**[2023] EWCOP 1**

**Case No: 13909989**

**IN THE COURT OF PROTECTION**
**IN THE MATTER OF THE MENTAL CAPACITY ACT 2005**
**IN THE MATTER OF AH**

Sessions House,
Lancaster Road,
PRESTON
PR1 2PD

Date: 4 January 2023

**Before :**

**HIS HONOUR JUDGE BURROWS**

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**Between :**

**LANCASHIRE & SOUTH CUMBRIA NHS FOUNDATION TRUST**
**-and-**
**LANCASHIRE COUNTY COUNCIL** — **Applicants**
**- and -**
**AH**
**(By her ALR, RE)** — **Respondent**

**(BEST INTERESTS)**

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**Adam Fullwood** (**Louise Wilson**- hand down only) (instructed by/of **Hill Dickinson & LCC Solicitor**) for the **Applicants**
**Ben McCormack** (instructed by **Southerns, Burnley**) for the **Respondent**

Hearing dates: 21 December 2022

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# JUDGMENT

This judgment was delivered in public. 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 AH 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.

**HIS HONOUR JUDGE BURROWS:**

## INTRODUCTION

1. This case is about AH. She suffers from type 1 diabetes. If her diabetes is properly managed, she is able to be fit and healthy. If it is not, she can rapidly become seriously unwell, and could die. In the past she has not been able to engage with those professionals who are responsible for her diabetes care. That led to her becoming seriously ill with ketoacidosis. She required hospital treatment. She was fortunate not to die.

2. AH was the subject of a judgment I handed down on 12 October 2022: see [2022] EWCOP 45. That was devoted to the subject of her capacity to make decisions concerning her residence and care in the context of her health and her inability independently to manage her diabetes.

3. In a reasonably lengthy judgment, I decided AH lacked the capacity to make these decisions. This judgment follows the hearing considering her best interests. There have been no challenges to the decision I made in my earlier judgment, nor to the evidence on which that decision was based. Although capacity is time as well as issue specific, and therefore may change over time, there is no reason for me to change my decision on AH's capacity. In fact, the evidence of her engagement since that decision would tend to confirm what I decided.

4. At the final hearing just before Christmas, no live witnesses were required by the parties. I did hear from AH herself, who spoke to me candidly about her views. However, those representing her did not actively challenge any of the evidence. That evidence comprised

mainly of updated statements from the Social Workers LA and Learning Disability Nurse, JC. I have also considered all the evidence that was the basis of my earlier judgment, too.

5. This judgment continues to protect AH's anonymity by using initials that are not hers. The names of her supporting professionals are not given.

**BRIEF BACKGROUND**

6. I will not repeat my earlier judgment, which sets out the background to this case. For present purposes the following only is relevant.

7. Due to the risk to AH's life because of her inconsistent engagement with services, I was asked initially to approve a care plan for AH that involved a period of assessment in Placement 1. That meant she would spend a period of a few months at the placement. She would be deprived of her liberty there because she was not free to leave and could only leave the placement for visits to her own flat with the permission of staff and was required to return in accordance with her care plan.

8. I am in no doubt that AH is deprived of her liberty. She does not want to be at Placement 1. She wants to be in her own home. She is allowed to go there, but she is in effect on leave when she does, and she has to return to Placement 1 when required. She is not allowed permanently to leave Placement 1 and reside somewhere else. Whilst she is at Placement 1 she is under continuous supervision and control, i.e. necessary monitoring, and is not free to leave as and when she wishes.

**OPTIONS**

9. It is important to pause at this stage to mention the way this case has been conducted by the parties. Between the interim and final hearing, those representing AH asked a number of questions of the public authorities designed to ensure that the Court was in possession of all the evidence it needed to make a final decision. These questions concerned the nature of AH's relationships with staff and residents, and her engagement with activities at the placement, and their position on AH's best interests for residence and care -which are pretty standard in cases of this sort. However, they also probed into the availability of various types of care package.

