Neutral Citation Number: [2023] EWCOP 47

Case No: 13630253

COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 27/10/2023

Before :

MS JUSTICE HENKE

\- -

Between :

East Suffolk and North Essex NHS Foundation Trust	**Applicant**
- and –	
(1) DL **(by her litigation friend the Official Solicitor)** **(2) Norfolk and Suffolk NHS Foundation Trust**	**Respondents**

\- -

\- -

Victoria Woodbridge (instructed by **East Suffolk and North Essex NHS Foundation Trust Legal Department**) for the **Applicant**
Ian Brownhill (instructed by the **Official Solicitor**) for the **First Respondent**
Katie Gollop KC (instructed by **Kennedys Law LLP**) for the **Second Respondent**

Hearing dates: 24-26 October 2023

\- -

Approved Judgment

This judgment was handed down remotely at 10.00am on 27 October 2023 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

....

MS JUSTICE HENKE

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. There is a transparency order in relation to this case first made on 24 October 2023 and varied 26 October 2023. All persons, including representatives of the media, must ensure that the terms of the transparency order are strictly complied with. Failure to do so will be a contempt of court.

Ms Justice Henke:

My decision in Summary

1. Having considered all the evidence placed before me: -

    a) Pursuant to S15 MCA 2005, I make a declaration that DL lacks the capacity to make decisions about her hydration and her nutrition.

    b) I declare that providing nutrition and hydration to DL in accordance with the “escalation plan” is lawful and in DL’s bests interests.

2. This judgment will be handed down electronically at 10 am on 27 October 2023. If DL wishes to meet with me, I will make myself available for a remote meeting.

3. I have already indicated to the advocates that I will be at court at their convenience all day on 27 October 2023 to deal with any matters arising from this judgment.

My Decision in Full

Introduction and relevant background

4. The application before me concerns a woman in her thirties who I shall call DL. DL is the first respondent to the application before me. DL lacks capacity to litigate. The Official Solicitor has agreed to act as her litigation friend.

5. DL is currently detained under section 3 of the Mental Health Act 1983 in a hospital operated by the Norfolk and Suffolk Trust. The Norfolk and Suffolk Trust are the second respondents to the application before me.

6. DL has a mild learning disability, complex PTSD, a dissociative disorder and an Emotionally Unstable Personality Disorder at a borderline level. She has a history of violent behaviours towards herself and others, including those caring for her.

7. Since about August 2023 DL has been restricting her intake of nutrition and hydration. Her current intake is incompatible with life. It is accepted by all parties before me that without intervention DL will die. All parties agree that DL wishes to live. It is the treatment plan which will sustain her life which is in dispute.

8. On 9 October 2023, a multi-disciplinary team of clinicians visited DL on the ward. This included clinicians from the East Suffolk and North Essex Foundation Trust who are the local acute Trust responsible for Hospital X. At that time DL was estimated to weigh between 45-50 kg and to have a BMI of 17. Her weight and BMI were estimated because her history of aggressive behaviours towards staff unless restrained made weighing her unrealistic.

9. Following the consultation on 9 October 2023, Dr S, a consultant gastroenterologist at Hospital X, wrote a letter which is in the bundle before me. In that letter she outlined the following:

    a) The MDT attempted to engage DL, but this was difficult, she indicated that she would not eat and “wanted to go to heaven.”

b) DL appeared emaciated and dehydrated.

c) There was little time to make a decision as to refeeding and that would need to be done within 48 hours to reduce the risk of further deterioration and potential death.

d) If DL continued to decline to eat, it was proposed that she is refed via NGTube whilst sedated on an intensive care unit. A ward environment was not considered suitable because of DL's behaviours as seen on the day of assessment and as set out in DL's history.

10. That proposal was not acted upon. DL has not been refed. Instead, a number of MDT meetings have taken place; 7 in total. Those meetings did not produce any treatment plan for DL that could be actioned. Instead, on 21 October 2023, an out of hours application was made by the Norfolk and Suffolk Trust for directions to be given for evidence to be filed so that this court could make a decision in respect of treatment for DL. One of the directions given was that the East Suffolk and North Essex Foundation Trust should be the applicant in these proceedings. They are the Trust that will deliver any treatment plan designed to feed and rehydrate DL.

