Neutral Citation Number: [2024] EWCA Civ 572

Case No: CA-2024-000781 & CA-2024-000787

IN THE COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM THE COURT OF PROTECTION
Mr Justice Poole
Case No. 13236134

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 23 May 2024

Before :

LORD JUSTICE UNDERHILL
(Vice-President of the Court of Appeal (Civil Division))

LORD JUSTICE PETER JACKSON
and
LADY JUSTICE NICOLA DAVIES

- -

Between:

(1) A LOCAL AUTHORITY	**1st Appellant**
(2) A (By her Litigation Friend, The Official Solicitor)	**2nd Appellant**
- and –	
(1) B	**1st Respondent**
(2) THE HOSPITAL TRUST	**2nd Respondent**

Re A (Covert Medication: Residence)

- -
- -

Katie Gollop KC (instructed by the **Local Authority**) for the **First Appellant**
Sam Karim KC (instructed by **David Auld & Co**) for the **Second Appellant**
Mike O'Brien KC (instructed by the **Thaliwal & Veja Solicitors**) for the **First Respondent**
Joseph O'Brien KC (instructed by the **Sintons LLP**) for the **Second Respondent**

Hearing date: 30 April 2024

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Approved Judgment

This judgment was handed down remotely at 10.30am on 23 May 2024 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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Lord Justice Peter Jackson:

Introduction

1. These are appeals by the First Appellant local authority ('the LA') and by the Second Appellant, the Official Solicitor ('the OS'), from a decision of Mr Justice Poole ('the judge') sitting in the Court of Protection, as contained in a judgment handed down on 20 March 2024 and an order of 10 April 2024. It is a best interests decision under the Mental Capacity Act 2005 ('the MCA 2005') in relation to A, a 25-year-old woman who lacks capacity to make decisions about her residence, care, contact and medical treatment.

2. The Appellants challenge final declarations under section 15 MCA 2005 that it is in A's best interests:

   (1) to cease to be given covert medication ('CM'),

   (2) to be informed that she has been covertly medicated, and

   (3) to leave her current care home ('Placement A'), where she has been living for five years, and to return to live with her mother, the First Respondent B.

3. The judge fixed a one-day hearing on 18 April at which the detailed arrangements for the planning and timing of A's change of residence, the cessation of CM, and the informing of A were to be determined, but that was postponed to await our decision.

4. The appeals, which concern the substance of the judge's decision and the fairness of the process by which he reached it, are supported by the Second Respondent NHS Trust ('the Trust'), which delivers A's medical care. They are opposed by A's mother, B.

5. The judge directed that there shall be no identification of A or her family (beyond the fact that they live in the North of England), or of the LA or the Trust, or the medical witness Dr X. That order remains in effect and must be complied with.

6. As will become clear, A's circumstances are extraordinary, and gave rise to a genuinely difficult best interests decision. The statutory term 'best interests' has an inherent optimism, but there are cases where every option is problematic and even the best outcome is troubling. This was just such a case.

The background

7. A was born in 1998. Her parents separated shortly after her first birthday and she was brought up by her mother alone. She was home-schooled by B and has never had any formal education. In 2010, at the age of 11, she was prescribed medication for epilepsy. Aged 15, she was identified by the LA as a child in need but B repeatedly refused to engage with social services. A has a relationship with her maternal grandmother, who lives near to the family home.

8. In September 2017, after B had told a GP that A had been fitting, the GP insisted on calling an ambulance and A was admitted to hospital. The medical staff were concerned at B's resistance to the admission and refusal to let A speak for herself, and at the fact

that A, then 18, had not experienced puberty and was living an isolated life. After two weeks A was discharged home.

The Court of Protection proceedings

9. In April 2018 the LA was driven to issue proceedings in the Court of Protection as a result of B's persistent lack of co-operation with medical and social work professionals. A was assessed to lack capacity and (although B openly disagreed for several years) that has not changed. She was seen by the Trust's endocrinologist, Dr X, who has advised throughout the proceedings.

10. It was by that stage established that A has the following life-long conditions: Mild Learning Disability (IQ 65); Autistic Spectrum Disorder ('ASD') – Asperger's Syndrome; Epilepsy; Primary Ovarian Insufficiency ('POI'); and Vitamin D deficiency. Taken together, these conditions render A an extremely vulnerable person, physically, psychologically and socially.

11. The proceedings in respect of A's best interests have continued for fully six years. Their course is charted in five substantial judgments, the last being the subject of the present appeal:

    a) The Local Authority v A and B [2019] EWCOP 68 Her Honour Judge Moir, 18 June 2019;

    b) Unpublished judgment of Judge Moir, 17 June 2020;

    c) A Local Authority v A and B [2020] EWCOP 76 Judge Moir, 25 September 2020;

    d) Re A (Covert Medication: Closed Proceedings) [2022] EWCOP 44 Poole J, 7 October 2022; and

    e) Re A (Covert Medication: Residence) [2024] EWCOP 19 Poole J, 20 March 2024.

    These uniformly high-quality judgments fully explain the complex sequence of events underlying the judge's present decision. For our purposes it is only necessary to describe the main features.

12. During the first year of the proceedings, when A was at home with B, the LA and the Trust made strenuous efforts to encourage and persuade B to give A the support she needed. These included: (1) accepting A's diagnoses of learning disability, ASD and POI; (2) allowing A to have unobstructed access to medical advice; and (3) supporting A to take Hormone Replacement Therapy ('HRT') to manage her POI and achieve puberty. Those efforts failed. There was also a high level of concern at A's social isolation. She had no social life away from B, no friends of her own, and few independent living skills. Dr X advised that the physical and emotional harm arising from not undergoing puberty were extremely serious but could easily be averted by taking HRT. However, A was refusing HRT and B was saying that she had the capacity to make up her own mind.

13. In these circumstances, on 9 April 2019 by order of HHJ Moir, A was removed from home and moved to Placement A. It is a residential care home for 20-40 year olds with learning difficulties and ASD. Contact between A and B was restricted and supervised.

14. In her first judgment in June 2019, given after a hearing lasting six days, Judge Moir gave this assessment of the reasons for B's response to A's need for HRT:

> "Sadly, I find that B has been so obsessed with her own wishes, views, and fears that she is being blinded to the obvious and risk-free advantages to her daughter of encouraging her to undergo the treatment and has, instead, failed to encourage her daughter to engage with the treatment or has actively dissuaded her daughter from doing so. Thus, the prospect that B will in the future support her daughter and positively encourage her to engage with the treatment must be extremely limited. Sadly, it is difficult to reach any conclusion other than B would prefer A not to "grow up" for want of a better description, that she would prefer A to remain the same, dependent upon her mother, and isolated within her mother's sphere without any outside influence or interference."

Judge Moir described B as having:

> "… a continuing negative influence on A in terms of A's compliance with any care or treatment required. A is now 20 years of age. Her enmeshed relationship with her mother is longstanding and established behaviours will take time to alter and B's influence diminish. A deserves and requires the opportunity to experience life as an independent adult with proper support. Sadly, I find it will not occur if she remains living with her mother at the present time."

The evidence of the consultant psychiatrist was that in order for a package of care to be effectively delivered at home, he would expect B to demonstrate an appreciation and understanding of A's needs and compliance with any plan.

15. Judge Moir's reasonable prediction that B's negative influence on A would diminish with separation and time has sadly been disconfirmed by the events of the last five years. From the outset of her time at Placement A, A refused to join in social activities and began to spend increasing time in her own room, neglecting her hygiene and appearance, and at times refusing to eat and drink or take her epilepsy medication. As this was considered to be in large part due to B's influence, contact was reduced and then suspended entirely in June 2020. Despite this, A still resolutely refused to take HRT and expressed the wish, supported by B, to go home.

16. So it was that the Trust applied in July 2020, in closed proceedings from which B was excluded, for a declaration that it was in A's best interests to be covertly medicated with HRT. Judge Moir granted the application by an order dated 28 September 2020 ('the CM order'). She also ordered that B was not to be told about the order so as to eliminate the risk of her subverting its implementation. CM, which began in December 2020 and continues to this day, involves A being offered HRT tablets by staff on a daily basis, and upon her refusal, the staff administering the tablets by crushing them into A's food, which she eats in her own time. The order was made as a last resort, after a

complete failure to secure A's voluntary acceptance of HRT in the 15 months since it had been declared to be in her best interests. Moreover, as Judge Moir had found, the treatment should have begun five years sooner, namely in 2014.

17. The adoption of a closed procedure inevitably added to the complexity of the proceedings, in that B and her legal representatives were unaware of the CM order. That state of affairs continued for two years, with the authorisation of CM being regularly reviewed at closed hearings. Contact, by telephone only and supervised, was resumed.

18. In April 2022, B issued an application for A to be returned home. It was then established that the administration of HRT had succeeded in its primary goal, in that A had achieved puberty, and in June 2022, the medication was changed to maintenance therapy (administered covertly by the same means). Dr X advised that this should continue. Puberty is irreversible and A will benefit permanently from having achieved it, but without continued maintenance medication she will be at a higher risk of early osteoporosis, fractures and cardiovascular complications. It was considered that A's willingness to socialise had somewhat increased. She had not reacted to the physical changes that she had undergone or expressed curiosity as to what had brought them about.

19. In the summer of 2022, the case was allocated to Poole J following the retirement of Judge Moir. On 15 September 2022, he held a closed hearing and within days delivered a closed judgment in which he reviewed the issues of A's capacity and her best interests in relation to HRT and CM. He found that she continued to lack capacity and that it continued to be in her interests to have HRT. As to CM, he considered it surprising that the process had not so far been discovered and he observed that its continuation was fraught with risk. He came to this conclusion:

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

20. The parties to the closed proceedings were united in their view that if B was informed of the use of CM there was a significant risk that she would find a way to tell A. Nevertheless, having thoroughly analysed the applicable principles and the competing factors at play, the judge determined that B should be informed of the past and ongoing administration of CM, and that she should be subject to an order preventing her from informing A about the CM. These orders, which were not appealed by the closed parties, brought the closed proceedings to an end.

