Neutral Citation Number: [2022] EWCOP 47

Case No: COP 13970383

COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 17/10/2022

Before :

MRS JUSTICE LIEVEN

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Between :

(1) CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
(2) CAMBRIDGESHIRE AND PETERBOROUGH NHS FOUNDATION TRUST
Applicants

and

(1) RD
(by her litigation friend, the Official Solicitor)
(2) MRS RD
(3) MR RD

Respondents

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Ms Claire Watson KC (instructed by **Kennedys Law and Browne Jacobson**) for the **Applicants**
Ms Bridget Dolan KC (instructed by the **Official Solicitor**) for the **First Respondent**
The Second and Third Respondent represented themselves

Hearing dates: **3, 5 and 12 August 2022**

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Approved Judgment

This judgment was handed down remotely at 10.30am on 17 October 2022 by circulation to the parties or their representatives by e-mail and by release to the National Archives

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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.

Mrs Justice Lieven DBE :

1. This is a particularly tragic case. It concerns RD, a 26 year old woman with a very complex diagnosis and a long history of serious self-harm. I held three hearings in the case, on 3, 5 and 12 August 2022, and made a final order, including a care and treatment plan agreed by all the parties at the last hearing. Given the complexity of the issues and the timing of that hearing, I reserved judgment. Sadly, the following week RD further self-harmed and died on 16 August 2022. I will write this judgment in the present tense and set out the issues and conclusions up to the hearing of 12 August.

2. The parties at the hearings were Cambridge University Hospitals NHS Foundation Trust and Cambridgeshire and Peterborough NHS Foundation Trust, who were the applicants and were represented by Ms Watson QC (as she then was); RD was represented, through the Official Solicitor, by Ms Dolan QC (as she then was) and RD's parents represented themselves.

3. RD has a long history of mental health difficulties and has spent significant periods in psychiatric units since the age of 15, frequently being detained under the Mental Health Act 1983 ("MHA"). Since 2021 she has had three periods of detention under the MHA.

4. RD has been diagnosed with Emotionally Unstable Personality Disorder ("EUPD"), Post Traumatic Stress Disorder ("PTSD") and at some points with psychosis. According to Dr A, the consultant psychiatrist who has been involved with RD's care for a long period, RD feels driven to hurt herself because of alleged adverse earlier experiences, and the impact on her mental health has been profound, long lasting and highly resistant to any treatment. She is particularly resistant to psychotropic medication.

5. RD has had many incidents of very serious self-harm. The current situation began in 2018 with deep inflicted cuts to her legs that led to infections and a long period of hospitalisation and sedation. She has had many admissions to the Intensive Care Unit ("ICU") at Addenbrooke's Hospital since 2018. She has a history of inflicting serious injuries to her neck and had a tracheal reconstruction in February 2022 at Charing Cross Hospital.

6. When on overnight leave from the psychiatric ward, RD cut her throat and was admitted to Addenbrooke's Hospital on 19 June 2022. She had sustained a further significant tracheal injury with total transection of her trachea. She underwent emergency surgery and was transferred to the ITU post-operatively with a tracheostomy in situ.

7. Two MDT meetings were held on 24 June 2022 and 6 July 2022 to discuss the concerns raised by the medical team that RD was at risk of pulling out her tracheostomy tube if her sedation was either withdrawn or reduced. At the first meeting, a clinical consensus was reached that RD should be cautiously weaned off sedation with support from the mental health team. At the second meeting it was agreed that in the event there was an attempt to self-harm as sedation was lifted, which posed a threat to RD's life, the least restrictive form of restraint would be used. There has been a consistent pattern in this case of clinicians seeking to respect RD's autonomy, and minimise any restraint placed upon her, whilst attempting to keep her alive.

8. On 5 July 2022 the sedation began to be lifted with the support of the psychiatric team and by the afternoon of 7 July 2022 RD was able to move with minimal assistance and stand unaided. On 7 July 2022 the tracheostomy was removed, and RD was transferred back to the Mulberry Unit at Fulbourn Hospital.

9. On 18 July 2022 RD was discharged from the Mulberry Unit to a supported housing placement for people with mental health difficulties. She had a care package which included 13 hours of support per week, which was increased to 26 hours for the first 8 weeks following her discharge.

