Neutral Citation Number: [2024] EWCOP 38 (T3)

Case No: COP20000015

IN THE COURT OF PROTECTION
AND IN THE HIGH COURT OF JUSTICE

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 12/07/2024

Before :

MS VICTORIA BUTLER-COLE KC
SITTING AS DEPUTY HIGH COURT JUDGE

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Between :

	(1) NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST (2) TEES ESK AND WEAR VALLEYS NHS TRUST	**Applicants**
	- and -	
	(1) KAG (a protected party, by her litigation friend the Official Solicitor) (2) MR G (3) STOCKTON ON TEES BOROUGH COUNCIL	**Respondents**

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Ms Bridget Dolan KC (instructed by **DAC Beachcroft**) for the **Applicants**
Mr Ian Brownhill (instructed by **the Official Solicitor**) for KAG
Mr Brett Davies (instructed by the local authority) for Stockton on Tees Borough Council
Mr G did not appear and was not represented

Hearing date: 12th July 2024
Judgment Hand Down 23rd July 2024

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Approved Judgment

This judgment was handed down remotely at 10.30am on 24th July 2024 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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MS VICTORIA BUTLER-COLE SITTING AS DEPUTY HIGH COURT JUDGE

Ms Butler-Cole KC:

1. These proceedings were issued by the applicant NHS Trusts in the Court of Protection on 1 July 2024 seeking the following declarations pursuant to s.15 Mental Capacity Act 2005 (MCA):

   i) It is in the best interests of KAG to undergo urgent placement of a percutaneous gastrostomy tube ('PEG');

   ii) the proposed PEG procedure could lawfully be undertaken pursuant to powers under s.63 Mental Health Act 1983 (MHA);

   iii) KAG is ineligible to be deprived of her liberty under Sched 1A MCA.

2. At a hearing on 12 July 2024, I heard submissions from the parties, save for KAG's husband, Mr G, who had unfortunately been taken ill and was not well enough to participate in the hearing. He had provided the Official Solicitor with questions he wanted to ask KAG's treating psychiatrist, and there was no application to adjourn the hearing. I heard brief oral evidence from Dr A, KAG's treating consultant psychiatrist, and Dr B, a consultant gastroenterologist.

3. At the conclusion of the hearing, I informed the parties that I would make the second of these declarations pursuant to the inherent jurisdiction of the High Court. The parties were by that time in agreement that the second declaration and only the second declaration should be made, and that it was appropriate for it to be made pursuant to the inherent jurisdiction rather than under s.15 MCA. This judgment sets out my reasons for that decision, and deals with a costs application that was made by the applicant Trusts against the local authority.

Background

4. KAG is a woman in her late 60s who has, over the course of her adult life, suffered occasional bouts of depression. In late December 2023 she underwent emergency surgery for a serious condition, which was successful. Sadly, on returning home, KAG developed severe depression which led her to neglect herself, including by not eating or drinking. She is reported to have lost as much as 20% of her bodyweight as a result, and since the middle of January 2024, she has been cared for in hospital. There have been two short periods of detention under s.2 MHA, at the end of January and the end of April. Neither was converted to detention under s.3, as each time, KAG agreed to remain in hospital and to continue to receive treatment. A nasogastric tube was inserted to provide KAG with clinically assisted nutrition and hydration (CANH) in January 2024, apparently in reliance on the MCA, and without KAG actively objecting. KAG has also been receiving psychiatric medications. There has been some improvement in KAG's mental health since she was first admitted to hospital, but she is still not eating and drinking enough to keep herself alive, she is very anxious, and her severe depression has not improved to any significant degree.

5. KAG was discharged from s.2 MHA on 15 May 2024 by a mental health tribunal, on the basis that "*despite the very obvious risks to KAG's own health and safety, particularly arising from her refusal to eat, […] she is likely to continue to engage in the assessment and accept treatment…*" Unfortunately, KAG has not continued to

engage with treatment. She has declined medication at times, and has expressed dissatisfaction with being fed by nasogastric tube.