10. The questions were:
    - Asking for confirmation as to whether the LA finance team has completed a financial assessment of AH and if so, whether she is required to contribute to the cost of her residential accommodation or her care and support, including details of any arrears?
    - Whether there are any other placements available for her that could meet her assessed needs?
    - Whether AH could live 3 nights at Placement 1 whilst retaining her flat?
    - Whether Placement 1 could continue to administer her twice daily insulin if i) AH were a part time resident there and ii) if she were not a resident there, should she return to reside at her flat?
    - Whether there are any care providers available that could provide the care and support, including her diabetic care and treatment, should she return to reside at her flat? The evidence was to address whether the care provider (nurse led provider with a registered nurse in employment) currently employ care workers trained to administer insulin or willing to consider specialist training for care staff to administer insulin as a delegated task?

- An assessment of the recommended staffing ratio of care and support to AH in her own flat and should there be a difference in ratios per provider the rationale for that.
- Whether any of AH's existing care providers presently employ a registered nurse or are willing to employ a registered nurse and, if they are, in principle, willing to train their staff to administer insulin as a delegated task with a view to AH returning to reside at her flat?
- Whether any of her three existing providers could support her practically to administer her own insulin, and if so, the scope of the practical support that they would be able to provide, should she return to reside at her flat?
- The outline of any trial of any of the options identified.

11. Those representing AH did not to seek to challenge the evidence given by the Applicants, including the answers to these questions. They are highly experienced practitioners in Court of Protection work and clearly this was a judgment they made. This was a highly efficient way of conducting the case, and was, of course, all subject to whether I agreed. In the circumstances, I did.

12. AH wants to go home. She does not want to remain in Placement 1. Those who act on her behalf, whilst not making submissions that this would be in her best interests, submit that these are her clear and consistently expressed wishes and feelings and I should give them a great deal of respect when making the decision.

13. The Applicants invited me to find that it is in AH's best interests to stay where she is.

14. It is important for me to consider why these are the only options a little more closely before continuing to make that decision. This is not least because decisions by the authorities and the legal framework more generally combine to limit the options that might otherwise be available to AH.

15. At present, whilst this Court considers its final decision, AH is subject to a care plan whereby she resides at Placement 1, she is allowed to leave there on a daily basis subject to a requirement to return as arranged or as required. I have referred to this as "leave"- a term borrowed from the Mental Health Act 1983 (MHA). What I mean by this is that AH is still subject to the regime at Placement 1, and still subject to the control exercised from there, and liable as a matter of law to be returned there in accordance with the Order of this Court. As part of that arrangement, she is permitted to spend a night- usually one a week- at her own home. This is very important to her. Although she says she is very unhappy at Placement 1, she is in fact enjoying a great deal of her own time. Being able to visit and stay at her own flat are clearly very important to her. Having read the exhibits to the ALR's most recent statement, it is very clear that having her own home, even if she is only able to be there some of the time, and only when others permit her to be there, is extremely significant to AH.

16. This is, in fact, the option I chose for AH on an interim basis. I did so in order for an assessment to take place which would educate me when I had to make a final decision. Indeed, if I could make a final decision that AH should continue to enjoy this "shared residence" arrangement, it would be very tempting. It provides her with the safety and security of a safe residence where her physical health and compliance with her insulin can be monitored, along with having her own place to enjoy- and over time, no doubt time at home would increase if and when her physical health was seen as more robust.

17. However, this is not an option. At the present time, AH is resident at Placement 1. She has to be resident there in order to receive the care she enjoys- including the proper supervision of the administration of her insulin injections.

18. Furthermore, the rent for her flat is being paid by housing benefit. It will, however, not be paid beyond the first anniversary of her residence at Placement 1. Both counsel tell me that by operation of the Housing Benefit Regulations 2006 (regs 7(11) and (12)) AH cannot have her rent paid if she is resident elsewhere. Her compulsory detention, and therefore residence elsewhere at Placement 1, does not stop her housing benefit until the first anniversary- which will be March 2023. After that, her rent would not be paid and she would lose her flat. In fact, it would be earlier than that if I made an order that she remain at Placement 1 for the long term. This is not least because her landlord would seek to terminate her tenancy on the grounds that it is not her residence anymore.

19. Furthermore, the managers of Placement 1 have made it clear that in order for AH to remain there, she would have to have a full-time placement. Without that, the ongoing supervision of her condition as well as the administration of her insulin could not continue.

20. The ICB and the LA would also be unable to commission a full-time placement at Placement 1 alongside a community package of care.

21. Finally, the District Nurses, who would be responsible for her diabetes care in her own flat would not be able to support her unless she was living in her flat full time.