10. On 22 July 2022 RD was admitted to Addenbrooke's Hospital again with a further severe, self-inflicted, anterior neck injury. On this occasion there was more extensive damage to RD's neck and trachea such that she is likely to need a permanent tracheostomy with a possible laryngectomy in the future. The evidence is that she is unlikely to be able to talk again as a result of the injury.

11. RD was heavily sedated and ventilated on the ICU after her emergency surgery on 22 July 2022 but attempts to wean her off sedation began on 1 August 2022.

12. The clinical team had significant concern that RD would try to pull out her tracheostomy tube and other indwelling lines as sedation is lightened or once she has been weaned off sedation completely, leading to a risk of serious harm or death by asphyxiation.

13. On 29 July 2022 Dr B, one of the treating intensive care consultants, discussed RD's treatment options with her parents, who are named attorneys under a health and welfare (and property and affairs) Lasting Power of Attorney. It was agreed that it was in RD's best interests to be subject to the least restrictive restraint should she take action which would pose a risk to her life, and a restraint plan was agreed with the psychiatric team.

14. Dr B, in his witness statement, explained the risks of ongoing sedation. Prolonged sedation and the consequential prolonged ventilation increases the risks of infection and of physical deconditioning. The deconditioning then presents difficulties with allowing patients to move off ventilation. The most complicated factor with RD is that any attempt to reduce the sedation leads to a risk of her further self-harming, including removing the tube. However, long term sedation is not a viable option.

15. The application to the Court was made on Friday 29 July and the Official Solicitor was notified and served with the application. A hearing was listed before me on 3 August, but the Official Solicitor was served with a very large number of medical records on 2 August, and the Applicant's witness evidence was only served during the day on 3 August. This inevitably made it impossible for any substantive orders to be made at the first hearing.

16. The first issue to consider in the proceedings is whether RD has capacity, particularly in respect of treatment of her trachea injury. Dr A in her witness statement for the 3 August hearing stated that RD's capacity to make relevant decisions was complex, and Dr A thought that RD might have fluctuating capacity when in a heightened state of emotion. However, on balance and taking into account the presumption of capacity even with impulsive acts, she thought RD might have capacity in this regard.

17. On the morning of 3 August RD was visited by Dr D, a consultant psychiatrist who had been instructed by the Applicant to conduct an independent capacity assessment. Unfortunately, the effects of sedation had not yet worn off and Dr D found it extremely difficult to establish a meaningful dialogue or rapport with RD when undertaking his capacity assessment. On the basis of the medical notes, Dr D concluded that there was sufficient evidence that RD's capacity to weigh decisions about her "tracheal care" is likely to be impaired at times as a consequence of her PTSD. He therefore concluded that she lacked capacity to make decisions in relation to her tracheal care.

18. On 3 August, having heard from counsel for the Applicant and the Official Solicitor, and from RD's parents, I made a case management order for evidence to be filed, including as to RD's own wishes, and listed the case to return on 5 August. I found on an interim basis that there was reason to believe that RD lacked capacity.

19. On the morning of 5 August 2022, a multi-disciplinary team meeting was convened which was attended by RD and her parents. The purpose of the meeting was to discuss and agree a treatment plan with RD. Dr B spoke to RD by her bedside, whilst others were present remotely. During the meeting RD repeatedly expressed a wish not to die; she asked the doctors to stop her if she did something that could end her life; and she asked to be provided with all forms of life-sustaining treatment if needed, including dialysis and CPR. Dr B gave oral evidence about this meeting. It was apparent that he spoke to RD with immense care and sensitivity, but also made the stark reality of the choices which she was facing clear to her.

20. There was no doubt, having heard Dr B's evidence, that in her calm moments RD wanted to live and wanted the clinicians to help her to do so. However, I also heard immensely moving evidence at each of the hearings from her parents. They described a pattern over the years of RD saying that she wanted treatment, and thus producing glimmers of hope, and then very quickly self-harming again.

21. This pattern was sadly repeated after the hearing of 5 August. There were two instances on 6 and 8 August 2022 when RD grabbed and pulled out her tracheostomy tube, partially dislodging it on the first occasion and pulling it out so that the cuff was at the stoma site on the second occasion. Each time the tube was repositioned or replaced. RD required heavy sedation and the use of arm splints to prevent her from removing the tube again on 8 August.

