



Neutral Citation Number: [2022] EWCOP 6

Case No: 13857152

COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 24/02/2022

Before:

The Honourable Mr Justice Hayden

Between:

Lancashire and South Cumbria NHS Foundation Trust

Applicant

- and -

**Q (by her litigation friend / ALR Philippa Curran (1)
East Lancashire Hospitals NHS Trust (2)
NHS East Lancashire Clinical Commissioning Group
(3)
Lancashire County Council (4)**

Respondents

Eloise Power (instructed by **Hill Dickinson**) for the **Applicant**
Leonie Hirst (instructed by **O'Donnell's Solicitors**) for the **First Respondent**
Mungo Wenban-Smith (instructed by **Hempsons**) for the **Second Respondent**
Ulele Burnham (instructed by **LCC**) for the **Third Respondent**

Hearing dates: 11th and 14th February 2022

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 application concerns Q who is a 50-year-old woman with a diagnosis of bulimia nervosa. She recognises that she has this condition and has struggled, unsuccessfully, to combat it for over a decade. Q also has a diagnosis of Emotionally Unstable Personality Disorder (EUPD), recurrent depression, a background of severe trauma and symptoms of Post-Traumatic Stress Disorder (PTSD). Q challenges some of these mental health diagnoses, but she certainly accepts that the combination of challenges she has faced in her life have had a significant impact upon her mental health. In simple terms, Q does not recognise some of the behavioural and attitudinal characteristics that are attributed to her. It is important to say from the beginning of this judgment, that psychiatric and medical assessments of Q, over the years, have varied, quite starkly, in their conclusions.
2. Q lives independently and has constructed a life which involves socialising, an interest in nature and regular trips into her local town. She very much enjoys sunsets and has photographed them regularly. It is impossible for Q to travel very far. She tires easily, her bulimia has had a significant impact on her body's capacity to function. Q suffers from episodes of life-threatening metabolic complications. By far the most significant of these, is her precariously low potassium level, a condition known as hypokalaemia. It is this condition which is central to the applications made by the applicant Trust.
3. Three declarations are sought which, logically, require to be placed in the following order:
 - a) a declaration as to whether Q lacks the capacity to litigate;
 - b) a declaration as to whether Q has the capacity to take decisions relating to her treatment for hypokalaemia;
 - c) a declaration as to whether an Advance Decision to Refuse Treatment (ADRT), made by Q on 14th October 2020, is valid or whether at the time of creating the document, Q lacked capacity.
4. During this hearing, Q gave evidence in the witness box. It is important to emphasise that this was entirely at her own request and, again at her own request, I heard from her first. There was no doubt that she is an eloquent, articulate woman who told me what she wanted to say in well-reasoned and carefully constructed terms. She was polite, interpersonally skilled, and, in my judgement, appropriately respectful of and grateful for the support of many of the professionals in her life, but particularly her General Practitioner, Dr Gauge. Later, when I heard from Dr Gauge, it was clear that this respect was mutual.
5. It is undoubtedly the case that Q has experienced trauma in her life. She signalled that she did not want to discuss these matters in the court room. Indeed, she does not like to discuss them generally. She has received a good deal of therapy, which she has found to be constructive and helpful, but it has not led her to being generally forthcoming in discussing these events. The papers reveal, and I found her to be, a woman who values her own privacy and guards her dignity. Having shared, with the professionals, the details of her trauma and having been frank about the nature and extent of her bulimia, in terms which are uncompromising and unambiguous, she rather resents having to repeat her history to those who enter the orbit of her care for the first time.

6. However, though Q did not want to talk about these issues in the witness box, it is important not to lose sight of them. They are intrinsically linked to the diagnosis of EUPD, in particular. Accordingly, evaluation of her capacity requires this diagnosis to be considered within the broader canvas of factors which may illuminate capacity in the spheres I am considering.
7. Q has a history of severe childhood trauma, including sexual abuse by her adoptive father. It also seems clear that her adoptive mother failed adequately to protect her from that abuse. Q described her as “cold” and “uncaring”. Furthermore, and perhaps significantly, she was deprived of food in the home. She recounts being constantly hungry and describes herself as receiving “scraps from the table”. She did, however, report a warm relationship with her Aunt B and Uncle N. In an assessment undertaken by Dr Tyrone Glover, a respected expert in this sphere, she describes them as “having food everywhere”. During her A-Level studies, problems began to emerge. She described herself to Dr Glover, as having “no sense of self”. She also began to attend A&E for what she described as “fake injuries”, for largely simple treatments. Dr Glover records her saying that she would “eat anything” at this period and as he puts it “acknowledged a lack of respect with regards to her nutritional intake”.
8. At 19, Q joined the army. There had been a family tradition of service in the armed forces. She served 3 years. Later, towards the end of the 1990s, Q worked as a volunteer in Romanian orphanages; she had been moved by the unfolding tragedy and wanted to help. Though she was manifestly committed to that work, some of her experiences have, in the view of the professionals, further traumatised her. Q married at 29 years of age and has three children. Following the breakdown of her marriage, Q’s mental health deteriorated to the point where she was no longer able to care for her children and they lived with their father. The breakdown of the relationship seriously compromised Q’s mental health and she has struggled ever since.
9. Q has been admitted to mental health units on at least 8 occasions. She has engaged in extensive treatments, during a 12-month admission to a therapeutic unit. She has been admitted to the Priory Hospital, Eating Disorder Ward on 2 occasions. Though there have been protracted periods of stability over the intervening years, Q’s metabolic state has been particularly unstable in the last two years. Low potassium levels can have serious consequences, most notably, a sudden onset, catastrophic and usually irreversible cardiac arrhythmia. Q has had numerous episodes during which her potassium level has reduced to a life-threatening level. On the 1st October 2020, Dr Gauge recorded a reading of 1.4 millimoles per litre (mmol/L), which she describes as “the lowest potassium in a living person in all my years of medicine”. I note that Dr Gauge qualified in 2004. An acceptable reading for potassium levels is, I have been told, between 3 and 3.5 mmol/L. The reading of the 1st October, was, as Dr Gauge describes it “severely life-threateningly low”. Q fully understands the seriousness of her situation and has told me how she regularly monitors her heart rate and worries about it. Dr Glover describes her as displaying “a comprehensive understanding” of the likely complications. In the course of an admission to hospital in July 2020, a DNA CPR (Do Not Attempt Cardio-Pulmonary Resuscitation) was put in place. The medical bundles record that this was done as “[Q] was felt to have capacity”. Whether that was in fact the case, may now be controversial but in any event, no-one now suggests it was inappropriate to put it in place.
10. On the 14th October 2020, Q completed an ADRT which, as Mr Wenban-Smith who acts on behalf of the second respondent, the Hospital Trust submits, requires to be read in

