Neutral Citation Number: [2020] EWCOP 76

COURT OF PROTECTION

Case No: 13236134

Date: 25 September 2020

IN THE MATTER OF: THE MENTAL CAPACITY ACT 2005

Before:

HER HONOUR JUDGE MOIR

(In Private)

Between:

A Local Authority	Applicant
- and -	
(1) A (by her litigation friend, The Official Solicitor)	1st Respondent
(2) B	2nd Respondent
(3) The Hospital Trust	3rd Respondent

REPORTING RESTRICTIONS APPLY

J U D G M E N T

Miss J James-Stadden (instructed by **Legal Services**) appeared on behalf of the **Applicant**
Mr S Karim QC (instructed by **David Auld & Co**) appeared on behalf of the **First Respondent**
The Second Respondent (B) did not appear and was not represented.
Mr J O'Brien (instructed by **Sintons LLP**) appeared on behalf of the **Third Respondent**

This judgment was delivered in private. HHJ Moir having retired, Mr Justice Poole has given leave for this version of the judgment to be published on condition that (irrespective of what is contained in the judgment) in any published version of the judgment the anonymity of A and members of their family must be strictly preserved. A Transparency Order has been made in these proceedings. All persons, including representatives of the media, must ensure that this condition and the Transparency Order are strictly complied with. Failure to do so will be a Contempt of Court.

HHJ MOIR:

1 This application is brought by the NHS Foundation Trust. The application is dated 28 July 2020. It relates to A who was born on 2 October 1998 and so she will be 22 years of age next week.

2 These proceedings have now been ongoing for some considerable time, and I gave a lengthy judgment on 18 June 2019 in which I made various declarations that A lacked capacity, and that it was in her best interests to receive medication in respect of her primary ovarian failure.

3 The court approved the plan that to ensure A's compliance with medication and her social progression that she should move to care home 1. I remind myself that the primary reason for the move to care home 1 was to deal with the unmet health needs, and to promote A's social and personal development. A has a diagnosis of mild learning disability and Asperger's syndrome, and I am satisfied upon the evidence of Dr Ince that she did lack capacity.

4 The matter has been back before the court on 17 June of this year when the court considered issues in relation to contact between A and her mother B, and her maternal grandparents. The present situation is that there is no direct or indirect contact between A and B, but she sees her grandparents, or has seen a grandparent, once in August, and is able to have telephone contact with them, although A herself has not taken up the telephone contact to any great extent.

5 This application is to consider the administration of covert medication in relation to the primary ovarian failure. B has not been informed of this hearing and, indeed, permission was granted on 28 July 2020 that this application should not be served on B. The rationale for the granting of that order was bound up in the detail of the judgment the previous year in which the court recognised the enmeshed nature of the relationship between A and her mother, and the concern is, and was, that if B was informed of this application it would render the application useless in that it would defeat the purpose of the orders sought because of the nature of the relationship and likely reaction of B to being informed that there was a plan that A should receive medication in a covert way.

6 Of course, I am concerned that a party to the litigation is being refused, or kept out of, information relating to the proceedings, and that B is not being given information about significant matters which affect the daughter. I have to be satisfied whether the approach of non-disclosure is both permissible and proportionate. Mr Karim, on behalf of the Official Solicitor, has referred me to a number of cases which are all relevant. In *Re B (Disclosure to Other Parties)* [2001] 2 FLR 1017 the court concluded that:

> "Although R is entitled under Article 6 to a fair trial, and although his right to a fair trial is absolute and cannot be qualified by either the mother's or the children's or, indeed, anybody else's, rights under Article 8 that does not mean that he must necessarily have an absolute and unqualified right to see all the documents. On this aspect of the matter I see nothing in subsequent Convention jurisprudence to cast any doubt on what the House of Lords said in *Re D (Minors) (Adoption Reports: Confidentiality)* [1996] AC 593 64. Although, as I have not acknowledged, the class of cases in which it may be appropriate to restrict the litigant's access to documents is somewhat wider than has hitherto been recognised, it remains a fact in my

> judgment that such cases will remain very much the exception and not the rule. It remains the fact that all such cases require the most anxious, rigorous and vigilant scrutiny."

It goes on to say that no such order should be made unless the situation imperatively demands it. No such order should extend any further than is necessary, and the test at the end of the day is one of strict necessity. I am satisfied that, bearing in mind that that authority, and the other authorities to which I will refer in a moment, that the court is justified in looking at the circumstances in this case as exceptional, and strictly necessary, as disclosure to B will completely undermine the purpose of the application.

7 In *Re A (A Child) (Family Proceedings: Disclosure of Information*) [2012] UKSC 60:

> "Are cases about the future care and upbringing of children any different? The whole purpose of such cases is to protect and promote the welfare of any child or children involved. So there are circumstances in which it is possible for the decision-maker to take into account material which has not been disclosed to the parties."