22. Dr C, another intensive care consultant treating RD said that she had spoken to RD a number of times over this period, and that her responses and behaviours were such that Dr C considered that she had capacity. After the incident on 8 August, RD asked Dr C to start sedation again. Dr C said that she thought RD's sudden change in behaviour was a manifestation of her underlying personality disorder.

23. A treatment plan was drawn up by the intensive care and psychiatric teams which was discussed with RD on 10 August 2022. It was explained to her that there were two options available to her: (i) she keeps the tracheostomy tube in and engages with the ICU staff to wean her off the ventilator, reduce and then stop sedation and undertake training to manage her tracheostomy in the longer term; or (ii) she wants the tracheostomy tube removed and will be offered care to remove it safely, following which a palliative care plan will be put into effect.

24. During this discussion on 10 August 2022 RD stated that she wanted to live and wanted the clinical teams to prevent her from dying; however, she also reported that there are times when she wants to live and times she wants to die. She was encouraged to reflect on the options and informed that a hearing would be taking place in the Court of Protection on 12 August 2022 to consider whether the proposed plan should be approved.

25. It was the hope of the medical team that RD would be weaned from sedation and liberated from mechanical ventilatory support; that she would continue to have a tracheostomy tube in situ and would undergo training to manage this device; that her carers would be similarly trained, and she would in due course be safely discharged from hospital. As at 13 August this had not been possible due to RD's agitation and repeated attempts to remove the tracheostomy.

26. In order to continue to provide life-sustaining treatment to RD, it would be necessary to continue to use physical and chemical restraint during periods when she is agitated and resists that treatment. In the weeks since her surgery, it has not been possible to reduce the sedatives administered to RD without her attempting to remove her tracheostomy and the only way to prevent her from removing the tracheostomy in the future would be to keep her sedated on the ICU indefinitely.

27. At the hearing on 12 August Dr A spoke very movingly about RD's psychological need for autonomy, and that the only realistic hope was for RD to believe that she was in control of her own life. Dr A hoped that if RD genuinely believed that nobody would intervene to prevent her from harming herself, she might choose not to remove the tube. However, Dr A accepted that this hope might not be fulfilled, and the plan being proposed might lead to RD's death.

28. Before the hearing on 12 August the clinical team produced a detailed Care Plan. The summary of the two alternative plans, depending on RD's wishes and actions, is as follows:

> "**Plan 1: [RD] indicating a desire to have medical support/intervention in order to prevent harm**
>
> - [RD] will keep the tracheostomy tube in for as long as advised by medical staff
> - [RD] will work with members of the ICU multidisciplinary team in order to rehabilitate and be liberated from assisted ventilation
> - [RD] will accept all treatments offered eg intra-venous access, nutrition, antibiotics if indicated, psychiatric medication.
> - [RD] will participate in training how to manage her tracheostomy
> - Until the next Court of Protection hearing, any and all intervention required to preserve life will be provided. This includes restraint to prevent removal of the tracheostomy tube.

Plan 2: [RD] indicating a desire for no treatment/intervention

- Subsequent to the next Court of Protection hearing, and it being ruled in [RD's] best interests and lawful, we will no longer intervene should [RD] attempt to remove her tracheostomy tube.

- Removal of the tube will be an irreversible action.

- We will ensure she can do this in the least traumatic way (eg cutting securing stitches to prevent skin injury).

- If the tracheostomy tube is to be removed, senior staff should supervise this process and it should be performed in a calm and quiet environment. In this scenario, CPR would not be provided.

- Palliative care specialists will be involved, and plans made for appropriate medications to be immediately available to treat any symptoms of breathlessness or distress.

- Discussions should be had with [RD] regarding who she would want present for or following removal of the tracheostomy, appreciating that this may be the end of her life. This could include family and/or friends, they will need to understand what the implications of the process are and the potential to see the end of [RD's] life.

- Similarly nursing and medical staff should be offered the opportunity to recuse themselves from this process."

29. The Official Solicitor had most helpfully agreed to act on RD's behalf at very short notice before the hearing on 3 August. At that hearing Ms Dolan raised considerable concerns about the lack of evidence of RD's capacity, particularly in the light of the fact that she had a similar admission only four weeks before, at which time the clinical view appeared to be that she did have capacity. Further, on 26 July it appeared RD had wanted to complete an Advance Directive form in respect of not being resuscitated and other medical treatment, but this was not facilitated because she was told she needed an advocate.