This Hearing

11. The application for a decision to be made in relation to DL's treatment came before me on Tuesday 24 October 2023 with a time estimate of 2 hours. That time estimate was a woeful underestimate. I thus made time available in my list on 25 October and 26 October 2023. This judgment has been handed down electronically at 10am on 27 October 2023. In the meanwhile, the evidence is that DL continues to decline to eat and is drinking no more than 100ml a day. It is common ground amongst the parties that that is not sufficient intake to maintain life. DL has changed her mind. She now wishes to live and all parties before me wish to give her the chance to live. The overarching issue before me really comes down to what intervention(s) should be made to enable DL to have that chance.

12. At this hearing the Applicant Trust has been represented by Ms Woodbridge. DL has been represented by the Official solicitor who has instructed Mr Brownhill and the second respondent by Miss Gollop KC. I am grateful to each for the assistance they have given the court.

13. DL's brother and sister have participated in this hearing and have been powerful advocates for their sister and the treatment they consider would be in her best interests. Their mutual bond and love for each other came through the evidence they gave me. They have written a statement which is before me, sent me emails with comments upon the evidence they have heard as it unfolded and have spoken to me directly. They told me of their lived experience of DL, especially over the last 4 years. DL has been placed on an acute ward before, about 18 months ago, with disastrous effect. They described to me a vicious cycle of hospital interventions which are so traumatic for DL that they worsened rather than improved DL's conditions. They are adamant that restraining DL to feed her by NG tube would be traumatic for her and would in all probability result in a further deterioration. Their strong view was that the better option is for DL to be refed under sedation. Her bloods are thankfully still within normal ranges. She had come through anaesthetic before. Whilst they acknowledged she is now physically weak, they

took the view that she is resilient. DL had told them that she wanted to go to sleep and wake up better. They supported her wishes and feelings. They also told me how DL would hate being a sideshow in a side cubicle. She would not want nor be able to cope with people peering at her. Her siblings told me that so complex and unique is DL's combination of conditions and thus presentation that she is an object of medical as well as public curiosity. They wished to protect her from that. As DL's sister put it "*she is not a goldfish in a bowl*".

14. I have had the benefit of a meeting DL over the link. The meeting was not planned because I had been told that she did not want to speak with me. However, at the start of proceedings on the second day, DL with her assistants, joined the hearing remotely. After initial pleasantries, I adjourned to meet with DL in the presence of her carers, who facilitated communication via Makaton. Mr Cullen, on behalf of the Official Solicitor, took a note of the meeting. That note has been agreed by me and distributed to all parties. I have taken that full note into account. However, it is right I record here some of the headlines that I took from it. With force DL told me that she wanted to go to hospital because they (hospitals) make people better. She clearly did not understand why she had not yet gone to hospital to get better and was querying why she was being treated differently. She wanted to go to sleep and wake up better. It was evident from what she said and how she said it, that at the moment DL very much wants to get better. DL told me how her transition from the ward to the hospital could be managed. DL suggested that she has her PAs with her when she goes, she wears her ear defenders, and she takes her doll Mel with her. All her suggestions seemed to me to be insightful. They were also practically possible. When I asked her in the context of a general anaesthetic, if she was scared she would not wake up, DL was unable to answer the question and moved on thus avoiding it. DL, however, very clearly told me that she did not like the idea of being touched and of people holding her. She was worried about the noise on a ward and told me, again forcefully, that she would kill people if placed on a ward.

15. In order to assist me to make decision in relation to DL I have heard from the following witnesses: -

    a) **Dr A**, a Consultant in General Psychiatry who has had clinical responsibility for DL on the ward since 6 March 2023. I have read a witness statement from Dr A, her annotations to the initial treatment plan proposed by the acute trust and I have heard her evidence. She gave her evidence to me on Tuesday of this week. She had seen DL the day before. She described to the court how DL is confined to her mattress on the floor of the seclusion unit in the ward. DL is now so weak she cannot roll over. She is no longer crawling around. She told me that from a psychiatric/psychological point of view refeeding under sedation was the best option for DL. Although there were risks involved with giving a General Anaesthetic, on balance those risks should be taken. It would be the least traumatic option for DL and would be in line with her wishes and feelings. The other option namely feeding on a side ward via NG tube and under restraint would be traumatic for DL and was frankly unrealistic. It is highly likely that DL would have to be restrained throughout her admission. That of itself would be traumatising. If mittens were used, DL would not be able to use Makaton to