21. At the beginning of the open hearing on 20 September 2022, listed to hear B's application for A's return home, the judge informed B that CM had been administered to A and that she had achieved puberty. The closed evidence, dating back to Judge Moir's CM order, was disclosed to B and her representatives, as was the closed judgment that followed the hearing on 15 September. After some time for reflection, B agreed to her application for A's return home being adjourned. She proposed that her contact with A be restored, that she should seek to persuade A to take HRT, and that upon A doing so, she should return home. The other parties argued for a more cautious approach. After further thorough consideration, the judge arrived at these conclusions, (Part One of this open judgment contained the closed judgment that had been delivered days earlier):

> "62. … Although I have not heard evidence from B and I have not heard her assertions tested in cross-examination, given the previous findings, I treat with considerable caution B's assurance that she would encourage A to take the hormone treatment and would ensure that it was taken if she were to look after A at home. Further, the evidence shows that during telephone contact B has never once made encouraging remarks to A to listen to those giving her healthcare advice or to take the hormone treatment. The lack of encouragement noted by HHJ Moir appears to have continued. Even if B genuinely tried to encourage A to take the medication, A might not necessarily be persuaded. The issue of what information and advice is given to A, by whom and in what circumstances, requires careful and skilled planning. It may be that B has a role to play in that planning and in a transition to open medication, if that is feasible, but she needs to demonstrate by her actions that she will play a positive role and will not create a risk of harm to A, as she has done in the past, in relation to the issue of her health and treatment.
>
> 63. Having considered all the circumstances, the views of B and of those caring for and treating A, and the provisions of s.1 and s.4 of the MCA 2005, in my judgement it is in A's best interests that:
>
> (i) She should continue to be administered hormone treatment. I addressed this in Part One of the judgment. Although she does not consent to the treatment, it is in A's best interests to receive it.
>
> (ii) The covert administration of hormone treatment in accordance with the current covert medication plan should continue. Again I have addressed this in Part One of the judgment. Nothing I have heard in the open proceedings has caused me to change my view.

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

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

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

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

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

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

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

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

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

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

22. The judge made these apposite closing reflections about the course the proceedings had necessarily taken:

> "86. In the present case in 2020 the court was asked to approve a covert medication plan and to do so without the knowledge of the family of the person involved. This was an exceptionally unusual situation for the Court of Protection to consider. Further distinctive features of this case were that the covertly administered medication would bring about obvious physical changes in the person treated and that the treatment would ideally be required to be continued for the rest of her life. Aside from the difficulties that this combination of exceptional features has presented to those caring for A, it has made the management of hearings extremely problematic. Although the Official Solicitor was involved in the closed proceedings representing A's interests, there was in fact no dissenting party and therefore no prospect of oversight by an appellate court. Open proceedings have been held in parallel with closed proceedings but information and material which was highly relevant in open proceedings was withheld from a party, B, and her legal representatives, who did not know that any information or material had been withheld. All this arose from fully reasoned decisions in A's best interests which were given the most anxious consideration. The court's role at these two most recent hearings, as set out in this judgment, has been to chart the best course forward rather than to hold a review into the proceedings to date."

23. Taking stock, the judge's decisions in September 2022 brought the closed proceedings to an end so that B once again had access to all material placed before the court. The judge determined that A's best interests were served by exploring the most effective way of transitioning from covert to open medication and/or ending covert medication in a way that is likely to cause the least harm to A. To give effect to this decision, the judge required the LA and the Trust to draw up a plan for a transition to open medication with A's consent and the informing of A about her medical history.

24. In consequence of the judge's decision in September 2022, general guidance about closed hearings in the Court of Protection was issued on 9 February 2023 by Hayden J, as Vice-President of the court.

25. Returning to the chronology, at the further hearing fixed for 15 November 2022, the judge gave directions about B's application for residence and about CM. Direct closely supervised contact between A and B then resumed at the end of November 2022 after a gap of over two years. It increased in frequency in the following year, with up to three visits a week, though the professionals had increasing concerns about the perceived negative effect of B's influence on A's previous willingness to engage in very limited activity outside the placement.

26. Between January and March 2023, three health promotion sessions were held with the aim of encouraging A to take HRT and accept the diagnosis of POI. At the last of these sessions A was informed that she had experienced puberty, but not that it was the result of CM. A further hearing took place before the judge on 13 March 2023.

27. Between May and July 2023, B attended four planning sessions with professionals ahead of a further session with A to encourage medication uptake, which took place in July 2023. A continued to reject HRT.

28. On 9 October 2023, the judge conducted a further hearing. His order recorded that the work undertaken to date had been unsuccessful in that A continued to say that she did not accept the diagnosis of POI and that she wanted a second opinion from a doctor independent of the NHS. The parties agreed that there was merit in facilitating an independent opinion on diagnosis, treatment, the benefits of HRT and the risks of stopping it. The OS was directed to obtain, by 30 November 2023, a report from an expert, whose identity was to be agreed. The parties further agreed that the most pressing best interests issue continued to be whether A could take her medication voluntarily. Detailed directions were given for a three-day hearing starting on 24 January 2024, described as a "final hearing", to determine:

> "a. A's capacity in the [relevant] domains;
>
> b. A's best interests in relation to maintenance medication;
>
> c. A's best interests in relation to residence, care and contact."

It was agreed that no party was seeking A's return home in the meantime, and that she should continue to receive CM.

29. At a meeting of the multi-disciplinary team ('MDT') on 20 November 2023, it was concluded that there appeared to be three possible options in relation to A's future support, residence and contact:

Option 1: A to remain at Placement A and for CM to continue for an extended period of time, subject to review and agreement by the court.

Option 2: A to remain at Placement A in the short term with CM, but for the LA to identify a supported independent living placement ('SIL'), where CM would or would not continue.

Option 3: A to return to live with B in the family home with or without a support package in place and for CM to stop because, while A would be advised by professionals to take it, she was likely to continue to refuse.

30. A's social worker accepted that the final best interests decision about A's care and residence was a difficult one. She discounted Option 1 because it was not compatible in the long run with A's wish to be nearer to her family home. Despite A's strong preference for Option 3, the social worker advocated Option 2, in the hope that this would give A greater independence and that she could be persuaded to take HRT, that being said to be the ongoing factor of magnetic importance in assessing her best interests.

31. The medication plan that the court had directed to be drawn up in September 2022 was never drawn up. The judge made no finding about why this was, but the LA informed us that the evidence showed that it was because the MDT did not consider that withdrawal of CM was in A's best interests.

32. Despite extensive efforts, the parties were unable to identify an independent endocrinologist, and no further expert could therefore be instructed. In the meantime, Dr X was due to retire and was replaced by Dr K. She visited Placement A on 11 January 2024, but A refused to see her.

33. Also on 11 January, A's solicitor attended on her. The judge described A as having used very clear and colourful language, but that does not fully convey her distressed and abusive presentation as recorded in the attendance note:

> "Sol. How many times are you having contact with mum?
>
> A. Twice a week. (sobbing) I want more time.
>
> Sol. Do you think your mum is encouraging you to take your medication?
>
> A. It's my choice and she knows it so she doesn't push it. I trust my mother.
>
> Sol. You say you trust your mother. She is working with the court and she wants you to take it because she knows it's safe and you need it.
>
> A. She won't force me because it's my body.
>
> Sol. If you trust your mother why won't you trust her and take the medication.
>
> A. I don't know, I guess I'm just nuts, aren't I?
>
> Sol. I don't think you trust your mother.
>
> A. Hey hey HEY I do trust my mother, don't say I don't trust my mother.
>
> Sol. If you trust her you should trust that she wants the best for you.
>
> A. No matter what, I will never believe or trust any of you.
>
> Sol. We have sought you an independent expert to clarify your diagnosis, but will you engage with them.
>
> A. No because I will never trust one of you. Let me go home and I will choose one myself out the phonebook when I am home not someone connected to you.

A. (Sobbing) I'm in hell. It's not that hard to see anyone working with you. I know you will have paid [them] off to say what you want.

Sol. This is not the case A. We are all working together to try and find a conclusion to this.

A. Yeah, rubbing your hands together taking all the money.

A. I want someone I can trust.

Sol. If they give you the same diagnosis will you trust them then?

A. I don't know do I, as long as [they're] not connected to you.

Sol. So a Dr not connected to Dr X giving you the diagnosis wouldn't help?

A. No, I will only listen to someone I find myself from the phone book when I am at home.

Sol. Ok, I will let the Judge know that.

A. I have had enough, shut up.

Sol. Is there anything else you would like to tell the court.

A. Just fucking cork it.

Sol. Ok [A] - as you know the hearing is at the end of this month and I will let you know the outcome. Bye.

A. Just fuck off."

The parties' positions at the start of the January 2024 hearing

34. It is an indicator of the extreme length of the proceedings that the papers before the judge included the 17th statement of the social worker, the 10th statement of B and the 10th statement of the OS's agent. As one of the issues on appeal concerns the fairness of the process, it is necessary to set out the parties' positions in some detail.