30. The role of the Official Solicitor was a particularly complex one in this case because of the difficulties in establishing the degree to which RD had capacity and of establishing what her wishes were. By the time of the 12 August hearing, the Official Solicitor's position was that RD, when capacitous, appeared to wish to live and for the clinicians to save her life, but when gripped by her distress she lost capacity and took action likely to end her life. The Official Solicitor accepted that the Court should seek to maximise RD's autonomy and that there is little prospect of any long term recovery from her mental ill-health. However, given RD's expressed wishes, the Court should not order the clinicians not to continue treatment, as long as they were willing to provide such treatment. An important issue at that hearing was therefore the degree to which the clinicians considered the current treatment of sedation, restraint and replacing the tube, was sustainable.

31. Dr B told the Court on 12 August that although the clinicians would replace the tracheostomy tube if ordered to do so by the Court, they were approaching the point where they would no longer be prepared to do so because they did not think such treatment met their ethical duty to RD.

32. RD's parents appeared and spoke at each hearing. Their love and commitment to RD was overwhelming. They had supported her through numerous earlier crises and had supported continued treatment and all efforts being made to keep her alive. However, they felt that the point had been reached at which RD should be allowed to make her own choice, and her actions should be respected. They spoke of a pattern of RD saying she wanted to live and then self-harming again. They also said they felt that she sometimes said she wanted to live because that is what they wanted. My sense was that they felt it was almost selfish to force treatment upon her when she was so unhappy and suffering so much.

Legal Framework

33. The following issues arise in this case:

    i. Does RD have capacity, in particular in respect of decisions about her treatment and the management of her tracheostomy tube?

    ii. Is this a case of fluctuating capacity?

    iii. If she does not have capacity in this respect what decisions about her future treatment are in her best interests?

34. The following principles relating to capacity are well known and do not require extensive elucidation:

    a. A person must be assumed to have capacity unless it is established that she lacks capacity: s.1(2) MCA. The burden is on the party asserting a lack of capacity (here, the Applicants) to establish it on the balance of probabilities: *KK v STC and Others* [2012] EWHC 2136 (COP), per Baker J, at para 18.

    b. The determination of capacity under MCA Part 1 is always 'decision specific.'

    c. Any lack of capacity must result from an impairment of, or a disturbance in, the functioning of the person's mind or brain: s.2(1).

    d. It does not matter whether the impairment or disturbance in the functioning of the mind or brain is permanent or temporary: s.2(2).

    e. A person is to be treated as unable to make the decision on the matter in issue for herself if she is unable to (i) understand the information relevant to the decision; (ii) retain that information; (iii) use or weigh that information as part of the process of making the decision; or (iv) communicate that decision: s.3(1).

    f. The fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him from being regarded as able to make the decision: s.3(3).

g. The 'information relevant to the decision' includes information about the reasonably foreseeable consequences of deciding one way or another: s.3(4)(a).

h. The Court should guard against overcomplicating what is the 'information relevant to the decision' for the purposes of s.3. As Baker J stated in *CC v KK & STCC* [2012] EWHC 2136 (COP), para 69, it is not necessary for a person to demonstrate a capacity to understand and weigh up every detail of the respective options, but merely the salient factors. However, "The more serious the decision, the greater the capacity required" (see *In re T (Adult: Refusal of Treatment)* [1993] Fam 95 at 113B; and *In The Mental Health Trust & others v DD* [2014] EWCOP 13 at 15 ii).

i. A person is not to be treated as unable to make a decision merely because she makes an unwise decision: s.1(4). As Peter Jackson J (as he then was) stated in *Heart of England NHS Foundation Trust v JB* [2014] EWHC 342 (COP), para 7:

> *"The temptation to base a judgement of a person's capacity upon whether they seem to have made a good or bad decision, and in particular upon whether they have accepted or rejected medical advice, is absolutely to be avoided. That would be to put the cart before the horse or, expressed another way, to allow the tail of welfare to wag the dog of capacity. Any tendency in this direction risks infringing the rights of that group of persons who, though vulnerable, are capable of making their own decisions. Many who suffer from mental illness are well able to make decisions about their medical treatment, and it is important not to make unjustified assumptions to the contrary."*

j. A lack of capacity cannot be established merely by reference to an aspect of her behaviour, which might lead others to make unjustified assumptions about her capacity: s.2(3).