full in order properly to understand the extent and reach of it. I agree. The document includes the following (in the event that Q should lose capacity):

“I want to refuse all treatment relating to low electrolytes, orally, intravenously regardless of my physical condition. This also includes immediate life-saving procedures and interventions such as, CPR, defibrillation, care in any hospital environments to include mental health wards, ICU, CCU, critical care or a hospital ward due to the consequences of my chronic bulimia ...

I do wish to be kept as physically comfortable as possible under any and all circumstances. This can include medication, physical and mental health support, district nurse and OT support. I want to be treated at home until I die and not be treated in any hospital environment. In short, no physical interventions to treat the consequences of chronic bulimia... the exception to this, is medication to keep me physically comfortable”

11. This ADRT is entirely valid in its format and has been provided to Q’s GP, care coordinator, a close friend, and her support worker. It was appropriately witnessed. The issue that arises from it is whether Q had the capacity to make the document at the time she completed it.
12. On the 10th January 2021, Q was detained under the aegis of Section 3 Mental Health Act 1983 (MHA) to ensure her compliance with medical treatment. Q’s account of that admission is disturbing. There is no doubt at all that she found the admission to be extremely traumatic. She was accommodated on a locked ward for a period of eight months. In order that intravenous potassium could be administered, it was frequently necessary to restrain her. In the witness box, she related and repeated a number of times, that she had been held down by “*five burly men*”. In any circumstances, that would have been traumatic but, having regard to her life history, it is unsurprising that it has had a profound impact on her.
13. On the 30th August 2021, Q was discharged by way of a Community Treatment Order (CTO). Section 17A of the MHA 1983 provides for the making of Community Treatment Orders subject to the following criteria:

(1) The responsible clinician may by order in writing discharge a detained patient from hospital subject to his being liable to recall in accordance with section 17E below.

(2) A detained patient is a patient who is liable to be detained in a hospital in pursuance of an application for admission for treatment.

(3) An order under subsection (1) above is referred to in this Act as a “community treatment order”

(4) The responsible clinician may not make a community treatment order unless—(a) in his opinion, the relevant criteria are met; and (b) an approved mental health professional states in writing—

(i) that he agrees with that opinion; and

(ii) that it is appropriate to make the order.

(5) *The relevant criteria are—*

(a) the patient is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment;

(b) it is necessary for his health or safety or for the protection of other persons that he should receive such treatment;

(c) subject to his being liable to be recalled as mentioned in paragraph (d) below, such treatment can be provided without his continuing to be detained in a hospital;

(d) it is necessary that the responsible clinician should be able to exercise the power under section 17E(1) below to recall the patient to hospital; and

(e) appropriate medical treatment is available for him.

(6) In determining whether the criterion in subsection (5)(d) above is met, the responsible clinician shall, in particular, consider, having regard to the patient's history of mental disorder and any other relevant factors, what risk there would be of a deterioration of the patient's condition if he were not detained in a hospital (as a result, for example, of his refusing or neglecting to receive the medical treatment he requires for his mental disorder).

In this Act—

“community patient” means a patient in respect of whom a community treatment order is in force;

“the community treatment order”, in relation to such a patient, means the community treatment order in force in respect of him; and

“the responsible hospital”, in relation to such a patient, means the hospital in which he was liable to be detained immediately before the community treatment order was made, subject to section 19A below.

14. A CTO endures for an initial period of six months. Provisions for its extension, where appropriate, for a further six months and then annually thereafter are set out at MHA 1983 s.20A(1)-(3). It is unnecessary to set those out here. A patient subject to a CTO may apply to the First Tier Tribunal (Mental Health) (“FTT”) under MHA 1983 s.66(1)(ca) to discharge the CTO during the first six months of each period that it remains in force, but not otherwise: see ss. 66(2)(ca) and 77(1)-(2).

15. The powers of the FTT, upon such an application, are set out at MHA 1983 s.72(1), namely:

“...the tribunal may in any case direct that the patient be discharged, and...—

(c) the tribunal shall direct the discharge of a community patient if it is not satisfied—

(i) that he is then suffering from mental disorder or mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment; or

(ii) that it is necessary for his health or safety or for the protection of other persons that he should receive such treatment; or

(iii) that it is necessary that the responsible clinician should be able to exercise the power under section 17E(1) above to recall the patient to hospital; or

(iv) that appropriate medical treatment is available for him; or

(v) in the case of an application by virtue of paragraph (g) of section 66(1) above, that the patient, if discharged, would be likely to act in a manner dangerous to other persons or to himself.

(1A) In determining whether the criterion in subsection (1)(c)(iii) above is met, the tribunal shall, in particular, consider, having regard to the patient's history of mental disorder and any other relevant factors, what risk there would be of a deterioration of the patient's condition if he were to continue not to be detained in a hospital (as a result, for example, of his refusing or neglecting to receive the medical treatment he requires for his mental disorder)”

16. Q was referred to the Tribunal, pursuant to these provisions, but the FTT upheld a continuing need for a CTO, on 14th October 2021. It follows that Q will have a further right to challenge the CTO, in the event that it is further extended, on the expiry of the existing six-month period, i.e., from 27th February 2022.
17. The conditions of the CTO impose the following requirements on Q to:
- i. make herself available for examination;
 - ii. take psychotropic medication regularly when prescribed;
 - iii. engage constructively with all health professionals in the community and attend all relevant appointments;
 - iv. engage constructively with all health professionals in the management of the consequences of the eating disorder.

