Neutral Citation Number: [2022] EWCOP 25

Case No: 12975950

COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 23/06/2022

Before:

MR JUSTICE HAYDEN
VICE PRESIDENT OF THE COURT OF PROTECTION

- -

Between:

A NHS Foundation Trust — **Applicant**

- and –

(1) G (by her litigation friend, the Official Solicitor) — **First Respondent**

-and-

(2) LF — **Second Respondent**

-and-

(3) The M CCG — **Third Respondent**

-and-

(4) M
(5) N (as a Litigant in Person) — **Fourth Respondent**

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- -

Ms Debra Powell QC (instructed by **Hill Dickinson**) for the **Applicant and Third Respondent**
Ms Sophia Roper QC (instructed by the **Official Solicitor**) for the **First Respondent**
Mr John McKendrick QC (instructed by **Irwin Mitchell**) for the **Second Respondent**
Ms Nicola Kohn (instructed by **Simpson Millar**) for the **Fourth Respondent**

Hearing dates: 8th – 13th June 2022

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Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

.....

THE HONOURABLE MR JUSTICE HAYDEN

The judge has given leave for this version of the judgment to be published on condition that (irrespective of what is contained in the judgment) in any published version of the judgment the anonymity of the incapacitated person and members of their family must be strictly preserved. All persons, including representatives of the media, must ensure that this condition is strictly complied with. Failure to do so will be a contempt of court.

Mr Justice Hayden:

1. This is an application, brought by the NHS Foundation Trust and the M Care Commissioning Group, seeking injunctive relief surrounding the care plan of G. G is a 27-year-old woman who has been a patient at the Trust's Hospital since May 2008. In December 2021, I delivered a judgment setting out why it is in G's best interests to be transferred to a specialist care home as a 'step down' measure to moving to her parent's care. I was entirely persuaded that the care home provided the most appropriate environment for G and that given that she had spent most of her adolescence and the entirety of her adulthood to date in a children's hospital, an immediate move home would from both a 'medical and safety point of view' be inappropriate. That was the advice given by Dr Andrew Bentley, Consultant in Respiratory and Intensive Care Medicine, and Alison Smith, independent expert Nurse, which reflected the consensus of professional opinion.

2. The December judgment, *[2021] EWCOP 69* requires to be read in conjunction with this one. G suffers from a rare and profound degenerative neurological condition which affects the entirety of her central nervous system. The condition is progressive and is neither receptive to treatment nor amenable to cure. She has significantly outlived her life expectancy. There are two clear reasons for this. Firstly, she has been continuously cared for by expert teams at the Hospital since she was 13 years of age. Secondly, she has had devoted round the clock support and care from her parents. 13 years ago, G's parents, in effect, gave up their lives and moved to live in hospital accommodation in order to support their daughter. They continue to live there, and their daughter remains in hospital. All agree that a hospital environment, particularly a children's hospital, is entirely inappropriate for G. I would go further because it needs to be signalled entirely unambiguously that G's continuing placement in this hospital fails to afford to her the respect for her dignity as an adult that she, like everybody else, is entitled to. Dr B, the Lead Consultant, has told me, once again, at this hearing that it is now more than 8 years since G was deemed fit for discharge.

3. In the face of coherent and compelling medical evidence, the father (LF) who, I am satisfied is the driving force in this couple, objected, at the December hearing, to the removal of G's central venous line. The father's language is suffused with medical terminology, reflecting that he has spent very many hours every day in the hospital for a period of 13 years. The maintenance of the line, in the opinion of two consultants specialising in Paediatric Respiratory Medicine and Long-term ventilation, was potentially dangerous and providing no benefit. It had already been in for far too long and ultimately, I had to authorise its removal in the face of LF's opposition. I do not doubt that LF's resistance to this necessary intervention was driven by his love and concern for his daughter but, it was not a sustainable position and could not be reconciled with her interests. It is also a marker that, for a complexity of reasons, his decision making is not always reliable. Further, until the December hearing, he had been opposing the professional consensus that there should be no further attempt at CPR.

4. At paragraph 63 of the December judgment, I set out how it was that LF's difficult relationship with the treating clinical team had led to confusion surrounding this important facet of her care. The wider medical picture set out in the earlier judgment, particularly G's extremely fragile bones, will immediately indicate why the medical view was both correct and essential. That it had been left uncertain for so long had

seriously compromised G's welfare. I find it necessary to say that which I stated more sensitively in the earlier judgment, these dangers had been created entirely by the father. I said then, and I reiterate now, that the tragedy of LF's behaviour is that it is generated by his love of his daughter. His decision making has become distorted by what strikes me as a visceral panic at any significant change in her circumstances and particularly, his apprehension that his own day to day involvement in his daughter's life may be diminished. It is this that has led to this appalling delay in moving G on from the hospital.

5. By December, it was already clear that the relationship between the hospital and LF was under great strain. However, there appeared to be some very tentative signs of convergence in mutual understanding. In particular, I had been left with the clear impression that both parents had recognised the fact that G is in the later stage of her life. I was told that a 'ceiling of care plan' could be constructed and in place within weeks of the hearing. Certainly, I was not anticipating a time scale beyond 8 weeks. I also took care to emphasise why the step-down arrangements, via the nursing home, were not only desirable but in my analysis, integral to her parents' wishes to care for her at home.