Clearly, in this case it is argued that the best interests of A require that B does not receive the material and knowledge of the proposals of the Trust and Local Authority. Mr Karim goes on to direct me to *In Re D (Minors) (Adoption Reports: Confidentiality)* [1996] AC 593 in which it is set out:

> "43. … the court should first consider whether disclosure of the material would involve a real possibility of significant harm to the child.
>
> 44. If it would, the court should next consider whether the overall interests of the child would benefit from non-disclosure, weighing on the one hand the interest of the child in having the material properly tested, and on the other both the magnitude of the risk that harm will occur and the gravity of the harm if it does occur.
>
> 45. If the court is satisfied that the interests of the child point towards nondisclosure, the next and final step is for the court to weigh that consideration, and its strength in the circumstances of the case, against the interest of the parent or other party in having an opportunity to see and respond to the material. In the latter regard the court should take into account the importance of the material to the issues in the case."

8 As Mr Karim says in submission to me, the latter part of that reference also includes consideration of best interest. There is no reason why the family cases should not be as relevant within the Court of Protection and, for avoidance of doubt, in *R(C) & Anor* [2015] EWCOP 131 the court said:

> "So, the jurisdiction to refuse disclosure of materials to the parties in children cases is clearly established … Do the same principles apply in cases in the Court of Protection relating to adults? To that question there can, in my judgment, be only one sensible answer: they do."

Thus, there is the jurisprudence to enable me to consider whether or not it is permissible and proportionate that B has not been informed of these proceedings.

9 Mr O'Brien argues the compelling reasons for this, in particular, the fact that B, over a period of time, has placed obstacles in the way of A receiving treatment and that in his submission the court can be satisfied that B will place obstacles in the way of A receiving treatment, in that she would seek to warn, by whatever means, A about the proposed plan.

10 The court, of course, finds uncomfortable the prospect of dealing with such significant and long reaching issues such as covert medication in the absence of B who, of course, has throughout A's life been her carer and with whom A has, as I have referred to, a very close relationship – I referred to it as "an enmeshed relationship", and that is the difficulty, because B has demonstrated throughout these proceedings her reluctance, for whatever reason, to support A in relation to receiving the medical treatment that she should have and, indeed, I have already found her best interests require.

11 The concept of fairness and Article 6 rights have to be part of the court's consideration but I am satisfied that if she was aware of the plan B would seek to subvert the medical treatment. That view is based upon my knowledge of B's approach throughout these proceedings. I found in 2019 although B might say that she accepted the treatment should be undertaken that I had no confidence that she would encourage or support A to take the medication, or keep hospital appointments, and Dr X, consultant endocrinologist (to whom the judgment will refer to as Dr X), in their more recent report in, I think, March 2020, repeated their concerns about B’s approach to A taking any medication. Therefore, I am satisfied that B should not be informed of the plan and therefore it is right that she should not have been notified of this hearing, or play a part within it.

12 I did raise how I would hear any opposing views and was reassured that in this particular case the Official Solicitor was in a position to put before me a balance sheet for my consideration, and Mr O'Brien rightly reminded me that in the circumstances of this case we have two public bodies, namely, the NHS Trust and the Local Authority, both of whom are professionals and take very seriously, as I am certain they do, the right of those persons with whom they are concerned, and their medical needs and interests. So, I have scrutiny by the Trust, by the Local Authority and the approach of the Official Solicitor, in considering the pros and cons of any medical treatment for A. So, having satisfied myself that it is permissible and legitimate to proceed in the absence of B, I now look to the other aspects of the application before me.

13 First, Mr Karim reminds me that I ought to look at whether or not A has capacity to make a decision in relation to medication and whether or not, if she knew about it, she would be willing to take the medication voluntarily. As far as capacity is concerned, Dr Ince gave careful evidence in June last year and, over a period of time prior to giving that evidence, had every opportunity to assess A's capacity, and he concluded that A lacked capacity to conduct the proceedings, and make decisions about medical treatment. There is no reason for me to look at those declarations again. There is no indication that her capacity has changed. The incapacity is due to the borderline mild learning disability and Asperger's Syndrome, and it is clear from Dr Ince's evidence that A is unable to understand, retain or weigh up, the relevant information to make an informed decision pursuant to section 3(1) of the Mental Capacity Act 2005 ("the MCA 2005").