35. The LA's opening stance was reflected in these passages from its position statement:

> "62. It appears to the Local Authority, which greatly regrets that we are where we are despite the best endeavours of the many professionals concerned with A's welfare over the past 5-6 years, that the court is faced with a stark choice:
>
> a) In accordance with what A says she wants, A returns to B's home and care, where her welfare is not promoted, the socially deprived life she had before these proceedings re-starts, and medication stops;
>
> or

> b) A remains in the care of the Local Authority, in which case the LA proposes that she moves to an Independent Supported Living Placement ("an ISLP"). Medication could continue. A would have access to all the opportunities that professional care provides. A would have the chance of developing independent living, communication, and relationship skills, and pursuing hobbies and friendships of her own.
>
> 76. After considerable anxious thought and reflection, the Local Authority's view is that moving A to an ISLP where A has contact with B is unlikely to serve any constructive purpose. The lesson from the current placement is that any contact with B causes A to disengage and turn her back on opportunities to make friends, socialise, go on outings and develop skills.
>
> 77. The only way in which an ISLP could provide A with the intended welfare benefits is if A had no contact with B for a significant length of time."
>
> "84. If, after a reasonable trial period, A was still refusing to engage with professionals, not attending to her personal hygiene, refusing to go out, not pursuing any activities or hobbies, not developing her existing or any new skills, not taking up opportunities to form friendships with people her own age, and was simply spending time in bed, on a screen, swearing at staff, then the Local Authority would feel that every reasonable attempt had been made to promote A's welfare and it was time for her to go back to B."

The LA said that it would formulate its final position after hearing the oral evidence.

36. The opening position statement of the OS described the situation as "beleaguered with complexity". It was "finely balanced and requires anxious scrutiny". It was unlikely that A would take HRT voluntarily and if she did not "there is a difficult balancing exercise to decipher whether it is in A's best interests or not to return home without medication."

37. B's opening position was that she was best placed to convince A to take her maintenance medication voluntarily and that this was best done at home. She suggested a trial period of 6/12 weeks at home with CM, while she took the lead in convincing A and getting her to see a doctor she could trust. If the court concluded that CM could not be delivered at home, A should nonetheless be returned home for 6 weeks without CM to see if B could convince A to take HRT voluntarily. The court was invited to consider A being informed about CM, as telling her would reduce the risks associated with her finding out.

38. The opening position of the Trust, in agreement with the LA, was that it was in A's best interests for CM to continue and for her to move to supported living when a placement was found.

The hearing and the parties' final positions

39. Evidence was given on the first day by Dr X, on the second day by B, and on the third day by the social worker. Unfortunately, time was lost for various reasons on the first and third days, with the result that oral submissions could not be made. Because of the difficulty of reassembling four leading counsel at a further hearing, it was agreed by all parties and approved by the judge that closing submissions would be made in writing.

40. It was common ground before the judge, and before us, that the key issue concerned the likelihood of A continuing to take HRT, by CM or otherwise and depending upon where she lived. The judge summarised Dr X's evidence, which he accepted, on the consequences of her not doing so:

> "28. … He advised that A has gone through puberty as a result of the covert medication and that that cannot be reversed. To optimise her health she requires maintenance HRT for the remainder of her life. If she were to stop HRT now then she would experience bleeding. In the short term she would have a significant chance of suffering hot flushes and night sweats – in effect she would be at risk of suffering from menopausal symptoms in her mid-twenties. She might suffer from less stable mood. In the longer term she would be likely to suffer a 20% loss of bone density. This would happen earlier in her life than it does for the great majority of women who experience menopause in middle age. Thus, she would be at risk of fractures earlier in life and, when she was herself older, she would be at increased risk of fractures compared with women of the same age. As a woman undergoing a very early menopause, she would have at least an 88% increased risk of cardio-vascular disease. I asked Dr X about what the absolute risk of cardio-vascular disease would be but he could not answer. Nevertheless, for the purposes of this application, I accept his evidence that a relatively increased risk of 88% is very significant.
>
> 29. Dr X advised that it would be difficult to monitor whether A was taking hormone medication, whether voluntarily or covertly, in the community. Blood tests would only reveal whether hormone medication had been taken in the previous 24 hours. Stopping hormone treatment would result in some loss of bone density even if it were later re-started, but there would certainly be value to A in re-starting at some point in the future even if she stopped taking the treatment now."

The issue of informing A of the CM was also canvassed during the evidence of Dr X, as can be seen at [64], cited below.

41. Through no fault of his own, Dr X had found himself acting as both clinician and expert witness throughout the proceedings. The judge observed that this should be avoided.

42. The court was told of a possibility of A being seen by an independent endocrinologist, Professor Z, but after the hearing that ultimately came to nothing as (amongst other

reasons) the LA was opposed to A travelling to London and Professor Z was not willing to travel to see A.

43. B gave evidence about her intentions if A came home, including the possible ways of delivering CM (which she said she was prepared to allow but was unwilling to administer herself). The judge found her evidence to be evasive and unrealistic in a number of respects.

44. The social worker spoke of A's strong wish to return home, but said that her horizons are so limited by her upbringing that it would be difficult for her to think any other way. She accepted that it was difficult to disentangle the effects of A's learning disability and Asperger's from the consequences of her upbringing and her relationship with B.

45. After the hearing, and before the judge gave his decision, the LA proposed to the other parties that there should be an adjournment to allow for further work by professionals and by A's grandmother, aimed at persuading A to take HRT voluntarily. On advice, B declined to participate in such discussions, preferring to allow the court to reach its decision on the evidence given at the hearing. Accordingly, by the middle of February written submissions running to some 50 pages were filed.

46. The LA's closing submissions (8 February) began in this way:

> "1. The purpose of the January 2024 hearing (as helpfully clarified by the NHS Trust) was to determine B's September 2022 application for declarations that it is in A's best interests immediately to move from her current residential placement with Local Authority care to B's home and B's sole, unsupervised care."

It invited the judge to dismiss that application and to make the following declarations and directions:

> "a) It is in A's best interests to receive endocrine advice and care from Dr K;
>
> b) It is in A's best interests for her next appointment with Dr K to take place at her grandmother's house with her grandmother present, if the grandmother is willing and able to accommodate that;
>
> c) The LA shall commence identification of a suitable independent supported living placement for A;
>
> d) The LA shall undertake, if it is able, an assessment of how it would meet A's needs if she returned to B's home;
>
> e) List a hearing in April at which the court can:
>
> i) be updated about the medication position;
>
> ii) ditto the search for an ISLP;
>
> iii) if A is not taking medication voluntarily there be a decision on whether it is appropriate and in A's best interests for the

> grandmother to be fully informed of the situation with a view to a further attempt at persuasion;
>
> and
>
> iv) perhaps give directions for a final hearing of best interests in relation to residence, care and contact with B."

47. B's closing submissions (8 February) included these passages:

> "2. This is a complex case with many variables in outcome so the Court is invited to make an in principle declarations and determinations about A's best interests. Detailed orders would follow at the next hearing.
>
> 3. B has applied for A to return home for a 12 week trial for the purpose of getting her to agree to take HRT voluntarily."

A draft order was provided that included this provision for a further hearing:

> "11. There shall be an in person final hearing before Mr Justice Poole sitting at the Leeds Family Court with a time estimate of half a day on DATE 2024 to determine:
>
> a. The detailed conditions for A's 12 week trial at home and in particular, the administration of covert medication on a daily basis.
>
> b. When and how A should be told that she has received covert medication now that the court has determined that she should be told this."

48. The Trust's closing submissions (9 February) included these passages:

> "2. As the Court is aware the hearing in January 2024 was listed to determine B's application for A's return home which was first adjourned on 22 April 2022 to September 2022 (when it was again adjourned) and listed for determination by order of 9 October 2023."

The Trust responded:

> "4. In summary, the Trust submits that:
>
> (a) the Court should dismiss B's application and determine that it is not in A's best interests to reside with B in the family home;
>
> (b) that it is in A's best interests to continue to reside at her current placement and to receive care there in accordance with her assessed needs;
>
> (c) that it is A's best interests for an independent supported living placement to be identified;

(d) for the covert medication to continue;

(e) for the injunction orders against B to continue."

49. The OS's closing position (13 February) was that:

"(a) A lacks capacity to make various decisions with a caveat that there be a yearly review…,

(b) It is in A's best interests to continue to receive her maintenance medication and for the same to be administered covertly and managed by Dr K of the Trust,

(c) There should be a review of the maintenance medication within 3 to 6 months…,

(d) B's application for residence should be refused,

(e) It is in A's best interests for an independent supported living placement to be identified by the applicant,

(f) The applicant should consider whether A can have overnight contact with B, and

(g) The current contact regime remain in place until a further hearing."

The OS described the strong advantages of continued medication before observing:

"12. The evidence from Dr X is cogent in terms of A's clinical best interests, however, there needs to be an holistic assessment of A's best interests (as per Lady Hale in *Aintree* [2013] UKSC 67 at [26]), which includes the following considerations:

(a) That the maintenance medication is not life sustaining treatment,

(b) The endocrine treatment of significance, which led to A achieving puberty, is no longer needed,

(c) A is adamant and has been consistent in her desire not to take any such treatment, as recently articulated in the attendance note dated 11 January 2024, and

(d) Some patients who have capacity *may* choose not to have this medication.

13. The balancing exercise is finely balanced.

14. No party seeks to assert that this medication is not in A's best interests. In fact, there appears to be *no* disadvantage of taking the medication, save that it is expressly in contradiction of A's wishes and feelings."

The judge's decision

50. On 20 March 2024, the judge handed down his judgment. He found that it was in A's best interests:

(1) To return home to B's care.

(2) For CM to cease.

(3) For A to be informed that she has been covertly administered HRT, that it has been of benefit to her health, that she has gone through puberty, and that stopping HRT would be harmful to her health, whereas she would benefit from continuing it.

(4) To allow B to try to persuade A to take HRT voluntarily.

(5) For support to A to be provided in the community whilst she lives at home.

51. The 30-page judgment must be read as a whole. It contains summaries of the law and the evidence about which there is, and could be, no complaint. In introduction, the judge made these observations: the feasible options are all fraught with risk and it is difficult to foresee a good outcome for A, whatever the decision; the decision about residence is bound up with the continuation or cessation of CM, and all parties had approached the hearing in that way; and that, at [4]:

> "I have considered whether, without a proposed plan about ending covert medication or informing A that she has been covertly medicated, I can make a decision in her best interest about residence. For the reasons given below I have concluded that I can."