communicate and would become isolated. If not restrained she is highly likely, almost to a point of certainty given her past behaviours, to pull tubes and cannulas out. However restrained DL is still likely to take any opportunity that presents to take her tubes and cannulas out and to do so repeatedly. That will compound the trauma she experiences. Dr A did not favour chemical restraint because DL is so weak and because she queries the efficacy of doses that would be safe for DL in her current condition. In Dr A's opinion the least worst option would be to refeed her under sedation. Whilst that carries risks which she factored into her thinking when she gave her evidence, it was the best option that could be devised for DL because it was the least traumatic. According to Dr A, trauma is the driver for most if not all of DL's conditions and presentation. DL has previously found an inpatient stay at an acute hospital traumatic. There is a real risk that any use of physical restraint to enable treatment will trigger past trauma. The environment on a ward, even in a side room, is noisy and busy. It brings with it a real risk to DL's mental and physical health and further deterioration in her presentation.

b) **Dr L**, a consultant gastroenterologist in Hospital I. He has experience of managing a multitude of patients requiring additional nutrition support with the aid of a nutrition team. He had provided to the court a statement dated 24 October 2023. Prior to making his statement he visited DL on the ward. He did not weigh her but assessed her weight to be between 40-45 kg. He agreed with Dr S' statements regarding the health risks to DL of reduced oral intake and the medical need for intervention. He considered it to be in her best interests if DL were treated urgently and that the treatment could be completed within 7 days to mitigate the risks of refeeding syndrome. Dr L outlined to DL the need to insert a NG tube and the need to use medication/restraint to help her mage with its insertion as well as taking bloods, which she appeared accepting of his proposals. Following his review, he spoke to Dr A and accepted her concerns about the psychological harm that would be caused by restraint but concluded that as DL was so weak, the restraint would be as minimal as possible. He also acknowledged the risk of physical harm that DL may pose to herself and others on the ward. He factored in the risks of anaesthetic including assisted ventilation. On balance and given DL's current acceptance of the need for hospitalisation and feeding, he felt she could be managed on the ward. He proposed treating DL in a large side room on the adult Gastrointestinal ward. DL's privacy could be enhanced by blocking the windows and doors with privacy blinds and using the cubicle curtains. The room could not be completely blocked off, but her privacy could be protected. When he had spoken to her, she had wanted multiple toys with her as well as posters in her current room. DL wished to have someone present who can enable her to communicate using Makaton. His trained staff would insert the NG tube and position it but it appeared to me from the totality of his evidence that he was reliant on ward staff providing restraint to enable his clinical staff to place the tube. The only staff he had access to that could apply restraint were security staff. Whilst Dr L's preferred option was to feed DL via NG tube using a bolus feed over 20-30 minutes at regular intervals 4

times a day. Physical and chemical restraint was likely to be needed to insert the tube, but mittens could be used during the feed to prevent the tube being pulled out. If that plan did not work, then there would be an escalation in accordance with the treatment plan to ITU. In cross-examination Dr L accepted that placing DL under an anaesthetic would have no real impact on her feeding, his concern was about the risks associated with general anaesthesia. In relation to feeding via a PIC line he considered that a riskier option because of the risk of infection and potentially sepsis. In his opinion enteral feeding was better at delivering nutrition than parenteral feeding. The safer option would be, in his opinion, the least restrictive option namely feeding via NG tube under physical restraint. However, he accepted that Dr S had come to a different view. Although he did not share her view, he accepted that her opinion fell within the band of reasonable opinions a gastroenterologist could have in the context of this case.