6. Sadly, any apparent resetting of the father/hospital relationship has proved to be entirely illusory. On the contrary, the relationship has now corroded to the point where it has become entirely dysfunctional. It has foundered to such a degree that it, in and of itself, compromises G's welfare. It is now characterised by both mutual distrust and poor, indeed entirely inadequate, communication. This generates fertile ground for confusion and error which jeopardises G's safety and wellbeing.

The legal framework

7. Mr McKendrick QC, acting on behalf of LF, raises preliminary points of law, challenging the jurisdictional basis for the injunctive relief that is sought. Ms Kohn, on behalf of M, supports his submissions. Mr McKendrick also advances arguments relating to the admissibility of hearsay evidence. With respect to his seductive and erudite submissions, I can address the points that have been raised relatively briefly. Firstly, it is contended that Section 16(5) of the Mental Capacity Act 2005 (the MCA) has been erroneously applied in the case law. It is necessary to set out the relevant provisions. Sections 15-17 of the Mental Capacity Act 2005 provide general powers of the Court of Protection, as follows:

> ***Power to make declarations***
>
> *15(1) The court may make declarations as to—*
>
> *(a) whether a person has or lacks capacity to make a decision specified in the declaration;*
>
> *(b) whether a person has or lacks capacity to make decisions on such matters as are described in the declaration;*
>
> *(c) the lawfulness or otherwise of any act done, or yet to be done, in relation to that person.*

(2) "Act" includes an omission and a course of conduct.

Powers to make decisions and appoint deputies: general

16(1) This section applies if a person ("P") lacks capacity in relation to a matter or matters concerning—

(a) P's personal welfare, or

(b) P's property and affairs.

(2) The court may—

(a) by making an order, make the decision or decisions on P's behalf in relation to the matter or matters, or

(b) appoint a person (a "deputy") to make decisions on P's behalf in relation to the matter or matters.

(3) The powers of the court under this section are subject to the provisions of this Act and, in particular, to sections 1 (the principles) and 4 (best interests).

(4) When deciding whether it is in P's best interests to appoint a deputy, the court must have regard (in addition to the matters mentioned in section 4) to the principles that—

(a) a decision by the court is to be preferred to the appointment of a deputy to make a decision, and

(b) the powers conferred on a deputy should be as limited in scope and duration as is reasonably practicable in the circumstances.

(5) The court may make such further orders or give such directions, and confer on a deputy such powers or impose on him such duties, as it thinks necessary or expedient for giving effect to, or otherwise in connection with, an order or appointment made by it under subsection (2).

(6) Without prejudice to section 4, the court may make the order, give the directions or make the appointment on such terms as it considers are in P's best interests, even though no application is before the court for an order, directions or an appointment on those terms.

(7) An order of the court may be varied or discharged by a subsequent order.

(8) The court may, in particular, revoke the appointment of a deputy or vary the powers conferred on him if it is satisfied that the deputy—

> *(a) has behaved, or is behaving, in a way that contravenes the authority conferred on him by the court or is not in P's best interests, or*
>
> *(b) proposes to behave in a way that would contravene that authority or would not be in P's best interests.*
>
> ***Powers: personal welfare***
>
> *17(1) The powers under section 16 as respects P's personal welfare extend in particular to—*
>
> *(a) deciding where P is to live;*
>
> *(b) deciding what contact, if any, P is to have with any specified persons;*
>
> *(c) making an order prohibiting a named person from having contact with P;*
>
> *(d) giving or refusing consent to the carrying out or continuation of a treatment by a person providing health care for P;*
>
> *(e) giving a direction that a person responsible for P's health care allow a different person to take over that responsibility.*
>
> *(2) Subsection (1) is subject to section 20 (restrictions on deputies).*

8. The thrust of Mr McKendrick's argument, again supported by Ms Kohn, centres upon the interpretation to be given to Section 16(5). Whilst he acknowledges that this section enables the court to make such orders as it thinks '*necessary or expedient'*, in giving effect to its orders, Mr McKendrick submits that this applies only in the context of the appointment of deputies. I do not consider this proposition to be sustainable. Firstly, the section expresses two clear and distinct objectives, in its heading: *"Powers to make decisions* ***and*** *Appoint deputies"* (my emphasis. Secondly, it would be entirely illogical to confer wide powers to facilitate the enforcement of orders in the context of the appointment of deputies and not upon the court more generally. Thirdly, when bearing in mind the identified twin objectives, it is plain that the phrase *"and confer on a deputy such powers…"* must be read as complementing the powers given to the Court generally, as captured by the opening phrase *"the court may make such further orders…"*. Fourthly, the provision can only be read with logical integrity if the phrase *"and confer on a deputy…"* is read as a subordinate clause, which is precisely how it is drafted grammatically.

9. Accordingly, I am satisfied that Section 16 and Section 17 of the MCA conjunctively provide an entirely cogent framework for the granting of injunctive relief to give effect to the Court's orders or directions in such cases where it finds it necessary or expedient to do so.

10. Having come to this conclusion, I do not, strictly, have to deal with Mr McKendrick's submission that Section 47(1) of the MCA is not apt to cover restricting behaviours in the context of either a hospital or care home on the basis that those are *"a matter between those family members and the staff employers"*. I regard this as a creative but ambitious submission. Again, I am clear that it cannot be sustained.