It is important, given how pertinent it is to the central issues in this case, to set out the terms of the CTO:

“As an example, the management of hypokalaemia should be as follows:

a) Regular monitoring with weekly renal bloods done by the GP surgery, to keep a close eye on potassium, with the option of spacing out blood tests further once potassium levels are stable.

b) If potassium were to drop below 3.0 then: Oral sando K, taken as prescribed and when advised by GP with the potential for increasing frequency of blood tests as needed

c) If potassium drops below 2.0 then the patient will need parenteral potassium as an emergency via A&E

d) If she displays severe symptoms of very low potassium such as limb weakness, chest pains, or palpitations, she needs to be admitted as an emergency via A&E for blood tests and potential replacement, regardless of potassium levels as it would be unsafe to wait for up to 12 hours in the community with severe symptoms

e) If potassium is dropping below 2.5 despite compliance with oral Sando K, or if purging, and not displaying severe symptoms, then to consider planned regular admissions to the infusion suite... for potassium infusions. THIS CAN ONLY BE DONE WITH HER BEING UNDER THE CARE OF SECONDARY CARE PHYSICIAN...

f) If potassium remains above 2.5 without symptoms, she can be managed at home, providing she concurs with Sando K and blood tests”

18. Because it may be relevant to some of the arguments below, it is important to emphasise that iv. (above), identifies the engagement as relating to the “consequences” of the eating disorder rather than the eating disorder itself. As part of her daily routine, Q takes oral potassium (SandoK) two or three times a day. As has been pointed out to me, this is not sufficient to maintain sustainable blood potassium levels, in light of the impact of her “purging” on her kidney function. The regulation of Q’s hypokalaemia, as required by the CTO, includes weekly blood tests by Q’s GP in order to monitor her potassium levels. Potassium injections or infusions are required, if the potassium level drops below 2 or is approaching it. To put this in context, Q was admitted on the 9th September 2021, with a potassium level of 2.3 mmol/L and discharged, following infusion, with a reading of 2.6 mmol/L. On the 22nd November 2021, admission level was 2.2 mmol/L, rising to 2.6 mmol/L by discharge. On the 6th January 2022, she was admitted at a level of 2.1 mmol/L and was discharged at 2.7 mmol/L. On the 2nd February 2022, she was admitted at a level of 2.3 mmol/L and was discharged at a level of 2.6. What is clear, is the regularity with which infusions are required and a recognition that the oral potassium is not, of itself, sufficient to maintain safe levels.
19. Dr Gauge stated that normal potassium levels are 3.5 and 5.5 mmol/L. In the context of the contemplated decisions, these are important figures. Q recognises this, she told me that whilst the regime might appear, at least objectively, only modestly intrusive, that is not her experience. She feels that it impacts very significantly on her day-to-day life. She highlights that following the weekly blood tests, she must wait a couple of days for the results. She appreciates how precarious her situation is and she tells me she worries a lot in the days waiting for the results. She is also anxious before she goes for her levels to be monitored. She tests her heart rate and wonders whether, as she put it “*today will be the day*”. Whilst she is anxious not to die, she finds the regime imposes a burden upon her which she finds difficult to bear. She is also deeply resistant to hospitalisation. Her protracted confinement under the MHA order generated a distress which is rekindled by her hospital admissions. As I have said, whilst she recognises the professional obligations on those involved, she finds the inquiries about her purging and medical background to be invasive of her privacy. My strong impression is that she finds her bulimia to be embarrassing and demeaning. I sensed that she is deeply upset by her own behaviour which she perceives as a failing. She told me how angry she feels when, having spent significant amount of her modest income on food, “*it all ends up down the pan*”.

20. Q told me that she recognises that, but for the CTO, “*she would not be here today*”. She has complied with the terms of the CTO and that has kept her alive. Dr Glover considers that she has made notable improvements under the CTO regime. However, Q tells me that her compliance is “*under duress*”. As she put it, “*if I don’t comply, the men in white coats will come along and take me back to the hospital*”. She elaborated, “*I have been there, it happened to me... I look through the window sometimes checking if they are there*”. As Ms Hirst, who acts on behalf of Q emphasises, coercion should not be construed as agreement. Q, all agree, has consistently and over a significant period of time, been very clear that she does not want to be hospitalised. Ms Power asked Q whether she would comply with the oral medication if she were to be released from the strictures of the CTO. Q said “*I have asked myself that 100 times and I don’t know. I think, sometimes I would and sometimes I would not, especially when I was worried about my levels following purging*”. I think that that response is likely to indicate some compliance, but inconsistent. Dr Glover agreed.

Capacity to litigate

21. There was confusion amongst some of the advocates, and other professionals, as to the applicable test. The observations of Mostyn J in *An NHS Trust v P* [2021] WL 01 700358 [2021] had been afforded greater weight than I am sure he would have intended. In particular, a good deal of reliance had been placed on the following observation:

“I would go further and say that it is virtually impossible to conceive of circumstances where someone lacks capacity to make a decision about medical treatment, but yet has capacity to make decisions about the manifold steps or stances needed to be addressed in litigation about that very same subject matter. It seems to me completely illogical to say that someone is incapable of making a decision about medical treatment, but is capable of making a decision about what to submit to a judge who is making that very determination” [para 33].”