52. The last 13 pages contain the judge's analysis. I will trace the stages of his reasoning.

53. First, he noted that the Option 2 proposal for a SIL placement had not been aired until shortly before the hearing. No placement had been identified and there was no evidence that such a placement would be suitable for A. The choice before the court was therefore between A continuing to live at Placement A, but with exploration of the possibility of moving to a SIL placement at some point, or A returning home to live with B: [44]. B had given plenty of notice of her application for A to return home. The related question of CM had been under active consideration for a long time and in the absence of good reason to the contrary, B's application should be determined on the evidence now available: [45]. The decision about residence was complex and could not be divorced from consideration of the continuation of CM. The need for A to receive hormone treatment was a key reason for removing her from her home: [46].

54. Next, the judge addressed the issues of HRT and CM in considerable detail at [47-64]. He considered the timescale for his decision:

> "59. I have to consider the length of time over which these very serious interferences with A's human rights may continue. Dr X's evidence is that it is in A's medical best interests to continue to receive hormone treatment for the rest of her life. Therefore I have to contemplate the possibility of A being deprived of her liberty, covertly medicated, and separated from her mother whether in a care

> home or in SIL, for the rest of her life. In nearly five years since A was removed from her mother's home no-one has persuaded her to take HRT voluntarily. Even now, it is proposed that further strategies are deployed to try to persuade her. Whilst it is understandable that attempts should continue, in my judgement the time has come to acknowledge that such attempts are unlikely to succeed. A has been remarkably consistent and tenacious in refusing HRT. Nothing that has been attempted - removing her from home, suspending all contact with her mother, providing information and education, building her trust in her carers – has made any difference. It is more in hope than expectation that new strategies are now suggested, even after the close of evidence. I proceed on the basis that if A remains at placement A or within SIL it is likely that she will continue to refuse to take HRT voluntarily. Hence, if undetected by A, covert medication could continue for many years ahead, potentially for the rest of A's life. Now that A has gone through puberty, the rationale for continuing HRT will remain for the foreseeable future. It would be wrong, therefore, to focus only on the next few months. A needs HRT for her health for the rest of her life. If, as I find, A is unlikely ever to agree to take HRT voluntarily, then for so long as she resides in placement A, a similar care home, or in SIL, then a decision has to be made to whether to continue covert medication for the foreseeable future."

55. The only aspect of Dr X's opinion that he did not accept was in relation to whether A should be told about the CM:

> "64. It was suggested by Dr X that a deliberate decision to inform A that she has been covertly medicated would be akin to deliberately stepping on a landmine, and that it might be better to at least try to navigate through the minefield, however difficult that journey may be. Why tell A that she has been covertly medicated when there might be a way to avoid her ever knowing? For a number of reasons I do not agree:
>
> i) It is unrealistic to believe that there is a safe route through the "minefield". It is likely that at some point A is going to discover that she has been covertly medicated. All it takes is for one person to make one mistake on one day.
>
> ii) If so, it would be in A's best interests for her to learn of the covert medication in a managed way.
>
> iii) Potentially the most effective route to the best outcome – A agreeing to take the medication voluntarily – is by being honest with her: she can be told that HRT has been beneficial to her health but it had to be given covertly because she would not agree to it. B did not know A was being covertly medicated until September 2022 but B now agrees with the medical professionals that it is important that A continues to take it so that she can get the full benefit from it."

56. The judge then summarised his conclusions about HRT and CM:

> "65. Given that the decisions about residence and covert medication are so closely interlinked, I need to consider other aspects of the decision on residence before reaching a final conclusion, but to summarise the complex issues discussed above:
>
> i) Continued HRT is beneficial for A's health. Stopping it would cause her to experience bleeding and may cause her to suffer menopausal symptoms. She would lose bone density much earlier in life than she would if she continued with HRT. This would give rise to a risk of earlier fractures. She would be at a very significantly increased risk of cardio-vascular disease. Albeit the most extreme risks to A would be some decades hence if she were to stop HRT now, those risks are of physical disability and even premature death. Her Art 2 and 3 Convention rights are engaged.
>
> ii) A has refused to take HRT voluntarily despite all efforts to educate and persuade her. It is unlikely that whilst she remains at placement A or in SIL she will change her mind.
>
> iii) Continued covert medication with A at placement A or in SIL is feasible.
>
> iv) Continued covert medication with A at home is not feasible in the medium or long term.
>
> v) There is a significant risk that so long as covert medication continues, A will discover that it is taking place.
>
> vi) Serious harm could come to A were she to discover that she is being, or has been, covertly medicated. This harm would probably be more serious were she being cared for in placement A or SIL at the time of such discovery, compared to the harm caused to her were she at home. The harm may be mitigated by informing A of the fact of covert medication in managed circumstances.
>
> vii) Continued covert medication in placement A or SIL would require the deprivation of A's liberty, separation from her mother and regulation of their contact with each other, and would be a significant infringement of A's Art 8 rights;
>
> viii) HRT is a lifelong requirement. Hence, the court has to contemplate the prospect of covert medication being given, and for the consequential deprivation of liberty and other human rights infringements continuing for the foreseeable future.
>
> ix) The medical benefits of HRT are significant but not as significant as they were when authorisation of the covert administration of HRT was given in 2020. A has now gone through puberty, which was the primary goal of the covert treatment, and that cannot be reversed.

> x) The best outcome would be for A to agree to take HRT voluntarily. All attempts to persuade her to do so have failed. The best possible chance of her now agreeing to take HRT is if she is told the truth and if B is involved in telling her – that way she will know that HRT has benefited her, and she will hear that from the person whom she trusts the most. However, it is also possible that upon informing A that she has been covertly medicated, she will lose all remaining trust in healthcare professionals, with adverse consequences for the future management of her various medical conditions."

57. The judge considered the lack of planning for ending CM:

> "66. I have not been provided with any plan for the transition of residence, the ending of covert medication, or the imparting of information to A about covert medication… Approximately 18 months ago I asked for a plan for transition from covert medication. I do not doubt the difficulties of managing that transition but my perception is that the only exit plan from the covert regime is to persuade A to take HRT voluntarily. That plan has not succeeded and there has been no detailed planning for the option of ceasing covert HRT without A agreeing to take HRT voluntarily. The prospect of A not taking HRT at all has not been actively contemplated. If a decision to permit A to return home comes with an acceptance that covert medication would cease, then a plan does need to be made for that transition. There are therefore some uncertainties as to the next steps and I have to consider whether I should make a decision in A's best interests about residence without further evidence and submissions on those next steps."

58. He then made this general observation:

> "67. I note again the Bulletin from the Royal College of Psychiatrists quoted above. Covert medication should be used exceptionally, for severely incapacitated patients, and in the least interventionist way consistent with their best interests. The present case demonstrates the difficulties inherent in using covert medication in the case of an adult who whilst lacking capacity to make decisions about their own treatment, is not severely incapacitous; of using covert medication over a prolonged period; and of having to take additional interventionist measures such as deprivation of liberty, separation from family, suspension of contact, and closed proceedings, to support the covert administration of medication. Before covert medication is begun it should be asked how and when it will end and to plan for that eventuality. In the present case, unless covert medication is to continue for the rest of A's life, it must end, but its ending is laden with complexity and risk."

59. The judge next assessed the relationship between A and B. He found that B was heavily responsible for A's isolation and lack of physical, mental, and social development and that their relationship remains enmeshed. Returning home will expose A to a

substantial risk of harm flowing from the nature of the relationship between her and B. There is nothing to show that B's approach would be different to what it was before. She has no real desire to change and gives no impression of thinking she has done anything wrong: [68-70]. However, the judge continued:

> "71. … I believe that some realism is required – A and B's relationship has been so enmeshed over such a long period, including during A's most formative years, that it is not possible to negate B's influence over her daughter. Suspension of any contact between A and B for a prolonged period did not bring about any significant changes in A's views and attitudes about HRT, about her trust in medical professionals, and about her social engagement. The effect of A and B's relationship on A will persist wherever A resides. The advances that A has made in placement A are, with respect to the staff, relatively minor. Her core behaviours have persisted. Her oppositional behaviour to healthcare and other professionals seems to be deeply entrenched and her unhappiness at being separated from her mother seems to make her dig her heels in even more."

The judge also acknowledged that there is a bond of love between A and B, that A strongly wishes to live with B, and that they share a love for A's grandmother: [72].