11. Section 47(1) provides that:

> *"The court has in connection with its jurisdiction the same powers, rights, privileges and authority as the High Court".*

12. The extent of those powers is set out in Section 37(1) of the Supreme Court Act 1981:

> *"Section 37 (1) of the 1981 Act states:*
>
> *The High Court may by order (whether interlocutory or final) grant an injunction or appoint a receiver in all cases in which it appears to the court to be just and convenient to do so."*

13. An enviably succinct analysis of the applicable principles is set out by Nugee J (as he then was) in *Hollyoake v Candy [2016] EWHC 97 (Ch)* at para. 8:

> *"Rather than discuss all the authorities put before me in turn, I propose to state my own understanding of the principles which apply:*
>
> *(1) Although s. 37 is broad in its terms, it is fallacious to say that it is completely unfettered. This was established very soon after the Judicature Acts, as illustrated by one of the authorities cited by Mr Trace, Day v BrowGigg (1878) 10 Ch D 294 . He cited it for the dictum by Sir George Jessel MR at 307 that "it must be "just" as well as "convenient", but it is apparent that what Sir George Jessel meant by that was that the Court could not grant an injunction whenever it seemed convenient but only in accordance with legal principle.*
>
> *(2) This judgment is not the place to examine the precise limits of the s. 37 power, something that (as appears from the cases referred to in Masri at [176]) is not yet settled at the Supreme Court level. What can be said is that in normal circumstances what is needed to persuade the Court to grant an injunction is a threat to do an act which constitutes an "invasion of a legal or equitable right" – see Maclaine Watson v ITC [1989] 1 Ch 286 at 303C per Kerr LJ, referring to what Lord Diplock had said in the Siskina case [1979] AC 210 at 256D and repeated by him in British Airways Board v Laker Airways Ltd [1985] AC 58 at 81B, and by Lord Brandon in South Carolina Insurance Co v Assurantie Maatschappij "De Zeven Provincien" NV [1987] AC 24 at 40C. The phrase itself can be traced back to the judgment of James LJ in Day v BrowGigg , where he said at 305:*

> *"It appears to me there is no damage alleged, there is no legal right alleged, the violation of which was the cause of damage. That being so, it is not for this Court to say that because somebody is doing something which it thinks not quite right, a thing which ought not to be done by one person to another, it should interfere. This Court can only interfere where there is an invasion of a legal or equitable right."*

14. Mr McKendrick, in his skeleton argument, seeks to extract both from the legislation and from the above authority the following proposition:

> *"The test for injunction in the Court of Protection therefore requires the court to be satisfied that the injunction is 'just and convenient' and not 'necessary or expedient'. How the unfettered nature of the section 37 (1) discretion should be exercised in the Court of Protection is an under-developed. It must however be a discretion exercised in accordance with legal principle - that requires identification of the legal right that is sought to be protected."*

15. With respect to Mr McKendrick, that is misconceived. As Nugee J made clear, when extracting the established principles from the case law, the power extends both to legal and equitable rights. The submission that the scope of Section 37(1) should be confined to *"legal rights"* is unsustainable. Indeed, the language of the provision is itself cast in the lexicon of equitable principles.

16. Turning to Mr McKendrick's submissions in relation to the admissibility of hearsay evidence, it is important to record that, at paragraph 20 below, I set out the hearsay evidence of a number of nurses who did not want to give evidence and who have remained anonymous. For reasons that will become clear, in the body of this judgment, there were sound reasons for this. Mr McKendrick contends that I should afford *"little or no weight"* to this evidence. Moreover, he submits there is no good basis for anonymity. It is argued that to permit *"members of staff"* to conceal their identity on the basis that they feel *"vulnerable or undermined"*, is likely to have, what Mr McKendrick describes as *"a chilling effect on public justice"* which he contends is wrong in principle. I approach this issue by application of the principles in Section 4 of the Civil Evidence Act 1995:

> *" 4.— Considerations relevant to weighing of hearsay evidence.*
>
> *(1) In estimating the weight (if any) to be given to hearsay evidence in civil proceedings the court shall have regard to any circumstances from which any inference can reasonably be drawn as to the reliability or otherwise of the evidence.*
>
> *(2) Regard may be had, in particular, to the following—*
>
> *(a) whether it would have been reasonable and practicable for the party by whom the evidence was adduced to have produced the maker of the original statement as a witness;*

> *(b) whether the original statement was made contemporaneously with the occurrence or existence of the matters stated;*
>
> *(c) whether the evidence involves multiple hearsay;*
>
> *(d) whether any person involved had any motive to conceal or misrepresent matters;*
>
> *(e) whether the original statement was an edited account, or was made in collaboration with another or for a particular purpose;*
>
> *(f) whether the circumstances in which the evidence is adduced as hearsay are such as to suggest an attempt to prevent proper evaluation of its weight."*

17. As I set out in my analysis below, I consider this evidence is not to be evaluated in isolation but requires to be woven into a survey of the broad canvas of available evidence, from which it gathers forensic weight. Similarly, when considering the anonymisation of the nurses, it is necessary to have regard to the broad sweep of the available evidence regarding the ongoing difficulties arising, particularly, from LF's relationship with the nurses and treating clinicians.

Events following the December judgment

18. As I have already indicated, G has not moved to the care home as had been planned. The ceiling of care plan has still not been put in place. G has languished in a hospital environment which I have denounced as contrary to her interests, for a further 6 months. The applicant Trust and the CCG assert that this is, once again, attributable to LF's intransigence. They seek injunctive orders both to implement and secure the placement at the identified nursing home. Ms Powell QC, on behalf of the applicants, submits that LF, his partner, (M) and his mother, (N) have remained fundamentally opposed to the move and have conducted a campaign of resistance to it. It requires to be stated that notwithstanding a great deal of equivocation in the witness box, LF eventually agreed that he was fundamentally opposed to the placement and not merely seeking *"answers to reasonable questions"*, as he had initially maintained.