c) **Dr N**. He is a consultant in Intensive Care Medicine and Anaesthetics in the acute trust. He has provided two statements which are before me. He gave oral evidence on Wednesday 26 October. He acknowledges the potential risks to mental health as stated by Dr A but was clear that although it is out with his expertise, he knows of no mental health condition that can be reversed with force feeding in ITU in 7 days. From his perspective DL's vital parameters and bloods remain within the normal limits. There is no need for organ support or any identified reversible pathology which will benefit from DL entering ITU. General anaesthesia or sedation may lead to delirium and confusion when the patient is brought around. Some of these effects may be transient but there is a risk of PTSD and post ITU psychosis syndrome. Admitting her to ITU for sedation without at least trying first other ward-based options potentially risk DL's life and increase her morbidity. She has lost a significant amount of weight and is very dehydrated; this poses a significant risk of circulatory collapse during anaesthetic induction. Should that occur then she would be on a ventilator throughout her stay on ITU and predisposed to a risk of lung injury. This is in turn will potentially set in train a further deterioration in her physical state, she may be weak, difficult to wean off a ventilator and may need a tracheostomy. Dr N was very clear in his statements that he preferred a step ladder approach which would exhaust all other options before admission onto the ITU.

16. In cross examination the difference between general anaesthetic and deep sedation was explored with Dr N by Ms Gollop KC. He told me that under deep sedation the patient would be asleep but would breathe independently. Deep sedation would take place on ITU in case airways became compromised and intervention was required. In deep sedation you can deliver nutrition via a PIC line which avoids the "massive" risk of aspiration associated with feeding via a NG tube under sedation. In terms of the risks arising from general anaesthesia when balanced against deep sedation, the differences were "marginal".

17. Under cross examination by Mr Brownhill, Dr N told the court that if DL were to lose consciousness or suffer cardiac arrhythmia, both of which may occur as her malnutrition and dehydration impacts upon her body, then she would be blue lighted into the acute hospital where she would be stabilised in the resuscitation area before being taken to ITU for rehydration and refeeding. It was in that context that it was put to the doctor: why not take the same steps now in the controlled environment of an elective admission rather than in response to a crisis? The response was that it could be done but that clinically he would prefer the step ladder approach. If the court determined that a planned admission to ITU was the best way forward, he would make that option available.

The Issues as Raised before Me

18. At the start of this hearing on 24 October 2023, the applicant asked this court to endorse a step ladder approach where the first rung was voluntary feeding and the last rung feeding via a NG tube under general anaesthetic. As the morning of the first day progressed the issues narrowed, the court was by then being asked to decide between two treatment options: -

    a) Restraining DL (physically and/or chemically) to insert and then maintain a NG tube in place to enable regular bolus feeding; or

    b) Feeding DL via a NG tube under general anaesthetic with an endotracheal tube being used, to prevent asphyxiation.

19. As the proceedings progressed, by the end of day 2 the issues for me to decide appeared to have narrowed and the option before the court had changed. A third way was proposed namely feeding DL via a PIC line under deep sedation rather than general anaesthetic. That would allow her to breathe independently. She would not need an endotracheal tube to be inserted unless her breathing became compromised. The treatment would be delivered on the intensive care unit thus enabling prompt action if her breathing was compromised. When I rose on 25 October, that appeared to be the only option for the court if there was to be intervention to sustain life. The option of physical restraint was, at that time, off the table. The Trust responsible for the ward where DL is currently accommodated indicated that they could not provide the staff that would be needed to restrain DL whilst DL was being fed by a NG tube in the acute hospital. The acute hospital trust did not have any appropriately trained medical staff and could only propose restraint by security staff which they recognised was inappropriate. At the conclusion of the day, I was told that a private agency could provide nursing staff who were trained in restraint but neither trust were currently proposing to pay for such a service. In those circumstances, I directed that the relevant director or officer authorised to make funding decisions in both Trusts should attend upon this court at 10 am on 26 October 2023.

20. By the morning of 26 October 2023 matters had changed again. Funding of restraint was no longer an issue. The acute Trust had found an agency who could provide the restraint they considered necessary, and they were willing to fund it. Shortly before court commenced on 26 October 2023, the applicant filed two fresh treatment plans. They were to be read in a linear fashion. The first was a refeeding treatment plan via a NG tube. The plan proposed elective admission to a side room on a ward of the Hospital X physical restraint to enable IV access and then initial chemical restraint /sedation to

a level where DL requires minimal physical restraint. The last paragraph of the plan reads: "*If DL is unable to be safely managed on the ward she will be escalated to ITU. Escalation will require sedation and a PICC line.*" The escalation plan to ITU confirmed deep sedation and the insertion of a PICC line to enable parenteral feeding. Both the treatment plan and escalation plan set out the benefits and burdens of each plan. I have factored those balances into my decision making.