60. The judge's final best interests analysis needs, and deserves, to be quoted in full:

> "73. The application before me is for a declaration that it is in A's best interests now to return home to live with her mother. I have to stand back and consider all the circumstances and those matters the court is specifically enjoined to consider by MCA 2005 s4. For the reasons given, I find as follows:
>
> i) Were A to return home it is likely that she would be exposed to the harmful consequences of her enmeshed relationship with her mother. They have a loving relationship but it has previously been antithetical to important aspects of A's health and welfare.
>
> ii) To some extent, A is protected from the adverse consequences of that enmeshed relationship whilst removed from her home and whilst her contact with B is regulated. However the influence of A's relationship with B is very strong and even their separation has not and will not negate all the harmful aspects of it. Furthermore, regulation of contact is a source of stress to A that seems to make her less, rather than more willing to change her attitudes and behaviour.
>
> iii) Separation from B and her home, and the regulation of contact with B, are infringements of A's Art 8 rights and necessitate deprivation of her liberty.
>
> iv) A's strong wish is to return home to live with her mother. I have to take account of the influence of her enmeshed

relationship with B on the expression of A's wishes and feelings. I have to take into account A's lack of capacity to make decisions about residence, care, and contact. However, her wish has been consistently and wholeheartedly expressed ever since she was removed from her mother's care in 2019 and I must have regard to it not least because I have to put myself in A's shoes when considering what is in her best interests.

v) Return home would allow for a more natural relationship between A and B, and between A and her grandmother. It would restore to her the family life with which she was familiar as she grew up and until she was removed in 2019.

vi) Return home would restore A's liberty and give her freedom to make choices about daily activities, including socialisation outside the home. However, that advantage has to be weighed with care because previously, although there were choices available to A, B's influence prevented A from being truly free to make choices for herself.

vii) It is unlikely that A will volunteer to take HRT so long as she remains in placement A or in SIL.

viii) Were A to return home it is possible, albeit unlikely, that she will be persuaded to volunteer to take hormone treatment.

ix) Were A to remain in a placement away from home, covert medication could continue, but its continuation would be a continued infringement of A's autonomy and freedom, and would carry with it the risk of disclosure which could cause significant harm to A, extinguishing all remaining trust in healthcare professionals, and rendering the future provision of treatment and care for her in a care home or SIL setting very problematic.

x) In my judgement, covert medication would be unsustainable in the medium or long term at home, and ought to be stopped on returning home. Stopping medication is likely to raise questions from A which might lead her to learn that she has been covertly medicated in placement A and to lose any remaining trust she has in healthcare professionals.

xi) Were covert HRT to be stopped either at home or in a placement, A would be exposed to all the risks and adverse consequences identified by Dr X. These would be harmful to A's health over her lifetime, but the extent of harm to her is less than it would have been had she never had HRT at all. Covert HRT has brought health benefits to her, some of which are not reversible.

xii) If covert medication is to stop, then it would be better for A's welfare and consistent with supporting her to make autonomous decisions about treatment in the future, to inform her of the fact that she has been covertly medicated, that it has been beneficial to her health, and that it would be best for her health to continue to take it. For that messaging to have any chance of being effective, B ought to be involved in delivering it to A.

74. The risks to A that arise from her relationship with B can be mitigated to some extent by ensuring that carers and social workers are allowed access to A at her home. Furthermore, it is clearly in A's best interests to take steps to ensure that she has access to medical assessment and advice when needed. These protective measures can be included within the plan for her future care and treatment. A will be very likely to continue to lack capacity to make decisions about her care and treatment, and so decisions will have to be made in her best interests even if she were to reside at home.

75. In short, the positive consequences of allowing B's application for A to return home are that it would meet A's strong wishes, end the continued deprivation of her liberty, end the serious infringement of her autonomy by terminating covert medication, end the regulation of her contact with her mother, and restore full respect for her family and private life. A would be very happy to be returning home. The negative consequences would be that she would be returning, without the protection that separation can provide, to an enmeshed relationship that has caused her significant harm in the past and is likely to expose her to the risk of harm in the future. It would not be practicable to administer HRT covertly and she would be unlikely to volunteer to take HRT. Hence, she would be exposed to the consequences of an early menopause and to significant risks of physical harm over the course of her life.

76. Keeping A in placement A with the possibility of a move to SIL, would allow covert medication to continue with consequential benefits to her health, but only for so long as A does not know that she is being covertly medicated. It would allow some protection to her from some of the harmful aspects of her enmeshed relationship with B and allow for continued educational and therapeutic work. On the other hand, A's behaviour and attitudes have not changed significantly even after nearly five years removed from home and after a prolonged period of suspended contact with her mother. She is being deprived of her liberty and prevented from enjoying a private and family life. She is being medicated against her will. Her wishes are not being met and that is upsetting to her. She has already benefitted from HRT medication and has gone through puberty – a process that cannot be reversed even if HRT ceased.

77. I have to have regard to all the circumstances. No-one can predict the future and there are many uncertainties in the present case. I take

into account A's wishes and feelings and the views as to her best interests of B and of those who presently care for A. B considers it to be in A's best interests to return home. I do not have evidence from every person caring for B at placement A but I proceed on the basis that they align themselves with the Local Authority's position that it is in A's best interests to remain in her placement with the possibility of a move to SIL. The Official Solicitor supports the Local Authority's position.

78. A was removed from her home nearly five years ago. The main reasons for her removal, and the subsequent suspension of contact with her mother, were the damaging effects of the enmeshed relationship between her and her mother, and her refusal to accept hormone treatment, which was considered to be aided and abetted by her mother. Of those, at the time when the decision was taken, it was the refusal to accept treatment that was described by Mr Karim KC for the Official Solicitor as of "magnetic importance". A continues to wish to return home and she continues to refuse hormone treatment. Her behaviour and attitudes have not significantly changed over those five years. I am concerned that the rationale for keeping her away from home, depriving her of her liberty, and medicating her without her knowledge and consent, will still be put forward in another five years from now, and indeed for the foreseeable future. A is unlikely to change in her refusal to accept HRT and so neither will the rationale for depriving her of her liberty.

79. The covert administration of HRT has brought benefits for A which are largely irreversible. Stopping HRT will be detrimental to her health but comparatively less detrimental than had she never been treated at all. Continuing covert HRT is fraught with risk. In my judgement, on balance, the continuation of covert medication is not in itself a sufficient justification, in A's best interests, for continuing to deprive her of her liberty, for overriding her autonomy, and for keeping her away from her home. Returning A home might allow B to persuade her to take HRT voluntarily. I doubt that that will happen, but it is at least a possibility and in my judgement the chances of A taking medication voluntarily are slightly higher if she is returned home than they are if she remains in a placement.

80. The relationship between A and B is deeply troubling and has caused significant harm to A, but her relationship with B and with her grandmother is the family life that A knows and to which she strongly wants to return. Some measures can be taken, in A's best interests to try to protect her from the most harmful aspects of her relationship with B, but it must be accepted that returning A home will remove a layer of protection that she has benefited from within the placement. However, if A's enmeshed relationship with B prevents it being in her best interests now to reside at home, it is unlikely that it will ever be in her best interests to reside at home. It is difficult to see how their relationship will change. Hence, if A does

> not return home now, she may very well be accommodated away from home, separated from her mother, against her strong wishes, for the foreseeable future. The influence B has over A has apparently survived all attempts to dismantle it over the past few years. It is entrenched and cannot be wished away. Realistically, it is too late now to try to undo the all the harmful effects of the relationship. The best that can be done is to try to mitigate them in the future.
>
> 81. The measures that have been taken, in A's best interests, to counter the influence of her enmeshed relationship with her mother, could hardly have been more extreme, but they have not succeeded. Covert medication has succeeded in allowing A to achieve puberty, which has supported her right to develop into adulthood. However, separation from her home and her mother has not had other significant benefits in terms of her development and independence. Were it not for the opportunity to administer HRT covertly, which placement of A in a care home provides, I do not believe that it could reasonably be argued that her continued separation from her home and family life could be justified as being in her best interests."

61. At [82], the judge then stated his conclusions as to best interests, as outlined above. He acknowledged that he was departing from the positions taken by the professional parties, but said that the court had to put itself in A's shoes and make a decision about what was best for her, taking into account, so far as practicable, her individual characteristics, likes and dislikes, values and approach to life. He concluded:

> "84. The assessment of best interests in this case is complex. Whatever decision is made, or if no decision is made, there will be both positive and negative consequences for A. I acknowledge the risk that my determination of A's best interests will result in her returning home to an unhealthy relationship and will expose her to the harmful consequences of ceasing HRT. However, those risks are outweighed by the benefits of ending the deprivation of A's liberty and the serious interference with her Art 8 rights, and of avoiding the risk of an unmanaged disclosure to her of the covert administration of HRT. The Court is enjoined to seek to achieve purposes "in a way that is less restrictive of the person's rights and freedom of action" (MCA 2005 s1(6)). Here, severe restrictions have been imposed in order to achieve the benefit of medical treatment. Now, the continuing and remaining benefits of treatment are not sufficient to justify the continued restrictions."

62. Finally, the judge addressed the steps that were necessary to implement his decision:

> "85. A's transition home should not happen immediately but will require some planning to ensure that it is done in a way that meets her best interests. The plan for a transition home will need to consider whether there should be an introductory period where A stays for a single night, say, before returning to placement A. Or will A find that very difficult? Should A's grandmother be told of the use of covert medication? What arrangements should be in place to

> ensure that healthcare professionals have adequate access to A? What information should be given to A, when and by whom? On the evidence I have received, it seems to me to be in A's best interests for information to be given to A in the following sequence: (i) that the plan is to return her home to live with her mother (this is what she has said she wishes but her continued wish to go home can be checked at this point); (ii) that she has been covertly medicated with HRT, and that this has caused her to go through puberty and to become a physically mature woman with many benefits to her health; (iii) that HRT will no longer be given to her covertly; (iv) what symptoms A is likely to experience now that HRT has stopped; then (v) that it would be greatly beneficial to A to choose to take HRT voluntarily (B should be involved in seeking to persuade her to do so). It will be necessary to go through stages (ii) to (v) as and when covert medication is stopped. Stage (v) may involve providing information to A over a sustained period with the involvement of her mother, perhaps her grandmother, and perhaps Professor Z.
>
> 86. Steps to return her home and to provide her with information need to be planned but I should make clear that A's return home should not be contingent on her volunteering to accept HRT – it should take place, in her best interests, whether or not she volunteers to accept HRT.
>
> 87. Clearly these steps and the transition to care at home will require careful planning, but I have not received a transition plan and I have not received evidence on the details of any such transition. Having considered all the circumstances, I do not regard the decisions set out at paragraph 82 above as being contingent on the approval of a transition plan. Nevertheless, planning for the transition home and the provision of information to A is now required, and with some expedition.
>
> 88. Accordingly, I shall give directions for the parties to provide evidence to the court as to the planning for A's return home, the cessation of covert medication, and the provision of information to her. The planning must include arrangements for providing access to A by healthcare professionals and the administration of her anti-epilepsy and vitamin D medication, as well as any provision of HRT tablets for her to decide whether to take. These plans are not directed as to whether A should return home but to how that can be managed in her best interests. I shall conduct a further hearing at which such plans can be considered by the court and the timing of a return home approved. That hearing shall be on 18 April 2024 and I anticipate that A will be returned home shortly after that hearing."