19. LF's communication with the care home and its broader organisation were selective in the information disclosed, combative and directly opposed to my conclusions in the December judgment. LF's concession was only made when the compelling evidence of his opposition to the placement made his continuing denials of it risible. Thus, the abandoned move to the care home, planned to have taken place on the 8th March 2022, can only be attributed to LF's tactical strategy designed to sabotage it. The strategy was very nearly successful. The senior management wavered in their commitment to offer G a place. They became concerned as to how LF's behaviour might undermine their own ability to care for G and the wider impact on other residents.

20. Ms Powell distils the concerns surrounding LF's behaviour:

> *"a. speaking to clinical staff at the Trust in a hostile and intimidating way and questioning their competence;*
>
> *b. questioning the competence of [the nursing home] staff when they visited [G] at the Hospital;*
>
> *c. writing to [the nursing home] and repeatedly to the Chief Executive of the [lead group] raising numerous alleged criticisms of [the nursing home] and its staff's competence to care for [G];*
>
> *d. causing journalists and a "public relations consultant" to contact the [lead group] to discuss the family's ongoing opposition to the move to [the nursing home]."*

21. (b) and (d) above, I am satisfied are established in evidence, not merely because there can be no sensible alternative construction, but because, as I have foreshadowed above, LF's own eventual concession to his own implacable resistance to the care home amounts effectively to an admission of these allegations. This said, I should emphasise that it was LF's mother who contacted the public relations consultant in order to campaign *"to get [G] home"*.

22. LF, at (a) above, is said to have spoken to the clinical staff in a *"hostile and intimidating"* way and was *"questioning their competence"*. The evidence in support of this is set out in the statement of Nurse T and amplified in her oral evidence before me. Nurse T is a Registered Paediatric Specialist who has worked for over 15 years in Critical Care in the High Dependency Unit (HDU) at the Hospital. She is a clinical nurse manager and acting ward manager (since October 2021). She told me in evidence that many staff had reported feeling undermined and intimidated by LF. So numerous were the complaints that the lead consultant, Dr B, asked Nurse T to investigate the matter. Nurse T had arranged for the Critical Care Psychology team to provide support sessions for anybody who had felt intimidated or vulnerable as a consequence of LF's behaviour. 30 nurses took the offer up. LF appears genuinely to struggle to understand this. He asserts that with one or two exceptions, he gets on very well with the nursing staff.

23. Given that G remains in the HDU and the nurses continue to care for her, they have been anonymised. At risk at over burdening this judgment, but in order to achieve context, it is necessary to set them out in full as Nurse T has done in her report. The emphasis below is mine.

24. Approximately two weeks ago when walking along the corridor Nurse A engaged in a conversation with LF who was returning to the unit after a day out with G. She started by saying *"hi"* to G and said how lovely she looked in her pink outfit. She asked if they had a nice day, to which LF replied *"Yes we always have nice days don't we G"* Nurse A went on to say that G didn't look like she was ready for her bed, to which LF then replied ***"Oh, don't you know G doesn't know where she is, nor does she know who I am nor her mother is"*** Nurse A was quite taken back by this as she had perceived this to have been a light conversation and was unsure how to respond. She replied by saying "/'m *sure she does."* LF replied, *"No not according to those in court you wouldn't believe what they had to say"* Nurse A had to intervene by saying *"[LF] I don't want*

to know, nor do 1 need to know" LF continued by saying *"There's a lot of horrible people in here, horrible."*

25. Nurse A's reply was *"I'm not sure who you're referring to by horrible, but I know of an awful lot of really nice people who genuinely care for G and they have looked after her for many years nothing has changed nor will it."* LF replied " *Well I'm not sure about that. Well, it's not over with yet, you just wait and see the best is yet to come."* Nurse A then held the door open for G and LF to enter the unit and they parted ways. Nothing more was said. Nurse A remained in yellow pod for the remainder of his stay (G is nursed in orange pod). For the rest of the night. Nurse A recalls she questioned herself on how a light-hearted chat on the corridor had turned out the way it had. She said she feels very guarded when she now speaks to LF. Nurse A said she feels sad for the nurses and doctors who have given the very best care to G for all the years she's been on the unit and for it now to be so uncomfortable and hostile at times. Regardless to what is going on the staff always maintain professionalism.

26. Nurse B reported to Nurse T that since December she has frequently felt anxious when required to speak with LF. She has been met with minimal to no acknowledgment when speaking to him and she has perceived a hostile demeanour towards her. She has been reluctant to be the team leader in the pod G is in due to the worry of being met with this hostility. She worries that staff could be named and that her own job and that of others could be compromised. Nurse B stated that she regularly thinks about the situation at work when she is off which is impacting on her personal life. She considers the atmosphere on HDU to sometimes leave her anxious to come to work and doubt her future on HDU.