22. I have little doubt that an individual who lacks capacity to decide about medical treatment will frequently lack the capacity to litigate in a case where that is the sole or predominant subject matter. I have equally no doubt, however, that the proposition is not ubiquitous, in the sense that the two tests should be regarded as synonymous. Though I would not put it as high as Mostyn J, I note that he does not discount it absolutely, but regards it as “*virtually impossible*” for the two decisions to be different.
23. The legislative framework of the Mental Capacity Act 2005 (MCA) is rooted in the case law developed in applications for declaratory relief made under the inherent jurisdiction of the High Court in the Family Division, where these cases were heard historically. There are fundamental principles identified in that case law which found clear expression in the MCA. Conspicuous amongst them is the presumption of capacity, which requires rebuttal and the recognition that capacity must be regarded as issue specific in this highly fact sensitive arena. Thus, litigation capacity is a distinct question to subject matter capacity, as Roberts J analysed in *Northamptonshire Healthcare NHS Foundation Trust v AB* [2020] EWCOP 40.
24. It is necessary to reiterate that the test remains that in *Masterman-Lister v Brutton & Co* [2002] EWCA Civ 1889; [2003] 1 WLR 1511, endorsed in *Dunhill v Burgin* [2014] UKSC 18; [2014] 1 WLR 933. The essence of those judgments is to confirm, unambiguously, that capacity to litigate is addressed by asking whether a party to

proceedings is capable of instructing a legal advisor “with sufficient clarity to enable P to understand the problem and to advise her appropriately” and can “understand and make decisions based upon, or otherwise give effect to, such advice as she may receive”. It follows that the issue of litigation will always fall to be determined in the context of the particular proceedings: *Sheffield City Council v E* [2005] Fam 236. None of this requires P to instruct his advisers in a particular way. Like any other litigant, in any sphere of law, he may instruct his lawyers in a way which might, objectively assessed, be regarded as contrary to the weight of the evidence.

25. In Q’s case, although Ms Curran accepted the appointment to act for Q as her Accredited Legal Representative in these proceedings, she has been confident throughout, both that Q understands the significance of the proceedings and is able to give instructions and take advice. The following extract from Q’s statement set out her own view:

“42. When I prepared my advance decision, I had no idea that the Court of Protection even existed or that it would be possible that I would end up in a court having to argue for my rights. I find the process difficult but I want it to be completed correctly so that decisions can be made, preferably by me and there is finally some certainty.

43. I have met with and spoken to my solicitor, Philippa Curran, and barrister, Leonie Hirst. I have felt listened to by them and I have confidence in their abilities to help and support me. I will need to depend on them for advice about the court proceedings because it is all alien to me. I could not and would not want to represent myself in court, but I feel able to understand their explanations to me and tell them what I want to do.

44. For example, I know that it is Dr Glover’s report which causes us to be in the court. I know that he has said that I lack capacity to make decisions now and at the time that the advance decision was made. I do not agree with him” ...

26. Although Dr Glover had considered that Q was “unable to appropriately instruct her legal team” because she would “almost certainly argue for a course of action that will lead to a significant risk to her life”, he yielded on this point, to the view of Q’s legal advisers. The guiding principle here, as always, is the importance of distinguishing an “unwise decision” from one upon which P lacks capacity. I consider that Dr Glover has taken the Mostyn J approach (i.e., that capacity to litigate and to take decisions relating to treatment are synonymous), either because he has taken that judgment to set out the test, or because it accords with his own views. In any event, I agree with Ms Hirst that Dr Glover has applied the incorrect test for litigation capacity. Ms Hirst goes further:

“With respect to Dr Glover, that assessment is flawed: it does not apply the correct test for litigation capacity, and wrongly conflates the issue of capacity with that of best interests / ‘unwise’ decision-making. [Q] may through these proceedings be pursuing a course of action which Dr Glover views as deeply unwise, but that does not mean that [Q] lacks capacity to conduct these proceedings.”

It is important that I record that Dr Glover now accepts that the two tests should not be regarded as synonymous. Whether he conflated the issue of capacity and best interests, as Ms Hirst submits, is a matter for me to consider when considering the separate issue of capacity to take decisions relating to Q's treatment for hypokalaemia. For the avoidance of doubt, I find that Q for the reasons I have set out, has the capacity to litigate.

Capacity to make decisions about treatment

27. In *ER v An NHS Foundation Trust* [2021] EWCOP 32, Lieven J had the benefit of what she described as “a very helpful note on the law”, which was agreed by the parties and is reproduced in the judgment. Ms Power, on behalf of the applicant Trust, has set that out in her position statement. It is helpful to replicate the core of that analysis here:

“25. Under section 1(2) MCA, a person must be assumed to have capacity unless it is established that they lack capacity. The burden of proof lies on the person asserting a lack of capacity and it is always decision specific. Capacity must be assessed at the time the decision needs to be made. Pursuant to section 2(1) MCA, a person lacks capacity in relation to a matter if at the material time they are unable to make a decision for themselves in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.

26. Pursuant to section 3(1) MCA, a person is unable to make a decision for himself if he is unable (a) to understand the information relevant to decision, (b) to retain that information, (c) to use or weigh that information as part of the process of making the decision or (d) to communicate his decision whether by talking, using sign language or any other means. An inability to undertake any one of these four aspects of the decision making process set out in section 3(1) MCA will be sufficient for a finding of incapacity provided the inability is because of an impairment of, or a disturbance in the functioning of, the mind or brain.

*27. As is clear from what is set out above, the real issue in this case is whether ER can meet section 3(1)(c) – i.e. whether she can use and weigh information. In the case of *PCT v P, AH and The Local Authority* [2009] EW Misc 10 (EWCOP) at paragraph 35, Hedley J described the ability to use and weigh information as “the capacity actually to engage in the decision making process itself and to be able to see the various parts of the argument and to relate one to another”.*

*28. Whilst the evidence of psychiatrists is likely to be determinative of the issue of whether there is an impairment of the mind for the purposes of section 2(1) MCA, the decision as to capacity is a judgment for the court to make (Re SB [2013] EWHC 1417 (COP)). In *PH v A Local Authority* [2011] EWHC 1704 (COP) Baker J as he then was observed at paragraph 16 that:*

“... in assessing the question of capacity, the court must consider all the relevant evidence. Clearly, the opinion of an independently-instructed expert will be likely to be of very

considerable importance, but in many cases the evidence of other clinicians and professionals who have experience of treating and working with P will be just as important and in some cases more important. In assessing that evidence, the court must be aware of the difficulties which may arise as a result of the close professional relationship between the clinicians treating, and the key professionals working with, P ...”