The Parties' Final and Settled Positions in Closing

21. During the morning, I heard closing submissions on behalf of all parties and DL's siblings.

22. The Applicant's settled position was that they preferred a linear sequential approach which tried the treatment plan first. However, they accepted that if I found the treatment plan on the ward to be as a matter of fact unmanageable, then the court could proceed to consider the escalation plan to be in DL's best interests. Ms Woodbridge in her closing submission confirmed to me that if the court concluded on the basis of all the evidence available to the court that the treatment plan was unmanageable, then the clinicians would agree that the only remaining option for treatment was the escalation plan to ITU and that it would be clinically indicated.

23. Miss Gollop KC on behalf of the second respondent had two overlapping sets of instructions. On behalf of her Trust, she set out how they were moving towards neutrality respecting the judgment of their colleagues in gastroenterology and intensive care in the acute Trust. Dr A had a different position. She wanted the court to know that she struggled on the evidence she had heard to identify what the risk of death was if DL was fed by NG tube on the ward or by PIC line under general anaesthetic or deep sedation- She *"really struggled to understand the clinical risk and come to a best interest decision."* From a psychiatric/psychological perspective, Dr A's opinion was that it would be in DL's best interests to respect her wishes and feelings, sedate her and refeed her whilst she was asleep. That would be the least intrusion into her right to autonomy under Article 8. It would take into account the wishes of her siblings. From a psychological perspective, Dr A considered that it minimises the risk of further trauma for DL and maximises the welfare outcome for DL going forward.

24. DL's siblings argued strongly in closing that I should respect DL's wishes and listen to what she has to say. They urged me to stop the vicious cycle of interventions which are of themselves traumatic and lead to a deterioration in their sister's conditions and consequent presentation.

25. Mr Brownhill on behalf of DL by her litigation friend, the Official solicitor submitted that there were five questions that I should consider: -

    a) Does DL have capacity to make decisions about hydration and nutrition? He submits that she does not and that I should make a declaration under S15 MAC 2005 in that regard.

    b) If DL does not have the capacity, what are the available options for DL's hydration and nutrition? However, the manner in which he proceeded to develop his submission refined that question - it became what are the realistic options placed before the court? The submission on behalf of

DL was that all the evidence pointed to the fact that the plan for treatment on the ward using a NG tube would not work and was not a realistic option.

c) Which of the available options was in DL's best interests? Applying section 4 of the Mental Capacity Act 2005 and all the factors set out therein, he concluded that the balance very firmly fell in favour of the plan to admit DL to the ITU for deep sedation and that once under sedation to refeed her via a PICC line. To act contrary to DL's wishes and feelings and to impose restraint would be to risk traumatising DL again. The unchallenged evidence of Dr A is that trauma was at the root of DL's disorders and retraumatising her would be likely to cause psychiatric and psychological harm.

d) What restrain, if any, will be necessary to deliver the refeeding? In closing he drew my attention to the lack of any restraint plan in this case. In those circumstances he submits that I cannot and should not make a S16 MCA order with a S4A order attached to it.

e) How will DL be transported to the acute Trust? On behalf of DL, the Official solicitor made no comment other than it would be by ambulance.

26. I agree with Mr Brownhill that the five questions he poses of me are the questions I must answer in this judgment. However, before I do so, I consider that it is important that I set out the legal framework that I will apply to the evidence I have heard to provide my answers.

The Legal Framework

27. I have been taken by Miss Gollop KC in her position statement for the hearing on 21 October 2023 to S63 and S145 MHA 1983, the MHA Code of Practice at paragraph 16.6 and three authorities namely *JK v A local Mental health Board* [2019] EWHC 679 (Fam*), A Healthcare and B NHS Trust v CC* [2020] EWHC 574 (Fam) and *A Further NHS Trust v Dr A* [2013] EWCOP 2442. I accept that that analysis of the law provides the legal basis for the agreement between the parties that the Court of Protection has jurisdiction in relation to DL and is the appropriate forum for making best interest decisions in relation to the treatment proposed to feed and hydrate her.