27. Nurse C described a conversation she had with LF following the court case. She recalls [LF] raising his disgust with *the lies* told during the hearing. He explained that they had found a company willing to provide a care package to get G home but two days before the hearing began, it was conveniently pulled and stated that the hospital and the commissioners were in it together. He stated that the hospital *has form* in doing underhand things and referred to the organ scandal. He told her how every single person on HDU had let G down, looking at Nurse C as though to include her. She felt this was unfair and made the atmosphere awkward. Nurse C responded by saying to him that she was unaware of things that have gone on behind the scenes for a long time and cannot comment on what other people may or may not have said. Nurse C said she refrained from giving any personal opinion throughout the conversation. [LF] made remarks about Dr B and questioned why a consultant only has one patient under her care. He also made remarks about the previous LTV consultant and how it was ok when they were getting large sums of money to start these children on long term ventilation but then they get to a certain age and then discontinue care. [LF] told Nurse C he had been in contact with many families who feel the same. He referred to the Care Home as an asylum. He stated there are old men wandering the corridors screaming and wailing and how that isn't an appropriate setting for G. He stated that she won't last three months there and the only way she will leave that place is in a box. He insinuated to Nurse C that the reason the Trust are sending her there is to die. As team leader on that shift, Nurse C felt it her duty to listen to him as G's father, however she said she felt very uneasy as it went on for some time and she was not willing to respond to any of the above points.

28. Whilst caring for G recently on a night shift, Nurse D noticed that G's tracheostomy duoderm dressing was lifting on the left-hand side of G's neck and lots of duoderm appeared to be stacked on top of each other. Nurse D noted that this was very unusual for G as her tracheostomy dressing is always immaculate and secure. Nurse D stated that she was aware that there had recently been a few incidents where unusual things had been happening for example, disconnection from the ventilator, profile settings on monitor changing, humidifier turned off, and got a sense of unease about the situation. Nurse D recalled an event on 15 March where it had been reported to the bedside nurse by G's grandmother that the 02 connected to her vent had been turned off very tightly. This was switched back on by her grandmother and the bedside nurse has insisted that she had not altered the 02 at all. Nurse D felt that these incidents are leaving staff feeling very vulnerable and most staff feel like they are being tested constantly. Safety checks are always performed at the start of every shift.

29. In recent months Nurse D said she has found herself feeling a sense of fear and dread as to what the day will bring with regards to the situation with G and her family. Nurse D stated that communication is very limited and body language from [LF] in particular is very intimidating. In her senior role Nurse D has supported several members of staff who have gone on to need support from the psychology team due to the way they have been spoken to or made to feel by [LF] and G's grandmother. Nurse D reported that the atmosphere on the HDU unit is completely different when [LF] is present. Nurse D stated that the situation the HDU nursing team find themselves in with G at the moment is all-consuming, the nursing staff are talking about the situation all the time, on breaks, when they leave to go home and this even spills into their home life. She feels very uneasy about the situation and is fearful for her job and that of her colleagues. Nurse D said she did not believe that the nursing team on HDU can deliver a high standard of care when they are working under these extremely stressful conditions, being constantly assessed and questioned.

30. Nurse E stated that she has often felt extremely anxious and on edge when looking after G. During one of Nurse E's first shifts looking after G, the rate on her feeds had been changed and was not correct. Nurse E recalls that certain things have been changed on numerous occasions which led her to perceive that she was being tested. She said this can make her over cautious and she is worried it could lead to mistakes. On one occasion when looking after G, Nurse E recalled that she was at the nursing station making a phone call to pharmacy, G became disconnected from the ventilator, G alarmed, and her heart rate and oxygen saturations had dropped. Nurse E immediately attended to her, increased oxygen, gave suction and G's observations soon resolved. When [LF] returned Nurse E informed him of the event before going on her break, she felt extremely intimidated in this moment as he was questioning her nursing ability. When on her break [LF] had been looking on both the nursing station monitor and bed space monitor regarding the event. When arriving back from her break [LF] did not engage in conversation with Nurse E he drew the curtains round and spoke to numerous professionals about the event, Nurse E overheard the word *'murderers'.* He had accused Nurse E of not responding to G for a minute, but Nurse E recalls it was within seconds. Nurse E felt extremely uncomfortable in this situation and felt very uneasy. Following this, Nurse E reported she has felt anxious and worried about coming into work. She had not looked after G since. Nurse E has walked past [LF] and been looking after patients in the same pod and has felt very uncomfortable when making any contact with him.

31. Nurse F stated that during her time looking after G, [LF] has made her feel very vulnerable, and this had increased recently since the court case in December. She feels very anxious and on edge when [LF] arrives on the ward as she often expects him to say something that will make her feel uncomfortable or she is fearful something could happen on her shift. Nurse F has noticed recently when she has been caring for G and when [LF] has left the ward that: her tracheostomy cuff has less water in than it should; her amount of oxygen has been turned up from her usual amount; the feed pump volume has changed; the monitor settings being changed from adult to child 2-7 years; the ventilator has not been properly secured onto her tracheostomy; and times where her emergency tracheostomy tray has been without duoderm as [LF] has not let her know he has used it all and it needed replenishing. Finding these things when [LF] has left and knowing this has not been done by Nurse F makes her feel as though he is trying to catch her out, she fears that these could cause harm to G and she is responsible for noticing these things quickly and amending them before anything bad happens.

32. Nurse F reported that [LF] has often talked very poorly of the hospital and staff in a very intimidating tone of voice to Nurse F and has made frequent statements about G's care which makes her feel as though she is backed into a comer and does not know how to respond as she believes that no answer is good enough. Nurse F has heard him tell other members of hospital staff *"''Have you heard what they are doing to her''* which makes her feel extremely uncomfortable as he knows Nurse F was in earshot of this statement and would not know how to respond. Nurse F said this made her feel as though it was her in the wrong. Nurse F reported that [LF] said to her '*I wish they would leave the child alone, where is the moral?"* and in that moment she was fearful as to how to respond so stayed silent.