28. There are several reported cases that have been cited to me by the advocates e.g., *Re: E (Medical Treatment) Anorexia* [2012] EWHC 16739 (CoP); *Betsy Cadwaladr University Local Health Board v Ms W* [2016] EWCOP 13; *Cheshire and Wirral Partnership NHS Foundation Trust v Z* [2016] EWCOP 56; *Northamptonshire Healthcare NHS Foundation Trust v AB* [2020] EWCOP 40; *Heart of England NHS Foundation Trust v JB* [2014] EWCOP 342. It is important to stress that many of those cases concern anorexia nervosa and its impact, on decision taking for the individual (P). Here, we are dealing with a case of bulimia nervosa. The different dynamic of this illness has been impressed upon me by the medical experts, particularly by Dr Glover. Additionally, the treatment that we are focussing upon, is not for the bulimia itself but for the physical consequences of it i.e., the hypokalaemia. That is an important distinction.
29. At the beginning of this case, Ms Power told me that her clients remained neutral, on this question of capacity. The case had been listed with an estimated hearing of 1 day. It was plainly an underestimate, but it was possible to conclude all the oral evidence within one day. Over the weekend, the parties had an opportunity to reflect and to present oral submissions on Monday morning. Having had the opportunity to consult with her team, Ms Power told me that the applicant Trust was no longer neutral and submitted that Q had the capacity to take these medical decisions herself.
30. Both Ms Power and Mr Wenban-Smith, on behalf of their respective Trusts, tested and probed the evidence in a way which was sensitive, focused, and constructive. It was a paradigm example of how the Court of Protection works most effectively in an investigative, non-adversarial sui generis framework. Mr Wenban-Smith’s clients have remained neutral but in his closing submissions, in order to give balance to the forensic investigation, he emphasised the strengths of Dr Glover’s approach. This ensured that the whole gamut of the evidence was addressed in a balanced way during submissions. It is convenient to record here that I have had the benefit of advocacy of the highest quality from each of the represented parties.
31. There is no dispute, nor could there be, that Q is able to understand the information informing the decision on whether to accept or refuse potassium treatment. Neither is there any doubt that she is able to communicate her decision. Indeed, everybody (and I emphasise without exception), has recognised that Q is a very articulate and reflective woman. Thus, no issue arises in relation to Section 3(1) MCA (a), (b), or (d) (see above). The sole question which falls for consideration is whether Q is able both to weigh and use information relevant to her potassium treatment for her hypokalaemia.
32. The first of the professional witnesses I heard from, was Dr Gauge, Q’s General Practitioner. What struck me most about Dr Gauge, if I may say so, was her contagious enthusiasm for her professional role and her unstinting commitment to her patient. She told me how she considered that one of the great advantages and professional rewards

for her, in general practice, is to build up relationships with her patients and to observe how both life's unexpected fortunes as well as its vicissitudes have an impact on their health and welfare. It was obvious to all that she had a strong mutually respectful relationship with Q. I was also impressed by the extent to which she had found the time, in a busy practice, and at a challenging period, to carve out space and time for her patient.

33. Dr Gauge has had the benefit of knowing Q since August 2018. She highlights the unwavering consistency with which Q has both revealed and articulated her views on her treatment over this period. Dr Gauge emphasises to me that those same "*steadfast wishes and beliefs*", as she terms them, have also been voiced to others within the medical group. In her evidence, Dr Gauge told me that Q explained how, since August 2021, she had only complied with the blood tests and treatment in order to avoid being recalled to hospital. Dr Gauge was very clear that Q finds medical intervention to be very distressing. I find that Dr Gauge is well placed fully to understand the extent and nature of Q's distress. Both in her oral evidence and in her thoughtful report, Dr Gauge was clear that "*repeated hospital admissions are distressing for [Q]*". She also records that Q has "*on many occasions*", described her hospital trips as feeling "*traumatising for her*". All this resonates, as is clear above, with the evidence that Q gave to me in the witness box. In his evidence, Dr Glover talked about how the potassium treatment regime was, objectively, relatively unintrusive. What Dr Gauge was able to communicate to me, however, was the nature and extent of its impact on her patient.

34. In addressing this question of capacity, which Dr Glover describes as "*delicately balanced*", I find that the juxtaposition of these two different approaches on this point, is of significance. Both have a validity, but it strikes me, with some diffidence, that only the Court is best placed to evaluate the weight to be given to these two differing perspectives. Baker J, as he then was, captured the point in *PH v A Local Authority* [2011] EWHC 17404 (COP), at paragraph 16:

"In assessing the question of capacity, the Court must consider all the relevant evidence. Clearly, the opinion of an independently instructed expert will be likely to be of very considerable importance, but in many cases the evidence of other clinicians and professionals who have experience of treating and working with P will be just as important and, in some cases, more important. In assessing that evidence, the Court must be aware of the difficulties which may arise as a result of the close professional relationship between the clinicians treating, and the key professionals working with, P..."

35. In detail in her report, and more summarily in her evidence, Dr Gauge recounts the discussions that she, or members of her team, have had with Q. It is not necessary for me to review those in detail. Dr Gauge was satisfied that Q understood the consequences of her low potassium; that refusing investigation or medical treatment may lead to sudden death or becoming seriously unwell. Q's capacity was assessed regularly throughout this period via the standard capacity assessment. Dr Gauge told me there was not a single occasion that she concluded that Q lacked capacity.