28. I have reminded myself of the relevant provisions of the MCA 2005. In particular of S1-4 inclusive and S15 and 16 of the Act.

29. I am grateful to Ms Woodbridge for taking me to two recent authorities *Nottingham University Trust v JM (by his litigation friend, the official solicitor* [2023] EWCOP 38 paragraphs 29-43 and *Norfolk and Norwich University Hospitals NHS foundation Trust etc v Jordan Tooke (by his litigation friend, the Official solicitor* [2023] EWCOP 45 paragraphs 10-20. I have reminded myself of the law carefully set out within both by Mr Justice Hayden and respectfully adopt it.

30. At paragraph 12, 13 and 14 of Hayden J's judgment in the *Norfolk* case above he says this

> *"12. Whilst careful consideration must, obviously, be afforded to the opinions and analysis of experienced medical professionals, these opinions always require to be considered in the context of all the other evidence. The roles of the court and the clinician or expert are entirely distinct. It is ultimately the court that is usually best placed to weigh expert evidence against and alongside other available evidence (see A County Council & K, D & L [2005] EWHC 144 (Fam); [2005] 1 FLR 851 per Charles J). It will be rare for the evidence of one doctor or indeed one area of specialism to be determinative of the outcome of a case. At the end of the day, it is the Judge not the doctor who determines the case and, always on the totality of the available evidence.*
>
> *13. Evaluating best interests of a protected party (P), where there is dispute, can truly only fall to the responsibility of the Judge because it will always require a survey of the broad canvas of material that frequently can only be properly assessed when it has been ventilated in a courtroom and put to the assay in cross-examination.*
>
> *14. As Lady Hale observed in Aintree University NHS Trust v James [2013] UKSC 67 at [39] , the approach to the framework in Section 4 Mental Capacity Act 2005 , should be as follows:*
>
>> *"...in considering best interest of this particular patient at this particular time, decision makers must look at welfare in the wider sense, not just medical but social and psychological. They must consider the nature of the medical treatment in question, what it involves and its prospects of success. They must consider the outcome of the treatment will be. They must try and put themselves in the place of the individual patient and ask what his attitude towards the particular treatment is or is likely to be and must consult others interested in his welfare of what the attitude might be.""*

Discussion and Decision

Capacity

31. I begin by considering whether DL has the capacity to make decisions in relation to her own nutrition and hydration. I conclude that she does not. I have come to that conclusion on the basis of the evidence of Dr A in her statement of 21 October 2023 and the oral evidence she gave. When cross examined by Mr Brownhill, Dr A told the court that DL understood the risk of being refed by tube. From DL's perspective those risks were two-fold (i) getting fat and (ii) being held down. According to Dr A, when considering being fed under anaesthesia, DL increasingly appreciated that it was associated with a risk of death. However, her evidence was that although DL could understand the risks and increasingly was able to retain knowledge about those risks, DL could not weigh the risks in the balance and make use of that information to make a choice. I accept Dr A's evidence. I find on the balance of probabilities that DL cannot use or weigh the information that she has as part of the process of making decisions about her hydration and nutrition. DL is unable to make a decision for herself in relation to her hydration and nutrition because of an impairment or disturbance in the functioning of her mind or brain.

32. Accordingly, and pursuant to S15 MCA 2005, I make a declaration that DL lacks the capacity to make decisions about her hydration and her nutrition.

Realistic Options.

33. I have considered the treatment plan and the escalation plan placed before the court for DL by the applicant trust. In the event that the treatment plan becomes *unmanageable* the applicant trust will escalate DL's treatment and provide hydration and nutrition in accordance with the escalation plan. That seems to me to beg the question whether the treatment plan is manageable in the first instance. On behalf of DL it is, in effect, submitted that the evidence before the court is such that the court can find on the balance of probabilities that the treatment plan is unmanageable and is not a realistic option in this case.