33. Nurse F recalled a recent incident when after [LF] had arrived on the ward and she was giving an update on G. Nurse F told him that G had appeared upset, and she was asked why by [LF].

34. She went on to explain that G had been pulling sad faces intermittently and she felt it was pain related. [LF] said in a firm tone *"Pull your mask down then and show me what faces she pulls if she's upset"* and in that moment she felt fearful of him, that she was in trouble for being concerned about G and he was trying to embarrass her by asking her to imitate G's facial expression. When Nurse F refused to do this [LF] said '*I find it interesting that you think she is upset when maybe she is just bored that she is lying here with no TV on".* Nurse F felt it is evident that [LF] has no regard for medical and nursing knowledge. Nurse F stated that speaking to Nurse T had also made her feel apprehensive as she was concerned for [LF]'s retaliation/reaction.

35. Nurse G recalled that she has nursed G for many years, and while LF's behaviour has often been difficult, she had noticed a significant decline since the court hearing in December. Nurse G felt he is frequently rude to nursing and medical staff including herself, either by ignoring them completely or by making sarcastic comments either to G or the staff directly. She finds him to be very passive aggressive and intimidating and has found herself avoiding having any contact with him whenever possible. Nurse G stated that she and other members of staff sometimes dread coming into work knowing they have to deal with him and several members of staff have left because of his unreasonable behaviour and the effect it has had on their mental health. Nurse G feared that if there was ever any incident involving G that his behaviour would escalate, as it has done in the past, and she would have to be the person to deal with him. Nurse G

reported that he has a history of not abiding to restrictions which were put in place as a result of his actions, and this makes her nervous as coordinator of a busy HDU which cares for many sick children and their families. Nurse G recalled an incident where [LF] was banned from the unit due to an incident of poor behaviour which put G at risk, and he still secretly gained entry to the unit and security and senior management needed to be called to deal with the situation. Nurse G said many of the junior staff have similar concerns and have frequently expressed these concerns to her and other senior members of staff.

36. Nurse H stated that since the court decision in December she has felt intimidated by [LF] many times whilst caring for G and due to the way [LF] speaks to her it is becoming increasingly unmanageable. Nurse H said she has been questioned by [LF] about the current situation regarding discharge to adult service to the point where she felt like she was being bullied and made out to be a liar despite her legitimate explanation that she was unaware of the details.

37. Nurse T made further observations of her own which require to be stated:

> *"16. I consider [LF]'s behaviour and demeanour to be intimidating, with an increased escalation since the court decision in December. Since transition planning started [LF] has ignored the majority of HDU staff. [LF] has recently decided to no longer wear a PPE mask as per hospital guidance as he's now exempt, his facial expression and eye contact is intimidating and aggressive, he visibly snarls and has a tense jaw, this is seen when walking towards [LF] and makes me feel very intimidated.*
>
> *17. There have been incidents within the unit that have unnerved the nursing team and as seen in accounts from nurses above, made them feel intimated, undermined and professionally vulnerable. In February 2022 G's ventilator tubing became disconnected from her tracheostomy and G became bradycardic and required oxygen to correct her drop in saturations. As Acting Ward Manager, I investigated this incident following an incident form being submitted and presented the findings as a Rapid Review to the governance team at The Hospital. The findings were also given to [LF] verbally alongside a copy of the written report. During the meeting I had with [LF] regarding the incident [LF] called me back to the bedside and said "You know how you said G can't communicate or express her feelings, well look at her now" at which point he smirked and turned round to G. The comment made by [LF] was in relation to my statement given as part of die court hearing in December. I did not feel it appropriate to respond to [LF] so I left the bed space.*
>
> *During Gs admission within The Hospital a disconnection from her tracheostomy and ventilator has happened twice before the incident in February 2022. In the following 2 weeks after the disconnection in February 2022 there were 2 further episodes of the ventilator tubing becoming disconnected and an incident*

> *where the dressing used to secure the tracheostomy was loose (seen and rectified quickly by a senior nurse), the dressing has never become loose prior to this at any point in G's admission on HDU. In view of this and the reaction of [LF] towards staff, stating it was "suspicious that these incidents have happened since a DG order had been placed" (said to me during the initial discussion relating to the incident) I became increasingly concerned for the HDU nursing team and their professional vulnerability because of the increased episodes of disconnections from the ventilator. I authorised Health Care Assistants (HCA's) to be ordered via NHSP to work alongside the registered nurse caring for G 24 hours a day. Since the HCA's being in place at the bedside there have been no further disconnection episodes witnessed by staff.*
>
> *19. During a conversation I had with the senior team at The care home the staff reported they had been made to feel intimidated by [LF] at the bedside when they came to visit G at The Hospital. They said they felt undermined as clinicians by his questioning and that they had to be very careful with their answers which made them feel vulnerable thinking towards her being admitted there. They said they found him to be extremely passive aggressive.*
>
> *20. I have seen the proposed Behavioural Framework and would welcome its implementation. The Behavioural Framework will aid the transition in the best interests for G by implementing delivery of care that is adapted to adult services. The Behavioural Framework will also give the Nursing and Medical team on HDU clear guidance on the interventions to be undertaken by G's family and in line with adult services and will be more appropriate to Gs privacy and dignity. The Behavioural Framework will restore a safe and conducive clinical environment that is needed for G and all patients on HDU and The care home by reducing the vulnerability and intimidation felt by staff. I believe the Behavioural Framework to be instrumental in the successful transition to The care home.*
>
> *I believe that the facts stated in this witness statement are true. I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth."*

38. Ms Powell explored in cross examination with LF, the matters set out in paragraph 18 of Nurse T's statement. They identify extremely troubling safeguarding concerns. I note that these concerns ceased completely when HCAs were put in place. Ultimately, Ms Powell did not press for findings on any of these matters and I make none.