6. There are a range of practical problems associated with the long-term use of a nasogastric tube to provide CANH, including the need to replace tubes when they reach the end of their life and to re-site them when they become displaced. It is difficult to ensure adequate provision of CANH because of the delays in administration while tests, x-rays and other ancillary steps are taken out to check that the tube is correctly sited. Ordinarily, a patient in KAG's position facing a need for long-term provision of CANH would have a PEG inserted, to provide a safer, more comfortable and more effective means of administering nutrition and hydration. In evidence filed with the Trusts' application, consultant gastroenterologist Dr C explained that *"KAG's physiological reserve is deteriorating on account of the length of her admission, reliance on NG feeding and largely untreated severe depression. Should things continue as they are, in terms of KAG's decreased nutritional intake, and depressive illness, there is a risk she will become too frail and unwell to undergo the PEG. With the loss of muscle mass and strength, KAG is at greater risk of aspiration pneumonia from the sedation used to undertake the PEG procedure. She will also be at increased risk of infection around the PEG site and potentially sepsis."*

7. KAG's treating doctors formed the view some weeks ago that she needed admission to a psychiatric hospital under s.3 MHA and on 3 June 2024, two medical recommendations for admission for treatment were completed. There was a practical impediment to immediate transfer, namely that the psychiatric units would not take a patient being fed by nasogastric tube, as they did not have the nursing expertise required to manage that method of provision of CANH. The Trusts were of the opinion that the insertion of a PEG was clinically appropriate for the reasons I have summarised, and that it could be carried out once KAG was detained under s.3 MHA and before her transfer to the psychiatric unit by application of the powers given to the responsible clinician under s.63 MHA, which permit treatment for a mental disorder or its symptoms to be given irrespective of whether the patient consents to that treatment.

8. The local authority, which was responsible for the process of arranging admission to hospital under s.3 MHA by the deployment of an Approved Mental Health Professional (AMHP), was initially not in agreement that the PEG could be inserted in reliance on powers under the MHA. The Trusts wrote a long letter to the local authority on 17 June explaining the legal framework and inviting them to agree to progress the s.3 admission, including by applying to displace Mr G as KAG's nearest relative pursuant to s.29 MHA, as at that time Mr G was objecting to the admission. The Trusts explained that if the local authority did not agree, then they would make an application to the High Court (not the Court of Protection).

9. The local authority accepted the Trusts' legal analysis and duly made an application on 18 June 2024 in the county court for an order displacing KAG's husband as her nearest relative on the basis that he was unreasonably objecting to her admission to hospital for treatment.

10. Before the local authority's change of position was confirmed, the Trusts put the Official Solicitor's office on notice by email that they might need to make an urgent

application to the Court of Protection, for a determination of whether KAG was eligible to be deprived of her liberty pursuant to Schedules 1A and A1 MCA. The lawyer at the Official Solicitor's office who picked up the enquiry responded setting out that he was inclined to the view, on the basis of the very limited information provided, that such an application would not be one which related to serious medical treatment in the terms of the Vice President's Guidance – that question being relevant to the manner in which the Official Solicitor would obtain and fund representation for KAG if she were joined as a party to the proceedings. The Trusts later confirmed that the eligibility issue was not a serious medical treatment question, but noted that '*in the unlikely event'* the court found KAG to be eligible to be deprived of her liberty pursuant to the MCA, then the court would be invited to determine the PEG issue.

11. A hearing took place in the displacement proceedings before a Circuit Judge on 27 June 2024. KAG was a party to those proceedings but did not have a litigation friend: the Official Solicitor had been invited to act as litigation friend by order dated 21 June 2024, on the basis that there was reason to believe KAG lacked capacity to conduct the proceedings, but by 27 June, she had not accepted the invitation as there was no security for her costs.