k. Where a person has capacity, they are entitled to make decisions about their medical treatment even if those decisions may lead to death. As Lord Goff set out in *Airedale NHS Trust v Bland* [1993] AC 789:

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

l. In *Newcastle Upon Tyne Hospitals NHS Foundation Trust v LM* [2014] EWHC 454 Peter Jackson J (as he then was) stated:

> *"There is no obligation on a patient with decision-making capacity to accept life-saving treatment, and doctors are neither entitled nor obliged to give it."*

35. The Applicant Trust also referred the Court to *Re DL (Vulnerable Adults with Capacity)* [2012] EWCA Civ 253 at [54] to [56] in respect of the High Court's inherent jurisdiction to afford protection to adults with capacity who fall outside the ambit of the

MCA. The real relevance of that caselaw in the present case lies more in the authorities that make clear that even where an individual is "vulnerable" it is lawful not to provide them with life sustaining treatment in appropriate circumstances.

36. In the context of a vulnerable patient who engaged in serious self-harm Mostyn J made a declaration under the inherent jurisdiction that it was lawful not to provide life-sustaining treatment to a young man detained under the MHA who was deemed to have capacity to refuse such treatment in *Nottinghamshire Healthcare NSH Trust v RC* [2014] EWCOP 1317. At [26] he stated:

> *"The Hippocratic duty to seek to save life, or the benign but paternalistic view that it is in someone's best interests to remain alive must all surely be subservient to the right to sovereignty over your own body. Beyond this, considerations such as whether the treatment would be futile will no doubt be relevant; for example, if the repair of a laceration would inevitably be followed by a new one or if the patient was suffering from another unrelated terminal disease."*

37. In *Keenan v UK* (2001) 33 EHRR 38 the European Court of Human Rights held that there had been no violation of Article 2 of the European Convention on Human Rights ("ECHR") where the applicant's mentally ill son committed suicide in prison and stated at [91]:

> *"The court has recognised that restraints will inevitably be placed on the preventive measures by the authorities by, for example in the context of police action, the guarantees of article 5 and 8 of the Convention. The prison authorities, similarly, must discharge their duties in a manner compatible with the rights and freedoms of the individual concerned. There are general measures and precautions which will be available to diminish the opportunities for self-harm, without infringing personal autonomy. Whether any more stringent measures are necessary in respect of a prisoner and whether it is reasonable to apply them will depend on the circumstances of the case."*

38. In *Savage v South Essex Partnership NHS Foundation Trust* [2008] UKHL 74 the House of Lords was mindful of the competing rights to personal autonomy and at [100] Baroness Hale stated:

> *"If the [Article 2] duty is triggered, it is, as it was put in Keenan's case 33 EHRR 913, para 92, to do "all that reasonably could have been expected of them to prevent that risk". In judging what can reasonably be expected, the court has shown itself aware of the need to take account of competing values in the Convention, in particular the liberty and autonomy rights protected by articles 5 and 8. The steps taken must be proportionate. If this is so in prison, it must be even more so in hospital, where the objectives of detention are therapeutic and protective rather than penal. Developing a patient's capacity to make sensible choices for herself, and providing her with as good a quality of life as possible, are important components in protecting her mental health. Keeping her absolutely safe from physical harm, by secluding or restraining her, or even by keeping her on a locked ward, may do more harm to her mental health."*

39. Where, as here, Article 2 of the ECHR is engaged or is likely to be engaged, the need for judicial scrutiny of any proposed treatment plan which gives effect to personal autonomy over the preservation of life is particularly important.

40. In determining the question of best interests, the MCA provides that:

    a. Any act done or taken in respect of a person who lacks capacity must be in his best interests: s. 1(5).

    b. The decision-maker must consider whether the purpose for which the act or decision is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action: s. 1(6).

    c. The person making a best interests determination must consider all the relevant circumstances (s. 4(2)), including:

        i. A person's past and present wishes and feelings, so far as is reasonably ascertainable (s. 4(6)(a));

        ii. The beliefs and values that would be likely to influence the person's decision if he had capacity (s. 4(6)(b)); and

        iii. The other factors that he would be likely to consider if he had capacity (s. 4(6)(c)).

        iv. The views of family members and others engaged in caring for the person or interests in his welfare (s. 4(7)).