63. At the hearing on 20 March 2024, the LA sought permission to appeal which was refused by the judge. Permission was granted by Baker LJ on 17 April 2024. From A's point of view the situation remains as it was before the judge's decision, though B is of course aware of the decision and the appeal.

The appeal

64. The LA and the OS, supported by the Trust, advance eight grounds of appeal. Grounds 1 and 2 concern the timing and fairness of the decision, while the remaining grounds challenge its substance.

> Grounds 1 and 2 – Timing of the Final Determination of All Issues
>
> 1) The court made a final determination of A's best interests in relation to residence when neither B, nor any other party, sought a final determination of that, or any other, issue.
>
> 2) Further and in the context of Ground 1), the court finally determined all issues in a way that was not in accordance with the relief sought by any party without canvassing its proposed final disposal in circumstances where:
>
> a) oral submissions at the end of the evidence were not possible; and
>
> b) no party's written submissions addressed the question of what, if any, final decisions on residence or any other issue were in A's best interests because there was no application for final disposal of any issue.
>
> Ground 3 – The decision that state actors provided A with protective measures to protect her from harm from B after she returned to live with B was not an available option and/or was unworkable and/or had no real prospect of safeguarding A's health or welfare
>
> 3) The court's final determination of the issues of residence and care were contingent on the LA providing A with "protective measures" that would mitigate the significant harm to which she would be exposed on a return to B. There was no evidence that state-provided protective measures were an available option or, if available, an option that was workable or had a real prospect of being effective in terms of either protecting A from harm or giving effect to her rights and promotion of her welfare.
>
> Grounds 4, 5 and 6: The decisions that A should stop receiving covert medication and be informed that she had been covertly medicated were wrong
>
> 4) The court failed to take into account the unanimous view of A's MDT that it was not in her best interests to be told that she had been or was being covertly medicated and its active contemplation of the option of A stopping taking HRT.
>
> 5) The Court wrongly determined that it was in A's best interests to be told that she had been covertly medicated. In particular, the Court wrongly concluded that it was likely that at some point A was going to discover she had been covertly medicated.

> 6) The judge's finding that "Covert medication should be used exceptionally, for severely incapacitated patients" was wrong and led him into error.
>
> Ground 7: Deprivation of Liberty
>
> 7) The court failed to take into account the fact that the degree of monitoring and supervision that A will need, and that B will impose, on a return to B's house and sole care is likely to meet the Cheshire West test so that she will be deprived of her liberty there.
>
> Ground 8: Prioritisation of Wishes and Feelings over ECHR Arts 2 and 3
>
> 8) The court wrongly, and prematurely, gave final priority to A's wishes and feelings rather than her Art 2 and Art 3 rights.

Grounds 1 and 2: Timing and fairness

65. Ms Katie Gollop KC explained that the LA does not submit that the judge's decision was wrong in all circumstances, and there may come a time when it is right. However, he was wrong to have made this decision without exhausting all other avenues. It was regrettable that the court ran out of time to have heard oral submissions on what the judge was proposing. The parties understood the issue to be as between the proposal supported by the three professional parties and B's application for a trial period at home. No party was suggesting that HRT should cease and no party positively advocated immediate cessation of CM. The decision did not need to be made now and the judge should have canvassed his proposed disposal with the LA and the Trust in advance, since they were to be charged with taking protective measures to facilitate the placement at home. That should have been done by convening a hearing for oral submissions or at least by informing the parties of his intentions and asking for further written submissions. The judge should have adopted the collaborative approach commended by Baker J in *A Local Authority v TZ (No 2)* [2014] EWHC 973 (COP) at [54]. Instead, his approach was not protective of A's rights and was procedurally unfair.

66. For the OS, Mr Sam Karim KC described this as a very difficult and finely balanced best interests determination. A final decision was not appropriate. B had said that she would apologise again to A for her failure to encourage her to take HRT in the past (something she had previously done in September 2023), and Dr X had placed significance on this happening. The judge was wrong to make any final decision before the apology was given. At that point the independent expert that might be identified could seek to persuade A to take HRT voluntarily.

67. For the Trust, Mr Joseph O'Brien KC told us that the parties thought that the issue was about a 12-week trial at home, which the professionals regarded as a flawed plan. It was not perceived that the judge might at this stage make a final order and direct the cessation of CM and A being informed about it. He should have alerted the parties to his intentions. The failure to do so deprived them of the opportunity to provide submissions and evidence. Oral submissions have a value. The court could have considered the views of the MDT, heard argument on the question of A's possible deprivation of liberty ('DOL') at home, and put the Trust and the LA into a position to

show that the protective services they could provide would be inadequate for A's protection. If that procedure had been followed, the judge might have been persuaded of the dangers of a return home. Instead, the decision was rushed and procedurally unfair.

68. For B, Mr Mike O'Brien KC submitted that the case needed direction amidst continued drift. A was living under draconian restrictions, with ongoing breach of her rights of which she was unaware. B's application had been repeatedly adjourned and all attempts to persuade A to take HRT had failed. Despite the direction set by the court in 2022, the other parties had put forward no proposal to end CM and were saying that A must therefore stay in care. The hearing was listed for the big decisions to be taken, and the parties had fair warning of them, as can be seen from the judgment in September 2022, the order in October 2023, and the position statements filed at the outset of the hearing. B had already apologised to A, and both B and A had been asking for an independent second opinion to Dr X's for years. Two members of the MDT gave evidence and the position of the team as a whole was very clear: they regarded B as an unmanageable risk and that was not going to change. B's position on residence was for a trial period, but she had consistently been arguing that A should return home. It was accepted that no one had argued for stopping CM. However, in regard to HRT B had identified four options, three of which involved it continuing, but she also contemplated it stopping during the trial period, as reflected in her closing submissions:

> "Although stopping is the least preferred of B's four options, she thinks it is better than no plan to get A to take HRT voluntarily. The absence of carers would not prevent A returning home to be convinced to take the HRT."

In any case, it is irrelevant that none of the parties recommended the outcome decided by the judge. The Court of Protection must in any event exercise its best interests jurisdiction pursuant to s.4 MCA 2005. The court is under considerable pressure, and it was perfectly proper for the judge to proceed with making a decision as opposed to incurring unnecessary delay by directing another hearing.

69. At the outset of the appeals the Appellants submitted that we should set aside the judge's order and direct a retrial, while accepting that this would cause significant delay. However, on reflection, they submitted at the end of the hearing that the matter could be remitted to the judge himself for further consideration. That would be on the basis that his order would be stayed or set aside and the matter relisted before him for further evidence and submissions so that he could retake the final decision. That might be the same or different, but it would be fully informed.

Ground 3: Protective measures

70. The Appellants argue that the judge's decision was contingent on the LA and the Trust providing A with 'protective measures' that would mitigate the significant harm to which she would be exposed on a return to B's care. There was no evidence that state-provided protective measures were available or would be effective to protect A from harm.

71. Ms Gollop argues that the judge prematurely made a decision about residence without having a full plan before him. She refers to the declaration at paragraph 2c of the judge's order which provides for:

> "A to return to B's home and to B's sole care in accordance with a Return to B With Community Support Plan aimed at providing A with protective measures to mitigate the risks to A that arise from her relationship with B, which Plan will be considered by the Court at a hearing on 18 April 2024;"

She argues that the decision leaves the LA not knowing which harms to focus on. It can do little more than take A out on trips into the community. There is a lack of clarity as to what is expected of the LA and the judgment gives no steer on how plans could be made to work to protect A from the unhealthy relationship with B. That issue could have been considered at the implementation hearing but that would be to put things the wrong way around. Further, there was no evidence before the judge that any safeguards could be sufficiently implemented to protect A from the risk of harm in B's care. Insofar as he was requiring the LA to obtain/supervise/administer/monitor/document compliance with anti-epilepsy and vitamin D medication (and HRT in the unlikely event that A agreed to take it) whilst A is living at home in B's sole care, his decision was one which he did not have the power to make. The LA owes no duty to provide medical support to a person where they are living in the community with a family carer: s.22(1) Care Act 2014.

72. Ms Gollop conceded that the judge's decision might be sustainable if the judge had said that everything had been tried and had failed, and that a return home without HRT was a price worth paying. Instead he made a best interests decision that involved the LA and charged the state with protecting A, an outcome that was neither fish nor fowl.

73. The Trust similarly contends that, as a matter of fairness to it and the LA, the judge was obliged to identify the specific harms that required protective measures and what those measures should include. Only then could the LA and other statutory bodies evaluate whether such measures were available options. Without that information, the plan for a return home, with or without a trial, was inchoate. The judge's failure to engage with the LA, the Trust and the OS about such matters before determining what was in A's best interests, compromised the best interests assessment and failed to ensure that A's fundamental rights were properly addressed.

Ground 4: The view of the MDT

74. The Appellants argue the court failed to take into account the unanimous view of A's MDT that it was not in her best interests to be told about CM or to seek its view on the option of A stopping taking HRT. They note that the MDT is not mentioned in the judgment. The judge was wrong to say that the prospect of A not taking HRT at all had not been actively contemplated, when the MDT had actively contemplated it and reached the unanimous view that it was not in her best interests.

Ground 5: Telling A about CM

75. It is said that the Court wrongly determined that it was in A's best interests to be told about the past CM and that it was likely that at some point A was going to find out.