12. KAG had a Relevant Person's Representative (RPR) appointed under Schedule A1 MCA 2005 as the local authority had previously granted a standard authorisation in respect of KAG's deprivation of liberty in hospital. The Trusts had however sought a review of that deprivation of liberty on the basis that KAG was no longer eligible, given her increasing objections to her treatment. A solicitor – Mr Z - who had apparently been approached by KAG and Mr G in connection with the displacement proceedings attended the hearing in those proceedings on 27 June and was apparently permitted to address the court, despite not being KAG's litigation friend, and not, it seems, having taken instructions from KAG directly. It appears that the Mr Z was intending to receive instructions from the Official Solicitor once appointed in the displacement proceedings. Mr Z informed the court that he had spoken to caseworkers at the Official Solicitor's office that day, and that the Official Solicitor's view was that the question of whether a PEG should be inserted was a serious medical treatment issue that needed to be decided by the Court of Protection. The Circuit Judge says in her judgment that:

> *"I was told… that the Official Solicitor … was firmly of the view that this was a serious medical treatment case and considered that the matter should be adjourned. The Official Solicitor considered that the fact that [KAG's husband'] was now agreeing the displacement heightened the need for [KAG] to be represented."*

13. It is not clear whether this was an accurate report of the Official Solicitor's view. The emails that had passed between the Trusts and the Official Solicitor's office, and which had been seen by Mr Z and the local authority, do not express any opinion on whether an application was required to the Court of Protection or any other court. It seems that Mr Z spoke to a different lawyer at the Official Solicitor's office on the 27 June, and Mr Z reported that the second lawyer, in consultation with the first lawyer, had said that an application to the Court of Protection was required and that the displacement proceedings should be stayed while further consideration was given to whether the PEG was in KAG's best interests. There is no note of the conversation

between the lawyer at the Official Solicitor's office and Mr Z. I am told by Mr Brownhill who appears on behalf of the Official Solicitor for KAG that Mr Z's account of the conversation as set out by the Circuit Judge is not accepted.

14. The Official Solicitor's very clear position at this hearing was that the insertion of a PEG to provide CANH for a patient like KAG whose refusal to eat is a manifestation of her mental disorder falls clearly within the provisions of s.63 and s.145 MHA 1983 and no court application is required. If there were uncertainty as to whether the PEG insertion did fall within s.63/s.145, because there was a dispute as to whether it was treatment for mental disorder within the meaning of those provisions, then an application should be brought by the detaining Trust for a declaration under the inherent jurisdiction, having first detained the patient pursuant to s.3 MHA. But if there was no such uncertainty and the issue in respect of the PEG insertion was that the patient or a family member objected to it, then the appropriate remedy was judicial review by the patient, acting if necessary through a litigation friend. There was no legal requirement nor expectation of good practice, that where a patient detained under s.3 MHA objected to treatment that was proposed to be given to them under s.63 MHA 1983, the detaining Trust should bring the matter before any court (whether the High Court or the Court of Protection) for determination.

15. The Circuit Judge said that *"I understand the position of the LA and the Trust that they consider this procedure to be appropriate treatment under the Mental Health Act 1983. However, the Official Solicitor takes a different view and considers this to be Serious Medical Treatment and I do not consider that it is appropriate for the court to ignore that firm position by the person who is charged with protecting the interests of vulnerable parties*." It seems entirely possible that had the Official Solicitor's view been presented as it was in this hearing, the Circuit Judge would not have taken the course she did, of staying the displacement proceedings and inviting the Trusts to make an application to the Court of Protection.

16. Following the decision of the Circuit Judge on 27 June, the AMHP who had completed the application forms for KAG's detention under s.3 MHA 1983 formed the view that she would not take any further steps pursuant to the MHA until either the High Court determined whether the PEG insertion fell within s.63 MHA (the AMHP's view being that it did) or the Court of Protection determined that KAG was ineligible to be deprived of her liberty pursuant to Schedules 1A and A1 MCA 2005.

17. By the time of the hearing before me, the local authority and the AMHP had changed their position, and no longer sought any declarations. The local authority suggested that the Trusts' application should be withdrawn, as the AMHP was now willing to complete the s.3 admission process. The driver for the change of position was that they had read Mr Brownhill's skeleton argument on behalf of the Official Solicitor, which set out the Official Solicitor's view that the proposed treatment fell within s.63 MHA 1983 and that it was in KAG's best interests to have the PEG inserted.