22. That means the options available are stark. If AH stays where she is, she will not only be in a place she consistently says she does not wish to be but will have nowhere else to go even for a short stay. More importantly, perhaps, she will have nowhere else to aspire to go.

23. On the other hand, if she is permitted to return to live in her own home, which she wants to do, she will be back to where she was a year ago and be at great risk of the cycle starting all over again- non-engagement, illness, hospitalisation and then a dispute as to her destination upon discharge- if she does not die first.

**THE LAW**

24. Having concluded AH lacks the capacity to make decisions concerning her residence, care, and treatment, the Court has to decide what decision, if any, should be made on her behalf.

25. That decision must be made in AH's best interests. I remind myself without any extensive quotation that I must apply and be guided by s. 4 of the Mental Capacity Act 2005 (MCA) when considering what decision to make. I am satisfied that it is unlikely due to my findings in my earlier judgment that she will regain (or perhaps the word ought to be gain) capacity to make these decisions. I am satisfied that she has been supported and encouraged to make these decisions but is unable to do so. I must consider her present and past wishes and feelings, her beliefs and values, and any other factors I consider relevant- I will come back to these later. I must consider the views of those responsible for supporting and caring for her.

26. In Aintree v James [2013] UKSC 67, the Supreme Court decided that this Court must consider the person concerned's "welfare in the widest sense", and not just look at narrow medical considerations. I am required to "consider matters from the patient's point of view" and to place in a position of great importance- although they are not necessarily determinative- the person's wishes and feelings.

27. In this case, the judgment of Peter Jackson, J. in Wye Valley NHS Trust v B [2015] EWCOP 60 is particularly relevant. I must not consider capacity to be like an 'on/off' switch. The Judge in that case made a particularly important point at [11] that "the wishes and feelings beliefs and values of people with mental disabilities are as important to them as they are to anyone else, and **maybe even more important**". An automatic "discount" should not be applied to take account of the person's status as mentally disabled. I added emphasis to the last four words of the quoted sentence because I was initially mystified by it. However, for reasons I will return to below, on reflection it makes perfect sense. The Judge went on to say that it is "important to ensure that people with a disability are not by the very fact of their disability deprived of the range of **reasonable outcomes** that are available to others" (my emphasis).

28. There is also the issue of whether in the case of one who is closer to the 'borderline' with capacity, as those representing AH submit, she is, should have their wishes and feelings given more weight than those further away from that point- as suggested in ITW v Z, M (etc) [2009] EWHC 2525 (Munby, J.).

29. There is a danger here when applying that case. As I made clear in my earlier judgment, AH's incapacity arises because she simply does not and cannot understand that she needs the level of care she does. I was persuaded by Dr Camden-Smith that AH's incapacity was

complex, with elements of personality disorder and maybe Autism "exacerbating the effects of AH's learning disability on her ability to make decisions about her care and treatment". Since her lack of capacity consists substantially in her inability to understand that she needs the care and treatment she manifestly does, it is almost impossible for me to say whether she is close to capacity or far away from it. Having considered this question, I am left with the strong view that the terms are meaningless in this case.

30. That being said to disregard AH's wishes and feelings would be a very serious step to take because of the impact it would have on her sense of self-worth. This would be particularly so where the decision would lead her (reasonably) to conclude that the arrangement was permanent. With the loss of her flat of 17 years would go her hope of "escape" as she would see it.

31. It is only natural that I should be referred to Peter Jackson, J. in Re M (Best Interests: Deprivation of Liberty) [2013] EWHC 3456 (COP), because that was a case concerning another person with diabetes along with a mild mental health condition who was in a care home to keep her safe. If she did not go home, she would be looked after and safe- albeit unhappy. If she did go home, she may become happy, but would be at risk of suffering from non-engagement. That could be a slow decline in her physical and (in her case) mental health, or it could mean a rapid decline.

32. In that case, the Court decided that it was not in P's best interests to remain in a care home- or, put another way, of the options available it was in her best interests to return home. I will not quote great chunks of Peter Jackson, J's judgment, not least because there were differences in the risk/benefit analysis in that case, including that P was at risk of causing

herself deliberate harm, not a risk identified in this case. However, at [38], His Lordship makes this very significant observation (my emphasis):

> "In the end, if M remains confined in a home she is entitled to ask "What for?". The only answer that could be provided at the moment is "To keep you alive as long as possible". In my view that is not a sufficient answer. **The right to life and the state's obligation to protect it is not absolute and the court must surely have regard to the person's own assessment of her quality of life**. In M's case there is little to be said for a solution that attempts without any guarantee of success, to preserve for her a daily life without meaning or happiness and which she, with some justification, regards as insupportable".