34. I have had the benefit of hearing from Dr N and Dr L. They both gave their evidence from the perspective of their individual specialty. Each has been careful to stay within the area of their own expertise. Similarly, Dr A has given opinion evidence from the perspective of her area of expertise and has been careful to stay within the confines of her own expertise. My task is different to theirs. I survey the broad canvas of evidence before me which includes but is not limited to the medical evidence I have heard. My task is to stand back and look at the evidence as a whole. If I consider that it is necessary to make findings, then I must do so on the balance of probabilities remembering always that the burden falls on the party who asserts.

35. The broad canvas of evidence that is placed before me includes the context in which DL is currently detained under S3 MHA 1983. Although she is weakened by her malnutrition and dehydration, she continues to be held in a segregation unit on the ward as a result of past assaultive behaviours. She has no contact with other patients because it continues to be unsafe for her to do so. In her statement dated 21 October 2023 Dr A evidence, which was not challenged, was that as of that date DL was still assaulting staff members. Her aggressive behaviours mean that it continues to be unsafe to weigh DL. DL continues to need a high staff ratio.

36. I also take into account that DL is adamant that she does not want a NG tube and that she has stated she will pull it out. DL has also forcefully stated that she does not want to be placed on a ward and that if she is placed there against her will- she *will kill, kill, kill*. I find that there is cogent evidence before me upon which I can and do find that there is a very real and high risk that if DL is subjected to such actions against her will, she will cause physical harm to herself and others.

37. I also accept the evidence of DL's siblings that DL's last admission to a ward in a general hospital ended disastrously. I have no doubt the intentions at that time were good, but the effect was to cause further harm to DL.

38. Under the treatment plan, it is proposed to use restraint (physical and chemical) to enable insertion of the NG tube and to keep it in place. It is proposed that such restraint will keep DL and others safe from harm. However, there is as yet no restraint plan in place.

39. Further there is a problem with the use of restraint, particularly, physical restraint. The unchallenged evidence is that DL does not like to be touched and held. Attempting to

restrain her against her will is likely to aggravate her and her presentation. Dr A's evidence to me was that trauma was at the root of DL's disorders. Physically restraining her is likely to trigger her responses. According to Dr A, attempting to treat DL under restraint simply will not work. Physical restraint will only cause DL to deteriorate. Further chemical restraint is unlikely to be of value because the drugs and dosages that can be used by reason of her frailty are unlikely to be sufficient.

40. Standing back and looking at the evidence as a whole, I can appreciate why Dr N and Dr L consider that the treatment plan could work. As Dr N told me in evidence the plan is in accordance with the clinical guidance to which he adheres. That guidance favours an incremental approach. However, whilst that approach is understandable, it is theoretical based on the general rather than the individual. My task is to consider DL as a unique person at this moment. When I do that and put the theoretical into the context of DL's reality, about which I have already made findings, I find that the treatment plan is unrealistic.

41. There is an inevitability in this case that the treatment plan would be unmanageable from the start and the escalation plan triggered. I find that even to attempt to implement the treatment plan would present a significant risk of harm to DL. She is likely to be traumatised by the attempt which I find is highly likely to fail.

Best Interests

42. I remind myself that I should only endorse the escalation plan if I consider that plan to be in DL's best interests. In that regard I have very properly been taken by Counsel to S4 MCA 2005. According to S4(2) MCA 2005 I must consider all the relevant circumstances of the case before coming to a decision.

43. I consider that it is relevant to the decision that I must make that DL's disorders are rooted in trauma. Her past trauma is, I find, likely to be triggered by imposing restraint against her will or passing a tube through her nose against her will. There is a significant risk on the facts of this case that those events will cause additional trauma and cause DL's disorders to be aggravated and her presentation to deteriorate still further. There is a significant risk of DL being caused further psychological or psychiatric harm by any such interventions.

44. I accept the evidence of DL's siblings that DL has been caught in a cycle of treatments against her will which have traumatised her still further.

45. I factor in the risks arising from deep sedation that Dr N has placed before the court in his evidence. The risks come from the medication that would be used and the deep sedation itself. He rightly brings to my attention that treatment on an ITU comes with continuous physiological monitoring, invasive measurements of blood pressure and the insertion of a urethral catheter. There is a significant risk of cardiac depression, low blood pressure, and on emergence withdrawal or delirium or aggravation of existing psychological and psychiatric illness. Whilst deep sedation would allow DL to breath independently, invasive action would be needed if her air way is compromised. Deep sedation will lead to reduced mobility, increased risk of pressure sores and a catabolic metabolism with rapid bone demineralisation. I accept Dr N evidence about the risks and I weigh them in the balance.