36. Dr Gauge and the CMHT Team Leader communicated regularly and in a phone call in November 2020, recognised "*there is a school of thought to say that admitting her to hospital is traumatic and is not in her best interests in the long run*". At an MDT meeting held at around that time, Dr Moosa, Q's named CMHT Consultant, made the following

observation which was recorded in the minutes: “*HM advised that it is traumatic being detained into hospital; however, it is needed. He felt that the Courts would not be in favour to let a patient die when they can be medically treated especially when they have a mental health/eating disorder*”. This reflects, to my mind, the difficulty that the clinical team has had in balancing the complex and competing factors that arise in this case. It is also a further illustration of the real determination of all those involved to do their best for Q. Q fully recognises this and appreciates the work and effort that has been put in on her behalf.

37. The real professional dilemma for Dr Gauge was expressed in her report, thus:

“I have been asked to state whether I feel it is in her best interest to continue to receive potassium monitoring and treatment against her wishes. The alternative is likely death within weeks or months unless her pattern of purging were to change. I have spent many hours considering this ethical dilemma, as to whether death is a better alternative for her than living in the way she is currently doing, and do not have a clear belief about which option is in her best interests. However, I do feel that [Q’s] wishes need to be strongly considered in the decision as I see and acknowledge her distress with the status quo. I see the physical and mental burden on this lady of living with chronically low potassium levels and with her eating disorder.”

38. Of course, if the conclusion is that Q has capacity in this sphere, it is her decisions that prevail and not any views the Court might have as to where her best interests lie. However, this passage also signals to me that the consistency and strength of Q’s wishes, as well as her visceral distress with the ‘status quo’, would fall to be considered very carefully, even if the Court concluded that she lacked capacity. Indeed, they would require to be given very significant weight. This best interests’ ‘dilemma’ (should it fall to be considered) is one that Dr Gauge has not resolved in her own mind and prefers to leave to the Court.

39. I heard evidence from Dr Razia Hussain, a Consultant Psychiatrist, who reviewed Q in her clinic as recently as the 24th January 2022. She told me that she found Q to be well able to both challenge and assess the issues regarding her mental health diagnosis and that she also talked to her about her physical health generally and the medications that she has been taking, as prescribed by her General Practitioner. In her report, dated 3rd February 2022, she made the following observations:

“I have the opportunity to see [Q] on the 24/1/2022 for a CPA review accompanied by Gillian McKie who is the care co-ordinator. This CPA review was quite beneficial and meaningful for me to provide more information regarding [Q] mental state and capacity specific to her [Q’s] wishes to decline future medical intervention. [Q] was aware of her appointment and attended the clinic independently as per planned according to the date and the time. Her speech was spontaneous and addressed all the issues in details. [Q] presented as a very rational, reflective and confident individual especially with regards to her care planning and treatment. She appears to be a confident lady with good self-esteem. (my emphasis)

[Q] has an ongoing issue regarding receiving treatment medical intervention as a consequence of Bulimia nervosa. We had a lengthy discussion about this issue. [Q] was well orientated with time, place and person. There was no evidence of cognitive impairment. She was fully alert and was able to understand, register, recall information. There was no evidence of any confusional state. I am under the opinion that she has mental capacity to make decision regarding her treatment.”

40. More generally, but pertinently, Dr Hussain noted:

“She spontaneously talked about her diagnosis and appropriately challenged her diagnosis of Emotionally Unstable Personality Disorder. We have also discussed the link between the diagnosis of Emotionally Unstable Personality Disorder and Eating Disorder. We have also discussed about the link Eating Disorder and purging. We also discussed the complications and consequences of the longstanding behaviour to her physical health. We talked in-depth that this could be life-threatening which requires immediate treatment and attention. [Q] was fully aware and had a very good knowledge of her mental and physical health and needs. We talked in-depthly about [Q] accepting these physical health complications is associated with the longstanding difficulties. She did not present as being hopeless or other clinical signs of depression at time of assessment. There was no evidence of emotionally blunting. She appeared as with full of hope, looking forward to the future and having future plans such as going shopping. I am of the opinion that [Q] did not present as having a low regard for herself. She was interacting well in the context of assessment, appeared warm in her manner and gave relevant answers to all the questions related to the assessment.

Furthermore, I have accessed her electronic record and gathered information that she at times has accepted the food containing potassium such as beetroot and bananas. She has also tried oral potassium replacement to keep her fit especially at the time of the court case. She has good insight to her mental and physical health and her needs.

*During this review, we also had a discussion that [Q] is currently on morphine, and gabapentin which are high risk medications in case of overdosing. [Q] stated that it is not her intent to end her life. She agreed that she has a number of means to end her life, if that was her intentions, however she has no active plans to end her life at time of assessment. Rather she has accepted that death will be the ultimate consequence of her long-standing Bulimia. Following this discussion, I am in the opinion that **she is able to weigh up the information to make decisions regarding her treatment for physical health. Looking through her case records electronically and talking to her care co-ordinator, her mental capacity appears to be stable and her views has been consistent***

regarding her treatment request for physical health.” (my emphasis)

41. I have highlighted the above passage and that at paragraph 39, above, because they express a markedly different professional perception to that of Dr Glover, whose evidence I will turn to below. The rational, reflective and, at least outwardly, confident person that Dr Hussain describes, reflects the descriptions given by Dr Gauge. For good measure, all who heard Q in Court, regarded her as having engaged confidently and articulately with the Court process. The latter is an extraneous lay observation and requires to be identified as such. It is nonetheless part of the broad canvas of the evidence.
42. Dr Glover is a Consultant Psychiatrist who specialises in General and Eating Disorder Psychiatry. He is of undoubted expertise in this challenging area of work. He was the appointed expert in most of the cases that I have been referred to by the advocates. I found him to be an impressive witness, not least because he was fully prepared to acknowledge the significant contributions of others, particularly Dr Gauge who Dr Glover recognised knew her patient very well. Specifically, whilst Dr Glover held fast to his view that Q lacked capacity, he signaled, very clearly, that others might be better placed to evaluate where Q’s best interests lie were the Court to conclude that she lacked capacity to take the decision in respect of her potassium treatment. Indeed, I note that in his report, he expressed the view that best interests’ decisions are *“always best left to those as closely involved with the individual personally and the clinical situation professionally”*.
43. Dr Glover considered that Q has placed significantly less value on her own life over the last 8 to 10 years, i.e., following her separation, than she would have prior to that. He considered that the bulimia nervosa and EUPD impaired her decision making which he assessed as identifiable by its impact on her self-esteem, mood, and view of the future. This development of what he identified as *“pervasively low self-esteem and hopelessness”* both of which he considered to be directly attributable to her mental disorder, fundamentally impaired her ability to weigh matters of life in the balance.
44. In his evidence, Dr Glover repeatedly referred to *“Q’s inability to recognise the value of life”*. I formed the impression that Dr Glover afforded the value and/or sanctity of life very significant weight in his analysis of Q’s capacity. In his report he made the following observation:

“Q attributes little value to her own life and sees little of value in her future. It must follow that her ability to weigh life and death medical decisions in the balance, is impaired.”

I have considered this passage carefully. However, I do not think the second proposition follows, axiomatically, from the first. The value an individual attributes to life may correlate with their experience of it or their perception of its quality. An individual with motor neurone disease, for example, may attribute little value to his or her life and see little of value in the future. To my mind, that does not automatically establish an inability to weigh life and death in the balance. On the contrary, it may represent a finely calibrated utilitarian calculation.

45. Dr Glover articulates his analysis in various ways. Because it is so important fully to understand his reasoning, it is necessary to review his analysis in some detail. He considers that Q’s *“sense of worthlessness”* is *“profound”*. In his assessment, it is so

“pervasive and consistent” as to disable her from “weighing life and death decisions” in the balance. Dr Glover has referred, in his report, to Q’s “worthlessness”, which he emphasises is directly attributable to her mental health disorder, as being of “such magnitude” as to “significantly impair her ability to weigh life and death decisions in the balance”.

46. Dr Glover has visited Q twice, once at her flat. He gave me the impression that Q was as relaxed with him as the circumstances could reasonably permit. In his second addendum report, dated 20th January 2022, Dr Glover recounts this visit:

“2.5 Since her discharge at the end of August 2021 Q informed that she has continued to take oral supplements as prescribed. She explained she had required three “emergency” transfers to hospital for intravenous treatment of hypokalaemia (low potassium). On one occasion Q was required to stay overnight but on the other two occasions her length of stay in A&E was 12 to 14 hours. Q acknowledged that this was relatively efficient and has been made possible as Q has a specific patient treatment plan which is put in operation at Royal Blackburn Hospital A&E should she be admitted with life threateningly low potassium levels. I pointed out to Q that it seems clear this CTO is working well and three admissions to A&E in five months does not seem overly intrusive given that the only previous way in which she had been kept safe was to remain an inpatient in hospital. Q acknowledged this but went on to say “I can’t stand it. I just want to be left alone”.

“2.6 When pressed on why this CTO was so difficult for her to bear, Q explained that she is “sick of” the involvement of mental health practitioners in her life and feels the conditions of the CTO “hanging over me” all the time. Q did acknowledge that without the CTO she would not have been able to return home and enjoy living independently in her flat as she is currently.”

47. Dr Glover was also clear that Q described *“extremely severe bulimia nervosa”* to him. She binges and purges what he describes as *“an excessive quantity of food”* in a short period of time. This happens at least 4 times per day. Q told me how ashamed this made her feel. With a striking degree of candour, she impressed upon me the impact it has on her life. *“The first thing I do”,* she told me, *“when I go to a restaurant, is to check out the toilets to see if they are suitable for me to be able to throw up in”.* She was not asked what qualified as suitable, but I sensed that she was looking for a degree of privacy and cleanliness. Q has been able to impress upon Dr Gauge and others that her day-to-day life revolves around her bulimia, her treatment regime, and the anxiety both generate. She also articulated very clearly in the witness box, that she felt that she had no power over her own life. Dr Glover highlights the success that the CTO has achieved, but Q emphasises that her compliance is not consensual, it has only been achieved by coercion. In many ways, that is the objective of the CTO, the sanction for its breach includes a real potential for recall to hospital. This, I consider, also needs to be understood in the context of Q’s traumatic childhood in which her bodily autonomy was violated by her adoptive father, in collusion with a mother who did not seem motivated to protect her.

48. Dr Glover observed in his recent report that:

“2.7 It was difficult to gain any greater understanding of Q’s reasons for wishing to make such a clean break with mental health professionals when they seem, superficially, to have little significant involvement in her day-to-day life”

Having regard to the broad canvas of the evidence I have heard, I consider the key word in the above passage, as Dr Glover insinuates, is *“superficially”*. Objectively, the intervention of health professionals might indeed appear relatively unintrusive, but the subjective experience of Q is very different.

49. Dr Glover confronted Q with his view of the positive qualities of her life, in these terms:

“2.10 I tried gently to point out that within a short space of time Q had clearly revealed that she was able to take pleasure in a significant number of relatively simple aspects of her current life, the views, the flat, good quality food (notwithstanding its ultimate purpose) and questioned why she would seek to risk missing out on these simple pleasures by exposing herself to sudden cardiac death due to hypokalaemia when it has only taken three relatively brief visits to A&E in the last five months to prevent such a catastrophic event and allow her to remain living in the flat which she clearly enjoys.”

He also records Q’s response:

“2.11 Q’s answer was simply to repeat the comments detailed above. She again said that she was “sick of it” and said that she just wanted to be “allowed to get on with my life without interference.””

50. There is no doubt that Q enjoys many facets of life, I have described this above. It is important to make clear, as Dr Glover does, that Q fully recognises these pleasures. She particularly loves her flat, its dual aspect views affording her an opportunity to enjoy both the sunrise and sunset, as well as its pleasant westward views to a wooded hillside. She is fastidious in her insistence on *“real coffee”*, Dr Glover told me. His mental state examination on this last visit revealed the following:

“adequate self-care. clothes appropriate for situation and occasion; good eye contact. warm rapport rebuilt easily; appeared honest and sincere throughout; speech normal but slightly increased in rate; acknowledged difficulties with sense of identity; acknowledged mood instability; described several symptoms of depression including hopelessness, lethargy, demotivation, and worthlessness; convincingly denied suicidal ideation; described classical binge/purge symptoms pathognomonic of Bulimia Nervosa; expressed pleasure at various aspects of her life (see above) and no evidence of psychosis.”