33. That seems to me to be the nub of the matter in this case. There are a number of assessments of AH's quality of life from others, based upon her health and her engagement with other people. They characterise her quality of life in positive terms. However, AH's own assessment is very different. It is her life. She is 46. The plan the Applicants ask me to approve envisages an indeterminate stay in Placement 1. That could be for decades and it is a place she does not want to be.

34. AH's age works both ways here, however. If I were dealing with a much older person in AH's position, I would be able to avail myself of the words of Hedley, J. in P v M (Vulnerable Adult) [2011] 2 FLR 1375 namely, spending her "end time" in her own home would be in her best interests even if that led to her life ending sooner than it otherwise would. However, AH is relatively young. She will constantly be exposed to the risks of disengagement and the consequences that follow for decades. Her life could be shortened by many years. Her years could be blighted by ill health and hospital stays. She would not be happy in those circumstances. Or she could live in a place she does not want to be for decades in good health. She would not be happy in those circumstances, either.

35. This leads onto the next aspect of best interests analysis, which is the need for me to choose the least restrictive option. One thing is certain for AH: she will always have

diabetes. That means she will always need monitoring of her blood glucose levels and medication in the form of insulin. That means the involvement of professionals on a regular, daily basis. In the absence of that involvement, she will inevitably become ill, possibly quite rapidly, and will then need urgent treatment, almost certainly in the form of hospital admission.

36. I have to consider the least restrictive option under s. 1(6) MCA within that context- viz. the permanent need for interventions throughout the rest of her life, and, critically, where those interventions are to take place. This is a matter that concerned Cobb, J. in UF v X County Council & other (No. 2) [2014] EWCOP 18. In that case, the Judge took as his starting point what the least restriction principle actually means: namely, can the act or purpose be achieved in a way that is less restrictive of the person's rights and freedom of action? That seems to me to be the proper interpretation of the section. The Judge said at [83]:

> "While the difference between living at home and living in a care home is one which vividly engages the 'best interest' arguments, I am not sure that it engages the provisions of s 1(6) to the same degree, if at all; while it may well be (and is likely to be in many cases) that the care at home is less restrictive, it is necessary, in my judgment to analyse the specific care regime in place in each setting to decide which is the least restrictive on the facts of the case".

37. At one stage during the final hearing, I repeated an observation I had made at an earlier hearing, that maybe the ideal legal regime for AH would be something along the lines of guardianship under ss. 7 and 8 of the MHA, albeit modified and implemented under the MCA. That would mean she would have to reside in a particular place (her home), but be required to attend a place for treatment, or to allow a clinician to attend her home to administer treatment. In addition, and unlike guardianship, this Court could authorise those responsible for AH's care to use reasonable force to ensure that she receives treatment and attends at a place for that treatment and monitoring.

38. Mr Fullwood, on behalf of the Applicants told me that it was not an approach the professionals in this case would wish to use. I can see why that is. There is already a considerable amount of conflict between AH and professionals, and the use of coercive powers would likely make things worse. The use of reasonable force therefore appears not to be a readily available option for the Court to choose.

39. This also clarifies the issue raised by Cobb, J. in UF. In this case, although care and treatment will be provided in the community if AH returns to her flat, her home will not be turned into a place of forced treatment.

40. Finally, on the issue of returning home, I remind myself that there is no presumption of a return home under Article 8 of the ECHR- see K v LBX [2012] EWCA Civ 79 (at [63]).

## DISCUSSION

41. Having heard and read excellent and focused submissions from Mr Fullwood and Mr McCormack, as well as extensive evidence on AH's wishes and feelings over time from Ms Eastham, the ALR, and her colleague Ms Ireland, the context of my decision is clear.