46. I accept the evidence of Dr L that parenteral nutrition is not as efficacious as enteral feeding. However, I also factor in that parenteral nutrition is better than no nutritional intake at all.

47. I also place in the balance that if DL has no treatment which affords her nutrition and hydration, death is a certainty. Without nutrition and hydration, she will die. DL wants to live. I remind myself that Lady Black, in *NHS Trust v Y* [2018] UKSC 46 observed [91]:

> *"Permeating the determination of the issue that arises in this case must be a full recognition of the value of human life, and of the respect in which it must be held. No life is to be relinquished easily."*

48. I have considered DL's wishes and feelings. I accept the evidence that she wishes to be put to sleep and to wake up, treated and well. Having spoken to her and read what she has wanted to tell me, I do not consider that DL really understands that being sedated carries with it a risk of death. However, she has been consistent in her wish to live and to be put to sleep so she can be fed and hydrated. DL has been equally consistent in stating that she would find a NG tube intolerable and that she does not want to be touched and held. I accept that, in so far as I can on the facts, honouring DL's wishes and feelings is the least intrusive option in that it is the least intrusion into her autonomy.

49. I have already found the treatment plan to be unrealistic. As I have stated above, in my judgment to attempt it is to risk DL suffering further psychological and/or psychiatric harm.

50. However, I remind myself that I have to consider the prospects of success of the escalation plan. Dr N told the court that when DL emerges from sedation after 5-7 days, there is a real risk of further psychological/psychiatric consequences for DL. He tells the court that there is nothing in the literature to suggest that DL will awake from sleep and eat and drink normally. Dr A accepts that. However, DL is unique. Based on past behaviours, Dr A considers that there is a real possibility that DL will do as she has stated, awake from sleep and be better. I consider that on the evidence there is at least a chance that will happen. In contrast I find that a plan to feed DL via NG tube under restraint has little or no chance of bringing about the change needed. Instead, it is likely to be part of a vicious cycle with no positive end in sight.

51. I have been reminded of S4(7) MCA 2005. I factor into my determination the heartfelt views of DL's siblings. I accept that they know their sister better than anyone else. They have lived experience of her functioning and her likely reaction to restraint and the placement of a NG tube against her wishes. Based on their experiences, even if placed in a side room, the noises, the people going to and fro, the people treating her, the people restraining her are all likely to trigger an adverse reaction from DL. They are adamant that they wish to respect DL's wishes. That is an informed decision into which they have factored the risks associated with sedation. They take the view that they are risks worth taking. I consider that their views should have weight because they are based on their lived experience of DL who they love dearly.

52. I also factor in the sincerely held views of DL's clinicians in both Trusts. They each give their opinion from the perspective of their own discipline. As I have already stated,

I however must view the evidence as a whole. I place their views in the context of all the other evidence that I have about DL.

53. Accordingly in conclusion, I now stand back and look at all the evidence. I weigh all the factors in the balance. Having done so I have decided that what is termed the escalation plan is in DL's best interests. Accordingly, I declare that providing nutrition and hydration to DL in accordance with the escalation plan is lawful and in DL's bests interests.

Transport Plan

54. I have been provided with a transport plan which will enable DL to be taken from the ward to Hospital X for the treatment I have sanctioned. The plan is uncontroversial and accepted by all the parties. The proposed journey is short as the two hospitals are proximate to each other and are effectively across the road from each other. I sanction the plan as being in DL's best interests. I however observe that it would be improved if DL wishes her doll Mel goes with her.

Restraint

55. Given the decisions I have made above, there is no need for me to say anything else about restraint.

Conclusion

56. I will hand the written judgment down electronically on 27 October 2023. I will make myself available to speak to DL that day if she wishes to meet with me. I will be at court and available to deal with any ancillary matters arising from the judgment upon which my adjudication is required. My understanding is that once my decision is known both Trusts will implement the plan I have endorsed, namely the escalation plan, today.

57. I declare that providing nutrition and hydration to DL in accordance with the escalation plan is lawful and in DL's bests interests.