76. As to the first element, Ms Gollop raised particular objection to the judge's plan for B to be involved in telling A about the CM. She asserted that, by making B a key messenger, the judge promoted her as a figure A can trust, when the truth is that B has harmed A in the past and is a risk to her in the future. A will not understand that B is the reason why CM was necessary. She will be deceived and her trust in health professionals will be damaged by the disclosure. The judgement might have been workable if there was the slightest sign that B had insight into A's best interests, but she does not.

77. Further, the finding that A was likely to discover she had been covertly medicated failed to take account of A's lack of reaction to undergoing puberty, the paucity of individuals who might give the game away, considering A's isolated social situation, and the MDT's robust contingency plan in the eventuality of inadvertent discovery. The risk of B telling A could be controlled by continuing the injunction.

78. The OS agrees that A should have been given more chance to take HRT voluntarily. The sequence should have been: apology, second opinion, final consideration of CM, and only then should a decision on residence have been made. Mr Karim extends this argument to a wider submission that the judge placed insufficient weight on his own extensive findings against B. He should have found that the least restrictive option was to achieve a situation in which A took her medication.

79. Mr Joseph O'Brien KC accepted that the central justification for removing A from home has been the administration of HRT, and that the social situation at home, though unhealthy, would not of itself justify removal. The Trust, also considers the decision premature when no party was seeking to tell A about the CM. It should have been reserved until all options had been exhausted.

80. For B, it is said that there was an increasing risk, appreciated by all parties, that A would find out about CM inadvertently. This challenge to the judge's finding represents a change in the Appellants' position.

Ground 6: Professional guidance

81. It is submitted that the judge misdirected himself at [67] that "covert medication should be used exceptionally, for severely incapacitated persons", and that this led him into error. At [27] he cited a 2020 judgment that had referred to the Psychiatric Bulletin from the Royal College of Psychiatrists, dated 2 January 2018, which detailed the College Statement on Covert Administration of Medicine, in which those words appeared. In fact, the Bulletin dated from 2004, pre-dating the MCA 2005. Since then, there has been guidance from NICE in 2014 and 2017 and from the CQC in November 2022, in each case containing a short reference to CM. None of that guidance suggests that covert medication should only be used for severely incapacitated persons, nor that there should be an end plan for CM before it is begun. The judge's observation suggests that he doubted that A should have been covertly medicated in the first place.

82. For B it is said that the misattribution of a more recent date to the Bulletin is immaterial because the judge attached minimal weight to the guidance. It was no more than an expression of the obligation to take the least interventionist approach, as required by section 6(1) MCA 2005. The claim that the judge doubted the original decision for CM is baffling, as he had repeatedly approved it at earlier hearings.

Ground 7: Deprivation of liberty

83. It is said by the Appellants that the court failed to consider that A will be deprived of liberty in B's care. The judge was wrong at [73vi] to consider that "Return home would restore A's liberty and give her freedom to make choices about daily activities, including socialisation outside the home", when A is likely to require constant supervision. The Trust agrees. A DOL at home was not discussed.

84. B acknowledges that there may be a deprivation of liberty in the community, but there is a qualitative difference between depriving A of her liberty at Placement A and her living at a home where she has wants to be.

Ground 8: Wishes and feelings

85. The Appellants, supported by the Trust, assert that the court wrongly and prematurely prioritised A's wishes and feelings over her Article 2 and 3 rights. It failed to weigh in the round the very significant medical and social risks to A in returning home. The correct and proportionate decision would have been for A to experience independent supported living with the option of no contact with B so as to promote her welfare and ensure the administration of vital medication.

86. The OS submits that A's wishes and feelings are an important factor in the balancing exercise but the judge failed to undertake a full balancing exercise in respect of the competing Articles of the ECHR: 2, 3, 5 and 8. He accepted that Articles 2 and 3 were engaged, but failed to consider the nature of those rights as absolute and as imposing positive obligations on the State. Conversely, Articles 5 and 8 are qualified rights from which derogation may be permissible.

Analysis and conclusion

87. There are two aspects to these appeals: Grounds 1 and 2 concern issues of process, while the remaining grounds relate to issues of substance. Before addressing these aspects in turn, I make five general observations about matters of principle.

88. The first is that A's circumstances are highly abnormal, even in the world of the Court of Protection. As a result of a series of careful best interests decisions she has been taken from her home, separated from her family, and detained against her will in Placement A for five years. She has resolutely rejected HRT, but for well over half of that time she has been taking this significant medication in ignorance. The judge was right at [59] to regard these matters as very serious interferences with A's rights, particularly as the main goal of HRT had been achieved, and to face up to the fact that there was no obvious end in sight to the present state of affairs.

89. The second matter is the length of time that the proceedings have lasted. The overriding objective in rule 1.1 of the Court of Protection Rules 2017 requires the court to deal with a case expeditiously, fairly, proportionately and economically. Rule 1.3, which mandates active case management, requires the court to avoid delay and keep costs down. The burden is always on those arguing for proceedings to be extended, and submissions that the judge's decision was premature or rushed have to be seen in the context of proceedings that had continued since April 2018. Their exceptional length

was bound to influence on the court's approach to case management, including its decision about when a final decision should be made.

90. Third, and relatedly, the Court of Protection exists to make decisions about whether a particular decision or action is in the best interests of the individual. It is not a supervisory court, as confirmed by Baroness Hale, giving the judgment of the Supreme Court in *N v ACCG* [2017] UKSC 22, [2017] AC 549 at [24], in a passage referred to by the judge:

> "…the jurisdiction of the Court of Protection (and for that matter the inherent jurisdiction of the High Court relating to people who lack capacity) is limited to decisions that a person is unable to take for himself. It is not to be equated with the jurisdiction of family courts under the Children Act 1989, to take children away from their families and place them in the care of a local authority, which then acquires parental responsibility for, and numerous statutory duties towards, those children. There is no such thing as a care order in respect of a person of 18 or over. Nor is the jurisdiction to be equated with the wardship jurisdiction of the High Court. Both may have their historical roots in the ancient powers of the Crown as *parens patriae* over people who were then termed infants, idiots and the insane. But the Court of Protection does not become the guardian of an adult who lacks capacity and the adult does not become the ward of the court."

The Court of Protection is not, therefore, A's guardian, and nor are any of the professional parties, whatever duties they may owe her. This should not be forgotten amidst the need for rolling reviews of the 2020 CM order, and the fact that B's application, issued in April 2022, remained undetermined for so long. The Court of Protection has become a fixture in A and B's lives. If that is necessary because the court is for good reason unable to bring its involvement to an end, so be it, but it should not be mistaken for normality. In this connection, I repeat what I said in *Cases A & B (Court of Protection: Delay and Costs)* [2014] EWCOP 48, in a paragraph approved by Sir James Munby P in this court in *N v ACCG* (see *Re MN (Adult)* [2015] EWCA Civ 411, [2016] Fam 87 at [104]):

> "14. Another common driver of delay and expense is the search for the ideal solution, leading to decent but imperfect outcomes being rejected. People with mental capacity do not expect perfect solutions in life, and the requirement in Section 1(5) of the Mental Capacity Act 2005 that *"An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests"* calls for a sensible decision, not the pursuit of perfection."

Here, the court's task was to select the best practical outcome that was realistically available, even though all options were, to say the least, imperfect. It was beyond its powers to eliminate risk or make A's many problems go away.

91. Fourth, while the Court of Protection's role is not supervisory, it is inquisitorial. Subject always to the demands of fairness, the judge was obliged to reach his own

assessment, and he was not limited to choosing between the positions taken up by the parties. The demands of fairness are sensitive to context, and in the present context the parties were entitled to have the opportunity to present evidence and argument about the outcomes that were properly open to the court before a decision was made.

92. Lastly, I repeat that this was a genuinely difficult decision. The case, described by all the parties as very finely balanced, had become stuck. The direction of travel identified by the court in September 2022 had not been advanced. All the professional advice went one way, and A's litigation friend, the OS, was advocating an outcome that was directly contrary to her wishes. The only party who argued for a different outcome, B, had limited credibility and was the subject of justified criticism for her misguided and gravely damaging parenting. A's predicament called for an energetic response from the court, one way or the other. In these circumstances, the well-known statement of Baroness Hale in *In re J (a child)* [2005] UKHL 40, [2006] 1 AC 80 is on point:

> "12. If there is indeed a discretion in which various factors are relevant, the evaluation and balancing of those factors is also a matter for the trial judge. Only if his decision is so plainly wrong that he must have given far too much weight to a particular factor is the appellate court entitled to interfere: see *G v G (Minors: Custody Appeal) [*1985] 1 WLR 647. Too ready an interference by the appellate court, particularly if it always seems to be in the direction of one result rather than the other, risks robbing the trial judge of the discretion entrusted to him by the law. In short, if trial judges are led to believe that, even if they direct themselves impeccably on the law, make findings of fact which are open to them on the evidence, and are careful, as this judge undoubtedly was, in their evaluation and weighing of the relevant factors, their decisions are liable to be overturned unless they reach a particular conclusion, they will come to believe that they do not in fact have any choice or discretion in the matter."

This judge had lengthy experience of A's situation and his judgments show a profound understanding of all aspects of this exceptionally difficult matter. We should therefore pay particular respect to his thorough and considered evaluative decision.

93. Having identified these matters of principle, I can now express my conclusions on the grounds of appeal.

Grounds 1 and 2: procedural fairness

94. These grounds concern the timing and fairness of the judge's decision. The Appellants and the Trust assert that the court was wrong to make a final determination in relation to residence when neither B, nor any other party, sought a final determination of that, or any other, issue (Ground 1), and to make a final decision that was not in accordance with the relief sought by any party without giving the parties the opportunity to make oral or written submissions about the proposed outcome (Ground 2).