39. In analysing the evidential weight to be attached to the anonymous complaints, it is important to set out the wider canvas. Dr B gave wide ranging evidence before me. She

emphasised that the planned move on the 8th March 2022, had been very well advanced, including to the point of arranging a private ambulance company to affect the transfer. LF's direct approach to the CEO of the nursing home led to a decision on their part to place arrangements on pause. Dr B was very clear that following the December hearing, there was a distinct change in LF's manner towards her. In February 2022, LF made an application to remove the reporting restrictions. I declined the application which was entirely without foundation. The anonymity afforded to G is to achieve peace and privacy for this crucial stage in her life.

40. From February, Dr B considered that LF's behaviour became *"challenging and verbally confrontational".* On the 28th February 2022, when Dr B started to discuss with LF the anticipated discharge date on the 8th March 2022, she told me that he responded by saying, *"that she should communicate with his legal team directly"*. As I understand LF's evidence, he does not dispute this response but contends that Dr B has put a deliberately negative gloss on it. In that same conversation, Dr B told me that LF had said that *"she is a very poor doctor"*. Though Dr B is experienced and resilient, it struck me that as she related the conversation, in the witness box, it caused her distress. Dr B also said that LF had called her a *"liar"*.

41. LF has a different perspective. He contends that he told Dr B that she had *"behaved dishonestly"* but he denied saying she is a poor doctor. Where LF's evidence conflicts with Dr B's, I have no difficulty in preferring Dr B's account as more reliable. Again, I think it is important to emphasise that LF strikes me as a man under very great strain whose perspective on day-to-day events has become distorted by his own anxiety. I consider it likely that there have been times when even these dedicated nurses tending to seriously ill children, for whom compassion to parents is both profound and instinctive, have lost sympathy with him. The atmosphere surrounding G's care has plainly been febrile over the course of the last 6 months. Both the nurses and LF consider that this has been kept from or concealed from G, I am bound to say that I am less sanguine. The relationship between G and her father is intensely close and intimate. It would be unusual if she did not intuitively pick up on his anxiety, distress, and, as I find, anger. If G has the greater levels of awareness that LF and the family describe, then this is even more likely to be the case. Conflict is ultimately irreconcilable either with good care or good parenting. It is also important that I record in this judgment that three of the nurses on the HDU have left the Trust. In their reasoning, each of them cited LF's behaviour as contributing significantly to their decision. All this, I regret to say, leads to the inevitable conclusion that LF has been creating an atmosphere of stress, general unhappiness and deep mistrust on the HDU.

42. Ms Powell cross examined LF with courtesy but with forensic rigour. In her submissions, she described him as evasive and dogmatic in his responses. He presented, in my assessment, as a man who was making an intense effort to retain his composure. Though he managed to retain it, it was plainly fragile. Ms Powell suggests that his responses to the complaints of the nursing staff and to Dr B were entirely lacking in credibility. I agree. Ms Powell is not as benign in her analysis of LF's behaviour as I have been. She contends:

> *"It is not that he lacks insight into his behaviour and is simply unaware of what he is doing or the effect he has: he is, knowingly, frustrated and angry and taking that out on the staff, undermining them, questioning their competence, and refusing*

> *to acknowledge or respect their clinical experience and expertise"*

43. Ms Powell highlights some key aspects of LF's evidence:

> *"He admitted that he had deliberately taken [G] out of the ward on three occasions in August 2020 when he had been expressly told not to for reasons of Covid safety, and that he had returned to the ward when he was excluded.*
>
> *He admitted that he had sought to persuade [the CEO] to withdraw the offer of a place for [G], knowing that that was completely contrary to what the Court had determined was in [G]'s best interests. He admitted that the sending of numerous emails was designed to put further pressure on her to withdraw the place. He was driven, ultimately, to admit that he had lied in his witness statement when he claimed that he had accepted the Court's decision that [G] should move to [the care home].*
>
> *Finally, he admitted that, if he wasn't prevented from doing so, he would continue to do whatever he could to prevent the move taking place."*

44. These are significant concessions. LF's actions are a deliberate attempt to sabotage the placement and to undermine the confidence of the staff. The evidence, in its totality, permits of no other sensible inference. I should also add that the correspondence sent by LF to the care home and the company group responsible for it, is not a simple request for information but a sustained attempt to intimidate and undermine, in a way which mirrored his behaviour in the HDU. In particular, it focused on what he regards as the inadequate training of the staff. I do not propose to copy LF's correspondence into this judgment, but it is a cascade of criticisms and unfounded allegations and far from the genuine enquiry as to the contemplated care provisions that LF asserts it to be. I agree with Ms Powell when she analyses that this is not a lack of insight into his behaviour, but the deliberate and determined execution of an objective that he has now, in the witness box, accepted i.e., to stop the placement going ahead.