The court's role

18. The Trusts did not seek permission to withdraw their application and instead urged me to make a declaration as to the lawfulness of the insertion of a PEG for KAG under the MHA 1983, not because they considered that this was strictly necessary, but because they were very anxious to avoid any further confusion about the applicable

legal framework as that would result in yet more delay to KAG receiving effective treatment for her mental health. Given the complex background to the application, the unusual circumstances, and the obvious potential for further confusion and delay, I considered it appropriate to make the declaration sought at the conclusion of the hearing.

19. Before setting out my reasons for making the declaration, I must state clearly – as the Official Solicitor invited me to – that this application was not required. The AMHP rightly determined that the MHA was the correct legal framework to provide treatment to KAG for her mental disorder, including the provision of CANH, and that is the framework that should have been applied. While there will be cases where the scope of s.63 MHA is in question, this was not one of them. The Official Solicitor did not object to the court making a declaration of lawfulness in the exceptional circumstances of this case, but did not expect similar applications to be made in future. This judgment should not be taken as any sort of encouragement to statutory bodies to seek the court's intervention where there is no uncertainty on the part of a treating Trust as to whether treatment can be provided under s.63 and s.145 MHA, even in the face of objection by a patient.

20. As Lieven J explained in in **Re JK** [2019] EWHC 67 (Fam) at §66:

> *"The MHA gives the power to decide whether to compulsorily treat a patient to the responsible clinician and not to the Court. This is a fundamentally different scheme to that in the MCA where many decisions are given by statute to the court. The difference makes sense because the MHA is a statutory scheme for, inter alia, detention and compulsory treatment in the public interest, where the responsible clinician has a specific role in the statutory scheme. There is no statutory process in the MHA to question the decision of the clinician. However, if the clinician decides to impose treatment, then the individual can judicially review that decision."*

21. The observation by Mrs Justice Lieven in the subsequent case of **A Healthcare and B NHS Trust v CC** [2020] EWHC 574 (Fam) at paragraph 48 needs to be read carefully. The judge accepted a submission that "*considerable care needs to be taken in the use of section 63 [MHA] if it is not to become a way of treating detained mental patients, with or without capacity, without their consent. However, the safeguard that is in place is the requirement set out by Baker J in* **NHS Trust v A** [2013] EWHC 2442 (Fam) *at [80] that in cases of uncertainty, the appropriate course is to apply to the Court."* Lieven J is there referring to a risk that s.63 MHA is given such a broad interpretation that it can be relied on to treat conditions that are not manifestations or symptoms of a mental disorder – it is self-evident that s.63 MHA permits the treatment of mental disorders without consent. The uncertainty referred to by Baker J (as he then was) is "*doubt as to whether the treatment falls within section 145 and section 63 MHA*". It is not a reference to cases where the detained patient objects to treatment.

22. The question whether, where a detained patient objects to treatment being imposed on them under the MHA, and lacks capacity to conduct proceedings or to instruct a representative to bring proceedings for judicial review, the treating Trust has any duty to find a litigation friend for the patient or take any other steps to bring the dispute

before a court, does not fall to be determined in this case, as the Trusts have in fact brought an application in respect of the lawfulness of the proposed treatment.

The declaration sought

23. I accepted and agreed with the submissions of the represented parties who were in agreement that:

    i) Provision of CANH by means such as a PEG is, in principle, a form of treatment that can fall within s.63 and s.145 MHA (**B v Croydon Health Authority** [1995] 1 ALL ER 683.)

    ii) The critical question is whether CANH is a treatment for a symptom or manifestation of a mental disorder.

    iii) The answer to that question is likely to be strongly influenced by medical evidence: "*The interrelationship between the patient's mental disorder and the treatment which is proposed, is in my view one primarily of medical expertise rather than legal analysis*" **(Re JK** at paragraph 69).

    iv) Here, the clear medical evidence of Dr A, supported by the two gastroenterologists, is that KAG's refusal to eat is a manifestation of her mental disorder. There is no other explanation or medical reason for her inability to eat and drink. The Official Solicitor notes that this is not a case of voluntarily stopping eating and drinking – KAG does not express any wish to die.

    v) *"[A]ny decision under the inherent jurisdiction both as to whether proposed treatment falls within s.63, as being for a manifestation of the mental disorder; and as to whether it is "treatment" within s.145 under the MHA, must […] involve a full merits review*" (**Re JK** at paragraph 68).