95. Although the two grounds are complementary, I start with the complaint about the making of a final order. In my view the assertion about residence is not entirely correct. The Appellants and the Trust were all seeking a final order dismissing B's application:

see paragraphs 46 and 48-49 above. It is true that B was only seeking an interim order, but she was in a weak litigation position and the judge was not constrained by her forensic stance. Even though the professional focus was understandably on the issue of HRT, it is important to remember that from A's perspective the most important matter was her residence. Looking at the history of the litigation as a whole, in my view the issue of her return home was at large and long overdue for decision.

96. As to the submission that no party was seeking that the proceedings should come to an end, I have noted that proceedings should only continue when they need to. Here, the Appellants and the Trust were arguing for yet more time (a) to investigate the possibility of a SIL placement, and (b) to persuade A to take HRT voluntarily. Mr Joseph O'Brien argues that oral argument would have enabled the court to consider the views of the MDT, hear argument on DOL at home, and put the Trust and the LA into a position to persuade the court that the protective services they could provide would be inadequate for A's protection. Mr Karim emphasised the need for B to make another apology to A and for an independent endocrinologist (yet to be identified) to be given the opportunity to change A's mind about HRT. I do not find these submissions persuasive for the reasons given below in relation to grounds 3, 4 and 7.

97. In relation to Ground 1, I therefore conclude that there were strong reasons for the judge to make a final decision in principle, while allowing an opportunity for a discussion of implementation at a subsequent hearing. This was an order that was properly open to him, whether or not the parties expected it, and no party suffered unfairness thereby. The course proposed by the Appellants and the Trust entailed significant and possibly indefinite prolongation of the proceedings with no very promising outcome beyond the beneficial aspects of continued CM in fragile and controversial circumstances.

98. It is further said that the judge should have adopted a collaborative approach to the development of a plan. However, there is a distinction to be drawn between decision-making and implementation. It is a matter for a judge to decide in the individual case whether, at what stage and in what manner the parties should contribute. In this case, the judge cannot be criticised for deciding that he did not need further information from the parties before making the central decision of principle.

99. In my view Ground 2 raises a more substantial issue. I have already observed that the judge was not bound by the parties' positions. However, I do have apprehensions about the course that the proceedings took once it became clear that oral submissions could not be given at the end of the hearing. Although it will often be an efficient use of resources for closing submissions to be made in writing, the process of oral argument can be of considerable value, particularly in a difficult case. Further, it will generally be good practice for the court to alert the parties by one means or another to the fact that it is considering an outcome not positively sought by them, so that they can make submissions about it or even seek to call further evidence. In this case, once the judge contemplated making a different and final order, he would have been well advised to ask the parties to address that in written submissions or to have investigated the possibility of reconvening for oral submissions, perhaps remotely. To that extent I accept Ms Gollop's submissions on this ground. The question for us is whether the judge's failure to take this course rendered the proceedings unfair.

100. The Appellants and the Trust point to the fact that B was only arguing for a trial at home, that no party positively advocated stopping HRT, and that no party proposed that

A should now be told about the CM programme. Again this is true to an extent. No party was advocating cessation of HRT, but B's case was that A should return home on trial, even if that led to temporary cessation.

101. However, I particularly understand the concern expressed about the judge not canvassing further views from the parties before making a decision about telling A about the CM in circumstances where no party positively advocated this and where it might have an adverse impact on her ability to trust professionals. On the other hand, A's mistrust of professionals was ingrained and the argument for controlled disclosure of CM was a powerful one. Further, the judge had flagged up this issue as long ago as September 2022 (see paragraph 21 above) and he found, in my view rightly, that the issues of residence, HRT and CM were bound up with each other. Telling A was also an issue that had featured significantly in the evidence (see paragraph 55 above) and I consider that the judge was entitled to grasp the nettle without hearing further submissions about it. Mr Joseph O'Brien's pithy submission that the judge's solution was "not out in argument" invites an unduly narrow interpretation of what the case has been about. Residence, HRT and CM had been live issues for years and the judge was well aware of the entrenched positions of the parties. It would have been preferable for him to have alerted them in some fashion to the court's intention, but they had extensive opportunities to present evidence and argument about all outcomes that were properly open to the court. The fact is that the judge's view of the case differed from that of the parties. His decision may have surprised experienced advocates, which puts one on inquiry, but that does not of itself render the process unfair. Of particular significance, if further submissions had been invited they would have been a familiar, though no doubt more detailed, rehearsal of arguments that had been exhaustively considered over a lengthy period. Overall, in these particular circumstances the process was not ideal but it was not unfair. I would therefore dismiss these grounds of appeal.

Grounds 3-8: the substance of the judge's decision

102. This aspect of the appeals is more straightforward, and I will address each ground in turn.

103. By Ground 3 the Appellants and the Trust argue that the judge's decision was contingent upon protective measures and that it was premature to make a decision without identifying what the risk of harm to A would be at home or consulting them about what safeguards could be put in place. These arguments are unconvincing. The type of harm that A is likely to suffer at home is well documented. The judge will have had a broad idea of the type of services that were realistically likely to be available to mitigate the harm and he had evidence about this from the social worker at paragraphs 32-48 of her statement of 8 December 2023. The court had ample information upon which to make a decision in principle, without which all progress would have been stymied. The anxiety of the LA and the Trust about A's situation cannot deter the court from reaching its own best interests decision.

104. Ground 4 is that the judge failed to take into account the unanimous view of the MDT. I do not accept this. The position of the MDT was copiously referred to in the evidence and submissions. The social worker's statement alone refers to the MDT almost fifty times and sets out its view with full clarity. The judge devoted eight paragraphs to the evidence of the two most significant members of the MDT. At [83] he acknowledged that he was acting contrary to the professional advice and was therefore taking pains to

explain his reasoning. The submission that he failed to take the professional position of the MDT into account rests entirely on the fact that he did not refer to the team by name. There is no substance to this ground.

105. Ground 5 challenges the judge's decision that A be told about the CM and his finding that she was likely to find out at some point. It was premature to make this decision until all other options were exhausted. I have to some extent dealt with this ground in the procedural context. As to the substance, the judge was entitled to find, after carefully assessing the evidence, that the ability to maintain CM as a secret was fragile and that controlled disclosure was a better course. That was an evaluative finding that was clearly open to him. He rejected the submission that A should not be told because he regarded frankness as offering the best chance of persuading A to take HRT voluntarily: again that was a judgement for him to make. Essentially this ground argues that the judge should have acted more cautiously, but he was entitled to consider that a cautious and highly restrictive approach had repeatedly failed since the summer of 2022.

106. Ground 6 concerns the judge's use of guidance on CM. I agree with the submission of Mr Mike O'Brien that this submission goes nowhere. The judge was not unduly influenced by the guidance or by any misunderstanding about its date and status.

107. Ground 7 is equally insubstantial. The degree of DOL that A experiences at Placement A is markedly greater than she would experience at home because of her strong feelings in the matter. Even assuming she would suffer DOL at home, an analysis of that issue takes the best interests assessment nowhere.

108. Ground 8 argues that the court wrongly and prematurely prioritised A's wishes and feelings over her Article 2 and 3 rights and failed to weigh in the round the harm that would come to her at home. The correct and proportionate course was for her to experience a SIL placement with the option of no contact with B in order to increase her independence and ensure she receives HRT.

109. I reject this wide-ranging submission. The judge scrupulously charted the harm that A had suffered at home and would be likely to experience on a return. He made all allowances in favour of the unidentified SIL placement, including the somewhat improbable possibility of CM continuing there. But he was confronted by the reality that A had entirely rejected Placement A and there was no basis for believing that she would accept any other alternative to going home, particularly if it had to be bolstered by stopping contact with B. The argument about the order of precedence of the various ECHR articles is sterile. What matters is the content of the rights that are engaged, not whether they are absolute or qualified. The judge had to balance A's deep unhappiness and the deception of CM against its significant medium and long term benefits for A's health. Mr Joseph O'Brien was right to accept that A's continued removal from her home could only be defended on the basis of the medical benefits that flowed from it, and that removal on the basis of the severe dysfunction of her home life could not be justified. I agree, particularly where A's life at Placement A is so limited in social terms. This ground also fails.

110. In summary, aside from the procedural issue that impacted only on the final step of the judge's journey, I can find no fault in his overall approach. He grasped the essence of this complex and concerning case and he appreciated that A's situation cried out for a

definitive decision. Wherever she lives she will suffer harm and gain some benefit, and a move home in the face of deep professional scepticism could only take place with a firm judicial lead. The judge might have followed the professional advice, but he explained why he did not. He might have approved a trial at home (though it seems in some respects the worst of all worlds) but he did not do that either. Instead he reached his own conclusion, based on his considered assessment of A's best interests, supported by coherent reasoning. For what it is worth, I find his analysis strongly persuasive. Once he had reached his decision, it was his task to see it through. The provision of a further day's hearing was an appropriate mechanism.

111. If we had allowed the appeal, I can see no alternative to A's entire situation being remitted to another judge. That prospect was so unsatisfactory that it led the Appellants to suggest as a fall-back that we should allow the appeals and remit the matter to the judge to hear oral submissions and to reconsider his decision. Unless the appeals are allowed, this issue does not arise, but I consider the fall-back position, though well-intentioned, would be unprincipled. It would place the judge in the impossible position of being required to reconsider a settled and carefully considered decision.

112. Finally, I record that when permission to appeal was granted, it was noted that this is said to be the first CM case to come before this court. The parties were therefore invited to include submissions about any general guidance that we might consider it appropriate to give. We express our grateful thanks to counsel for the Appellants and the Trust for having responded to this invitation by providing some carefully framed draft guidance. They did so with some diffidence, bearing in mind the complexity of the issue and the variability of the circumstances that may arise, and we are indeed of the clear view that this is not a case in which it is necessary or appropriate for this court to give general guidance.

113. For the reasons given above, I would dismiss the appeals and restore the matter to the judge to conduct the implementation hearing that he directed.

Lady Justice Nicola Davies:

114. I agree.

Lord Justice Underhill:

115. I also agree.