45. The correspondence, the direct evidence of Nurse T and Dr B, the admissions made by LF in the witness box, all provide the evidential framework for consideration of the anonymous evidence of the nurses. It is to be noted that the allegations that each of the nurses make identifies a pattern of behaviour which is, as I have demonstrated above, replicated with others. The allegations are internally consistent and extensive. Moreover, there is no rational or coherent reason as to why so many nurses should malevolently exaggerate or fabricate false evidence in the way that LF is driven to suggest. Accordingly, it would be entirely wrong to regard this evidence as having little or no weight as Mr McKendrick suggested. This evidence is, properly analysed, an intrinsic facet of a wider forensic canvas which reveals a consistent pattern of behaviour. Further, having regard to the atmosphere that has been created on the ward and the importance of achieving G's smooth and safe transition to the care home, I consider the continuing anonymity of the nurses to be essential.

46. All of the above establishes a compelling basis for the injunctive relief sought in respect of the father. However, relief is also sought against M and N. I should record that I found M to be a troubling witness. She was unable to engage with the paperwork in the court room because she had travelled to London without her reading glasses. I recall that she had made the same mistake in the December hearing. I do not consider that this was entirely accidental. I have formed the clear impression that she simply does not want to engage with the evidence. Her support for LF is complete, blind, and unquestioning. She told me, and in this she is supported by LF and N, that she is not very interested in computers. She does not send or receive emails. Though her name is included on the correspondence to the care home, none of the authorial content is hers. LF suggested, at one point, that he had read the whole of the emails out loud to M, but he later relented and suggested that she had appreciated the general thrust of the email content. I consider that the latter is probably correct.

47. M takes no part in social media; she has no interest in it. She receives very few calls on her mobile phone. I was told that she makes virtually no outgoing calls. At the December hearing, she told me that she often went to the gym in the afternoons and that LF would collect her. This routine, she told me, has now fallen away. In response to my own enquiry, she revealed that in the 14 years that G has been in hospital, she has never been out on her own to meet a friend for a coffee or a glass of wine. M very rarely goes into the hospital. She feels that her decision not to, attracts censure and disapproval from the nurses. She prefers her afternoons out with G and her partner. I should record that G is dressed strikingly and with great care. Her hair is the focus of much attention. M chooses the clothes and sends them over to the hospital with LF who gets her dressed and ready. I had assumed that it was M who attended to G's hair, but I have been told that this is also usually done by LF. N, who is temperamentally similar to her son, told me that she rarely, if ever, communicates with M by telephone, text, or any of the electronic alternatives. I am struck by what I regard as M's social isolation. She is largely impervious to the outside world. Her environment consists almost entirely of her partner and her daughter. I do not intend that any of this should be interpreted as a criticism. It is not. It is, however, an illustration of the tight parameters of the world that this couple has been living in for so long. There is no issue, arising in this case, upon which M and LF are not in total agreement. There is no light and shade, M gives her partner 100% support on everything. Her hostility to the care home is every bit as strong as his. In August 2020, she navigated her partner back on to the ward knowing that he had been excluded for failing to comply with the Covid regulations in place because of an outbreak in the hospital. Not only is she supportive of LF's position, but she has also revealed herself to be facilitative of the disruption that he causes.

48. N's criticisms of the Hospital staff, in her witness statement filed with this court, are as full throated and voluble as those of her son. N is adept with technology and social media. She is equally determined that her granddaughter should not go to the care home. I have heard evidence that if this placement were to be lost, it would take a very considerable time to identify another and it is unlikely that it would be in the locality. Thus, it would mean that this young woman would have to stay for many more months in a place that everybody agrees is entirely unsuitable and potentially move to a care home which risks limiting her contact with her parents. None of the family has confronted this dichotomy. Their minds, in my judgement, have simply been closed to the possibility of the care home from the outset.

49. N contacted a Ms S, a media consultant, to orchestrate a press release. Ms S contacted the care home group in similarly critical terms to those deployed by the family. N claims that Ms S was operating entirely without any instruction or encouragement on her part. Though Ms S' email expressed herself as effectively acting with the authority of N, she was not challenged by N on what it is now said was a misrepresentation of her authority. I find N's account of this to be unconvincing.

50. It is plain therefore, that both M and N are not only entirely supportive of LF's campaign, but they are also likely to become embroiled in the execution of a plan to derail the placement. It is for this reason that I have come to the conclusion that the injunctive relief sought in respect of them both is entirely necessary. The scope and ambit of the relief is to put in place clear boundaries to manage the family's behaviour. It is both justified and proportionate here to regulate N's personal and nursing care, permitting the staff to operate effectively in the provision of G's personal care, medication, nutrition, tracheostomy care and more generally, to establish her dignity as an adult. This last point requires particular emphasis. Incapacitated adults are not children. I do not think that either LF or M has, for reasons which are no doubt entirely understandable, absorbed this fundamental distinction and how integral it is to understanding G's needs. If it were possible to harness LF's strengths to make the placement work, this would be to G's very considerable benefit. I regret to say that I see no evidence of him being prepared to support the placement. On the contrary, he continues expressly to disavow it.

51. In December, and at this hearing, I drew the party's attention to: *Re W (A Child), Re [2021] EWHC 2844 (Fam).* The dynamics of that case were very different but the advantages of providing some therapeutic help to these parents seems to me to be both obvious and compelling. The approach in *Re W* may be, at least, a useful starting point in resetting the dynamics of the relationship between the parents and the carers.