jackson J's judgment). That prospect could be achieved only by forcible feeding by nasogastric tube under physical or chemical restraint for at least a year (§88 ibid.); in the instant case, Dr Glover, considered that the chance of successful outcome is 5% or less. This would require, in his view, a similar regime to that proposed in E, i.e. forcible feeding, by restraint if necessary, but for a period of up to two years; he added "*there is a 95-98% chance that she will spend a miserable time being forcibly fed before she then dies*";

ii) In *Re E*, Dr. Glover considered that "*treatment which might return E to relatively normal life is available but has not so far been tried, and that she*

should receive it" (§38 ibid.). There was a specialist eating disorders unit prepared to undertake the treatment. In this case, Ms X has been successfully treated in the past, but has then relapsed; there is no untried treatment in this case – all treatments have been offered and failed;

iii) The situation of Ms X was not as dire as the situation of Ms L. In Ms L's case the medical opinion was that the course of action proposed had a 'close to' 100% likelihood of causing Ms L's death; survival would in the view of the experts lead to serious adverse physical and psychological consequences for Ms L. No patient with a BMI of 7 kg/m² (Ms L's BMI) was reported to have survived such an enforced re-feeding regime whilst in intensive care.

57. I note that the factor identified in [56(ii)] above was key to Peter Jackson J's final analysis – see (§138 ibid.: "*the nature of the treatment is different to anything E has previously been offered*"). Moreover, it should be noted that treatment of Ms E was said to be "*a gargantuan task*" in order "*to take her from where she is now to where we want to go*" (Dr. Glover § 98). Dr. Glover told us that some 2 years after that decision, Ms E is still an in-patient receiving treatment.

Conclusion

58. This is an unusual and desperately sad case. I believe that I speak for all those who have had to grapple with the issues – medical professionals and lawyers alike – in expressing the hope that Ms X does indeed access some medical treatments which will have the effect of prolonging her life. I have, faithful to the guidance offered by Baroness Hale in the *Aintree* case, considered the welfare of Ms X "*in the widest sense*"; I have reflected on what treatment would mean for her, not just medically but socially and psychologically. So far as I can do so, I have endeavoured to put myself in the place of Ms X, and guided by what she has directly told me and others, I have considered what her attitude to the treatment is or would be likely to be. Having fully reviewed the circumstances of this case, and for the reasons discussed above, I have reached the clear conclusion that I should not compel treatment for Ms X's anorexia.

59. I hope that Ms X will nonetheless realise that it would be of enormous benefit to her to access treatments (at least in the form of palliative care, nursing support and dietetic guidance) which may improve the quality of the limited life she has left to her, if not to render more dignified its passing.

60. By order made on 12 September 2014, supported at that stage by an outline of the reasons which I have set out more fully in this judgment, I granted the relief sought by the applicant Trust, set out in [5] above.

61. That is my judgment.