42. Until she was placed at Placement 1 in March 2022, AH was able to live an independent life with some support. She is able, with that support, to meet her social care needs. She has lived in her flat for about 17 years. She has support throughout the week in the community. She received her treatment (insulin/monitoring) from District Nurses. She came and went as she wished. Unfortunately, there is one need she has which is extremely significant- namely proper and consistent monitoring and regulation of her diabetes. This

is where the disengagement (or perhaps inconsistent engagement) occurred leading to that need not being properly met. The consequences were dire- ketoacidosis and significant illness and potential death.

43. In the absence of proper and consistent engagement with diabetes services in the future, the same thing could happen again.

44. Risk is an important feature of the best interests assessment in this case. As debated during the hearing, the concept of risk has two aspects: first, the likelihood of something happening in certain circumstances and secondly, the seriousness of the consequences if it does. In AH's case if she disengages the consequences are likely to be very serious and quite possibly fatal. As far as the likelihood of her disengaging is concerned, she was very clear when she spoke to me that she would ensure she engage in the future. That, however, was subject to the usual qualifications as to how her treatment plan would be decided by her.

45. I conclude there is a reasonable prospect that AH will eventually cease to engage consistently, perhaps at all. At that point, it is inevitable that the Applicants may have to adopt a similar approach to the one they have adopted here by seeking the approval of the Court for the use of coercive powers that restrict AH's liberty or deprive her of it. As I have already said, that is if she is not unlucky and dies before those steps can be taken.

46. The issue of risk is the essence of the Applicants' case. AH is presently safe and well. She is regularly and consistently monitored and treated. This can go on indefinitely. She can remain well. She can continue to develop friendships with people at Placement 1. She can engage in activities there. The alternative is that she can go home. When she disengages,

and the word, according to the Applicants is "when" and not "if", her "decline is inevitable" to quote Mr Fullwood. Once that happens, she may die. Even if she does not die, she will need hospital treatment and then she will be in the same position as she was in March 2022- she will need a specialist placement where she can be monitored and treated.

47. Of further importance is that Placement 1 is in her home area. This enables her to live a life quite similar to the one she had before March 2022. In the event of a future emergency and the need to find a similar placement, it is far from inevitable- indeed it is highly unlikely- that a placement will be found in her local area. That would mean a move to somewhere away from the place AH knows.

48. All in all, the Applicants submit, the evidence and the factors I have to take into account all point towards AH remaining where she is.

49. Mr McCormack did not advance a positive case in support of AH's wishes and feelings. What he did, however, was to put those wishes and feelings into a proper context.

50. Firstly, AH's wishes and feelings are clear: she hates being at Placement 1 and she wants to go home.

51. Secondly, she is independent and values her independence. This echoes part of what the Applicants say in their own balance sheet analysis. In Ms A's last statement, when outlining the Applicants' best interest position, she states:

> "….[AH] is a very independent and capable lady who does not require the level of social care support that she self-reports. Therefore, AH's social care needs could

> easily be met back at her flat with her existing community social care package with [the agency]".

52. He moves on to the diabetes issue. The Applicants' case is that diabetes care cannot be provided at her flat. In Ms A's statement, however, she says this immediately after the passage quoted above (emphasis added):

> "However, due to the risks to her health around the complexities of meeting her diabetic needs, this option [i.e returning to her flat] is not felt to be a safe option. AH returning to her flat with district nursing input is **likely** to result in the same challenges and risks that were present prior to her moving to Placement 1"

53. A little after that, she goes on:

> "…..AH has had periods of refusing her insulin, requesting and making demands that only certain nurses administer her insulin, becoming agitated and elated if she is not happy with the way her insulin was delivered, making allegations against staffed becoming fixated on a nurse. However, **these risks are reduced and/or mitigated** having access to nursing on site 24/7 and all care interventions being delivered 2:1. The staff at Placement 1 are also skilled and experienced in managing these challenges".

54. In other words, adequate diabetes care will be **available** to AH in her flat, as it is at Placement 1. The difference between the two is that at the Placement nursing care is available all the time for constant monitoring and administration of the medication, whereas in the flat District Nurses will visit at certain times. Moving to her own flat is therefore an option. The thrust of Mr McCormack's implicit (if not explicit) submission is that I can properly balance AH's desire and right to independence with the risks to her health when deciding between the two options. I can properly favour giving AH her liberty even if there is a significant risk to her health as a result.

## DECISION

55. The lessons from the cases cited to me in argument, some of which I have referred to above, are clear if not entirely helpful when tasked with making a decision such as this.