14 A has shown no willingness to take the endocrine medication. She has refused, and has continued to refuse, to take the medication. Therefore, I need to look to the best interests of A. The Local Authority, the Trust and the Official Solicitor on behalf of A, all report that to

take the medication, and necessarily covertly, is in the best interests of A. That decision was made by the court now 15 months ago, and there has been no appeal, therefore no party seeks to persuade the court from the declaration which was made that it is in A's best interests to undergo the medical treatment for primary ovarian failure. The evidence as to that was very carefully considered, and argued, 15 months ago. It is relevant that we are 15 months on because the evidence of Dr X, both then and it continues, is that the delay reduces the efficacy of the treatment.

15 The evidence of Dr X was that there is universal expert consensus that these individuals, namely, those who suffer primary ovarian failure, are deeply unhappy, have not led fulfilling lives, are socially isolated and have major issues of body image and self-esteem. They also said that the delay exacerbates the risks of psychological and social impact, osteoporosis, namely fractures, by not achieving adequate peak bone density, and increased risk of coronary heart disease. The risks are life limiting, and the treatment, Mr Karim reminds me, was categorised as 'life sustaining treatment' given that Dr X was of the view that in the absence of the same A is likely to die.

16 The possibility of delaying the use of covert medication has been considered, although A is now engaging better with the staff at care home 1, and was taking her medication for epilepsy, Mr O'Brien reminds me that those considerations are in a different league to the consideration of taking endocrine medication which A has always been completely against. The issue of delay, therefore, must be considered as against A's best interest. Mr O'Brien also raises the point that there is a window of opportunity, as he puts it, as at the moment B is not having contact, and therefore any physical change in A will not be noted by her. Mr O'Brien asks the question: how long the court can wait in any event? This treatment should have occurred five years ago, and Dr X emphasises the very serious consequences of delay. So, if the treatment is going to take place, it is submitted that now is the golden opportunity to enable the treatment to be given.

17 It is submitted that the only way possible for the medication to be administered is by way of crushed tablets which are to be disguised within the food that A consumes. I look at the balance sheet that Mr Karim has prepared. He sets out the advantages, namely to achieve adulthood via puberty, the possibility of developing her own family, cognitive development and maturity, proportionate independence and personal autonomy, a hundred percent effectiveness, no associated risk, a normal life expectancy, no death by a serious fracture or cardiovascular disease by 30 to 40 years of age, and the fact that covert administration is the least restrictive approach pursuant to the MCA 2005. Each individual advantage was considered and referred to within the judgment of 18 June 2009, and it was found that those advantages added up to the fact that it was in A's best interests to undergo the treatment.

18 The disadvantages which Mr Karim points out are that it is against A's current wishes and, as such, interference with her Article 8 rights. It is against B’s wishes, even though she may articulate that she supports the treatment, it is apparent, as I found previously, that she would not enable it to happen, and the other disadvantage, and one which must be borne carefully in mind is that if A discovers that she has been covertly medicated she may lose trust or confidence with the placement. The latter matter is one which does concern me, and it is one that Mr O'Brien referred to. He set out in his skeleton argument that if there was a problem in this regard, that A's relationship with her carers could be managed by an experienced Social Care Team, and A's refusal to eat and drink would require reassurance that her food and drink is not in any way medicated and could, if necessary, be addressed by A preparing her own meals and drinks herself.

19 Balancing up the advantages and disadvantages it is clear that the advantages far outweigh the disadvantages, and the clear and significant advantages, set against the less concerning disadvantages, tell in favour of the covert medication being administered. In relation to Article 8 of the ECHR, I remind myself that what the court must be looking to do is protect the right to personal development and autonomy of AT, and Article 6(2) of the United Nations Conventions on the Rights of Persons with Disabilities states that:

> ". . . all appropriate measures should be taken all appropriate measures to ensure the full development, advancement and empowerment of women, for the purpose of guaranteeing them the exercise and enjoyment of the human rights and fundamental freedoms set out in the present Convention."

20 Against the background of this case, it is clear that A and B would not willingly facilitate the administration of the medication for the primary ovarian failure, and that without that treatment the future for A will be significantly affected and even possibly life-limiting. If there was another way that the court could be satisfied that this treatment could be undertaken, then that would be considered. But the only mechanism by which the treatment can be administered is covertly. It is unarguable, unassailable, that the treatment is in A's best interests, and having considered the balance sheet it is difficult to see how A's best interests are not served by approving the application of the Trust, supported by the Local Authority and the Official Solicitor, that medication should be administered covertly, and in the circumstances I have set out, I am satisfied that any interference with Article 8 is justified, and is the only way forward to try to achieve what Dr X so graphically described in their oral evidence, and has set out in their written evidence, namely, that A should be given the opportunity to reach maturity and have a happy, fulfilling existence and, therefore, I am satisfied that the application should be granted.

21 I should also say that I have had the opportunity to consider the plan for administering the medication and it seems to me that that plan is practicable, and I approve it.