51. Though Q perceives the CTO to be coercive, Dr Glover identifies it as *“a notable achievement”*. Q recognises this too. She says, *“I am here, I may not have been without it”*. Dr Glover continues:

“4.1 To have facilitated Q’s discharge from hospital at the end of August to reside full time in her own flat is a significantly better outcome than I would have anticipated at the time of my initial report. All involved in the construction and implementation of that plan should, in my opinion, be commended”

Equally, he recognises:

“4.2 There is, however, no doubt it continues to exert an influence over Q’s life and, perhaps, cast a shadow over her apparent independence.”

52. In response to Counsel’s questions, Dr Glover emphasised that the current treatment plan has led to significant clinical progress. Q, he said, *“is now based in her own home, living independently, the only restrictions on her are for her to take her potassium on a daily basis and to attend for blood tests.”* He draws the follow conclusion:

“In my opinion the restrictions imposed on Q are relatively minor considering the progress they have yielded. It would seem to me to be in Q’s best interests to remain on her current treatment plan resident in her own home and subject to the conditions of the treatment order.”

53. Dr Glover considered the prospects of any recovery at this stage to be slim. However, he said, *“sometimes something just changes in people’s lives, [Q] might develop her interest in a gardening group, that might just change things for her”*. Dr Glover’s real and muscular commitment to saving Q’s life, is powerful and impressive. But it is difficult to resist the conclusion that his instinctive professional desire to save Q’s life has, to some degree, obfuscated his focus on the central question of capacity. Jackson J described this as: *“to allow the tail of welfare to wag the dog of capacity.”* (*Heart of England NHS Foundation Trust v JB (supra)*). That is an ever-present danger for all the professionals involved in these cases including, if I may say so, the Judge.
54. Despite the unambiguous language and strong emphasis that Dr Glover afforded to his analysis of the impact on Q’s decision making of the worthlessness and low self-esteem that he identifies, it is very important to state that even in his earlier reports he regarded this as a *“finely balanced”* issue, in which he *“entirely understood”* the views of the other clinicians. In his final visit, he noted *“a significantly higher number of positive emotions being expressed”*. He did not recall any such positivity during his assessment of her whilst she was an inpatient. Dr Glover saw this as Q having made significant improvements. He is undoubtedly right, but those improvements must also resonate when assessing capacity. They are clearly relevant when evaluating whether Q’s sense of worthlessness or low self-esteem eclipses her capacity to take a decision on her potassium treatment.
55. In what was, on Dr Glover’s own analysis, a finely balanced decision, I consider that this must shift that balance more closely towards capacious decision-taking. Dr Gauge and Dr Hussain were never convinced that Q’s sense of worthlessness or low self-esteem was as pervasive as Dr Glover considered. They were both clear that Q has the capacity to take these decisions for the reasons I have set out above. Dr Glover, with consummate professionalism, was entirely right to indicate that the assessment of those who know Q well, most particularly Dr Gauge, require to be afforded significant weight. That in my judgement is not confined to the question of best interests, but has equal applicability to

their evaluation of capacity, having regard to the way that the issues have been framed. In simple terms, Dr Gauge is also very well placed to assess Q's self-esteem and sense of worth given the length of time she has spent with her patient and the number of occasions on which she has undertaken capacity assessments. The MCA erects a presumption of capacity; I have to ask myself whether that presumption has been rebutted. I have come to the clear conclusion that it has not.

56. It is also important to state that whilst Q loathes her own frailty, as she sees it, in being unable to combat her own eating disorder, I, like Dr Gauge, did not consider that crushed her self-esteem in other areas of her life. As I have already commented, her confidence in the witness box was striking and she responded thoughtfully and reflectively to Counsel's questions. She gave evidence because she wanted to and, by that stage, I had already concluded that she had litigation capacity. Her evidence was not structured in a way as to require her to assert her capacity on the central issue nor was she challenged on this by this experienced team of advocates. She was, however, sensitively, and properly questioned about her self-esteem. She turned to Counsel and said, "*I think all women have self-esteem issues of some kind*". It was an answer delivered with both confidence and humour. Additionally, Q lives independently and alone within the limits of her physical condition, she looks outwards towards the world and to other people. This too signals something of her self-confidence and self-worth, particularly if one has regard to the traumas of her past.
57. Q does not want to die, but she does not want to live under a medical and mental health regime which she finds oppressive and corrosive of her autonomy. As she puts it, she is simply "*sick of it*". On paper, that regime may not appear rigorous but for Q, it undoubtedly is. I regard her view, if she will forgive me for saying so, to be an unwise one. Whilst I hope that recovering her autonomy may be empowering for her, I consider, on the evidence, not least her own, that it is most likely to hasten her death. I am sure that those who have had regular dealings with her, and her friends will consider that a considerable loss. She is an engaging personality with much to offer. However, whilst her decision may be objectively unwise, it is hers and not mine. I must respect her autonomy.
58. The remaining declaration concerns the Advance Decision to Refuse Treatment, made on the 14th October 2020. For the avoidance of doubt, no party has sought to suggest that the ADRT is invalid for any technical reason. Ms Power submits, and I agree, that the issue of capacity at the time of the ADRT would stand or fall with the issue of current capacity. Whilst I have noted that Dr Glover identified greater positivity in his visit in 2022, the same degree of positivity was consistently observed by Dr Gauge and her team in 2020. I am satisfied that to whatever extent, Q may have exhibited low self-esteem and worthlessness, it is not evident to such a degree as to occlude capacitious decision-taking on this issue.