41. The courts have acknowledged that in assessing whether it is in a patient's best interests to receive treatment that may prolong their life, the fundamental principle of the sanctity of human life, although not absolute, will weigh heavily in the balance. (*Airedale NHS Trust v Bland* [1993] AC 789 per Lord Goff at 863H-865B; *W v M* [2011] EWHC 2443 (Fam)).

42. It is now well established that in assessing best interests, the court is not limited to consideration of best medical interests: best interests encompasses medical, emotional, psychological and social issues. As Baroness Hale observed in *Aintree University Hospitals NHS Foundation Trust v James and others* [2013] UKSC 67, at paragraphs 39:

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

Conclusions

43. This an intensely difficult case because of the intersection between RD's mental and physical issues. In respect of decisions about medical treatment, the evidence suggests that for most of the time RD does have capacity, but when she becomes distressed, she loses capacity and that is when she tries to remove the tube. However, the evidence also suggests that even when she has capacity, she is ambivalent about the future. She has said very clearly that she wishes to live, however she plainly understands that her future is bleak, possibly being unable to speak and with the need for long term interventions given the damage that has been done to her trachea.

44. Her parents, who are the people who know her best and have been closely involved with her care throughout, spoke about her cycles of response by which she can state that she wants to live but then shortly thereafter self-harm in a devastating manner. They felt that the time had come to let her make the choice. Given their knowledge of RD, and their love for her, I place a great deal of weight on their views.

45. I accept that there are times when RD loses capacity when she becomes distressed. Therefore, this is a case where the Court of Protection does have jurisdiction.

46. RD's wishes and feelings are themselves complicated, fluctuating and highly ambivalent. Dr B's evidence about the conversation on 5 August suggested a clear and settled wish to live and to be treated, if necessary, by restraint, to allow her to continue to live. Yet within a day she was trying to remove the tube. That pattern of discussion and behaviour followed precisely the cycle described by her parents at the first hearing. RD will say she wishes to live and then act to destroy herself. It is because of that repeating pattern and the physical and mental suffering it inflicts on RD, that her parents had reached the point where they believed that she should be allowed to die, and clinicians should no longer carry out interventionist treatment.

47. This is not a case where it is possible to rely on the authorities that establish that an adult with capacity can refuse treatment to save her life, because when capacitous RD does say she wishes to live. Further, it will be a very rare case where an adult who at times does not have capacity and who has expressed a will to live is allowed to die. The importance of the sanctity of life, and RD's own sometimes expressed wishes seem to militate against such an outcome. However, that is the point which this case has reached.

48. The evidence of Dr A, and RD's parents, is that the most important thing for RD is a sense of autonomy. That she is in charge of her own life and of her decisions. This would suggest that continued physical restraint, and replacing the tube if she removes it, undermines RD's autonomy and further damages her mental health.

49. There is also the more prosaic issue of how continued treatment can be managed. She cannot be kept sedated for a prolonged period of time given that she would need a period of 3-6 months of consistent engagement with medical therapy before it was possible to remove the tube. Dr B has explained the risks of prolonged sedation, and that those risks increase over time. However, if she is not sedated and/or physically restrained there is an extreme likelihood that she will again try to remove the tube. If she does remove the tube and it is not replaced, then there is a high risk she will die.

50. In my view, the treatment plan proposed by the Trust is in RD's best interests, and this includes not restraining her, whether physically or through medication, and not replacing the tube if she removes it. If she does remove it, or indicates she wants it removed, she should be provided with palliative care and as calm and quiet environment provided as possible.

51. I am guided by Dr A's evidence and that of RD's parents that what RD wants above all else is a sense of autonomy. Further, by the fact that restraining her and replacing the tube offers no long term solution to her physical or mental issues, and there is very little if any prospect of any long term improvement to her mental health. Therefore, that form of treatment appears to be futile in anything other than the very short term.

52. I therefore find that it is in RD's best interests, for the care and treatment plan proposed and agreed by all parties to be put in place, accepting that this may lead to RD's death.