What they do is to provide me with a number of factors I have to take into account. However, the weight I give to each factor, in my search for a 'magnetic' factor, depends on the circumstances of the case.

56. AH's medical needs are a major concern for all decision makers. If this case were simply about keeping AH alive and physically well, it would be an easy one to decide. The option that addresses her medical needs best is for her to stay where she is.

57. However, I also have to consider the other factors outlined in the case. Central to these are her wises and feelings. They are, in my judgment, clear, unequivocal and consistent. Of course, they are not and cannot be determinative, but in this case they are a powerful expression of what AH wants. She wants her liberty. She wants to be back in her home of 17 years.

58. It is important when addressing those wishes and feelings to remember what Peter Jackson, J. said in both Wye Valley and Re M about the need to recognise the importance of the wishes and feelings of those with mental disabilities and lack of capacity. They are so important to people such as AH because that is all they have- the right to express their wishes and feelings once legal capacity has been taken from them.

59. AH is a woman who is aware of what is happening around her. She is able to understand that decisions are being made for her and about her that are very important and which other people make for themselves, but she cannot. It is impossible not to conclude that has a negative impact on her sense of worth.

60. However, as I outlined in my earlier judgment, the essence of her incapacity is her failure to realise there is something that needs to be cared for, and the need to place her welfare in the hands of the professionals to a certain degree. The pattern of rancour, of complaints, of obsessions and fixations with staff have continued and are likely to continue. AH's expression of her wishes and feelings is oblivious to that. In the notes I read for this hearing I saw it had been contemplated that AH ought to have the vaccine against the virus that causes COVID-19. She objects. She "does not believe in COVID-19". Her beliefs, even though they are not grounded in reality, however, are her beliefs. They are all she has. To disregard them is a very significant matter.

61. If I choose for her to remain at Placement 1, I will also be removing her flat from her. I am sure that flat is a symbol to her of her freedom. To remove that from her would be much more than just surrendering a tenancy.

62. When I initially granted the application to place AH where she is it was for an assessment of her capacity and care needs. It was also on the basis that she would have her home available throughout. It was an assessment rather than a trial. Fortunately, during that period she has been able to enjoy the use of her flat for visits and overnight stays. If I grant the order sought by the Applicants, she will lose her flat, but also will lose a great deal of hope. She will also lose the benefit of not only going to her home, but knowing it is still there.

63. I have balanced all the matters I have discussed above. This is a finely balanced case. I have concluded that it is not in her best interests to remain at Placement 1. Whilst the benefits are clear and obvious, and the risk of going home is real and very serious, I do not consider

it to be necessary to require her to reside at Placement 1, where she does not wish to be when she could move back to her own home.

64. In her own home she will receive social care and will be able to access the community with or without support. District Nurses will be able to provide AH with diabetes care. It is uncertain whether she will engage with them and whether she will be able to keep herself well. There is a risk she will not be able to do this. There is a real risk she will suffer a decline- gradual or sudden. There is a risk she will find herself back in hospital and then in care afterwards again. There is a risk she will die.

65. However, in my judgment she has the right to her liberty and to remove it from her would be a devastating blow to her and would not properly recognise her right as a disabled person to be afforded respect and dignity for the way she wishes to live her life.

66. I therefore make the declarations I indicated above. It is likely there will need to be a short period to enable the package of care at home to be restarted- I will defer the effect of this order until that is in place.

67. I also add some comments on the professionals who provide AH with care, some of whom were instrumental in bringing these proceedings. Bringing this application was entirely right and justified. It was an expression of genuine and legitimate concerns over AH's health. Although the phrase "medical best interests" is often used, as any medical professional will immediately say, even medical best interests takes into account the wider issues that affect their patients. I have no doubt that the professionals in this case brought the application for AH as a person, not just as a difficult diabetes patient.

68. So far as the future is concerned, it is important to make declarations surrounding AH's future care. Those responsible for monitoring her and administering insulin should be supported by best interest declarations around that treatment.

69. So far as AH is concerned, I will give my decision orally in Court. I will explain it to her. I will also tell her that she must comply with the treatment plan the professionals put in place. I will emphasise that she is better now because of her treatment since March, and that she needs to continue with it in order to keep her safe and well. That is the best I can do.

70. That completes the judgment.