24. It is unquestionably in KAG's interests to receive CANH. Equally, it is clear to me that it is now in her interests for CANH to be administered by way of PEG rather than nasogastric tube. As I have previously set out, a PEG will be less risky, more comfortable and more effective. It is reversible, and KAG will be able to eat and drink normally while it is in place should she wish. While the operation to insert the PEG has the potential to be an unpleasant experience, sedating medication will be given, and it will only last for around 10 minutes. Once in place, KAG will be able to move to a suitable therapeutic environment where she can receive the treatment she needs for her mental disorder. Dr A was clear that this was simply not possible in her current hospital which is not a psychiatric hospital. Although KAG is fearful of the procedure, it is the only realistic option to maintain her physical health and to help her to get through this period of depression, as she has in the past.

25. Although Mr G has previously objected to the PEG, I was told that by the time of this hearing, he accepted that "*something has to give"*. In response to questions asked on his behalf, KAG's treating psychiatrist confirmed that KAG would have a new responsible clinician once detained under the MHA, and that any decisions about future treatment, including ECT, would be for that clinician. It was my impression that Mr G's concerns were less about the PEG procedure and more about what future

treatment KAG might be given for her mental health if detained. The merits of any future treatment for KAG's mental health are not a matter for me on this application.

26. I therefore declare pursuant to the inherent jurisdiction of the High Court, that in the event KAG is detained under the MHA, the insertion of a PEG for the provision of CANH will be treatment for purposes of s.145 MHA and falling within the meaning of s.63 MHA.

Costs

27. The Trusts agreed to pay 50% of the reasonable costs of the Official Solicitor at the outset of these proceedings, as is customary. The local authority has offered to pay 50% of those costs, so that the Trusts' share would only be 25% of the total.

28. The Trusts, however, apply for an order that the local authority pays the entirety of the 50% contribution to the costs of the Official Solicitor, and 100% of the costs of the Trusts.

29. The basis for that application is that these proceedings should never have been needed. Ms Dolan submits that following the hearing in the displacement proceedings on 27 June, the next step was for the local authority to consult the Official Solicitor to check whether their position was indeed as had been set out by Mr Z to the Circuit Judge. Instead, the AMHP wrote to the Trusts saying that she was "*not prepared to plough on without the matter being properly determined by the relevant court in view of the comments of the Official Solicitor and the judgment of [the Circuit Judge]"*.

30. For the local authority, Mr Davies says that following the 27 June hearing, an application to the court was inevitably required, for three reasons: the Official Solicitor's position (as it had been reported to the Circuit Judge); the fact that Mr G had only withdrawn his objection to admission under s.3 in order to avoid being displaced as nearest relative and was in reality still opposed to the proposed course of treatment; and because at the conclusion of the 27 June hearing, a solicitor who had attended the hearing for the Trust had confirmed to the court that an application would be made. That application, even if it had been brought by the local authority, would have required the Trusts to incur costs as parties, as the substance of the issue was a health matter.

31. Although the proceedings were issued in the Court of Protection, the central issue has been determined under the inherent jurisdiction. Under the Court of Protection Rules 2017, the starting point for costs would be that each party bears their own costs as these proceedings concern health and welfare. Under the inherent jurisdiction, the Civil Procedure Rules apply. The CPR provide for a general discretion as to costs, but where cases concern a vulnerable adult, the approach taken tends to be aligned to the Court of Protection welfare jurisdiction (see further **T v L (Inherent Jurisdiction: Costs**) [2021] EWHC 2147 (Fam)).

32. In my judgment, all the statutory bodies were put in a very difficult position by events at the hearing on 27 June, and in particular by Mr Z's report that the clear view of the Official Solicitor was that a further court application was necessary. This court did not hear from Mr Z or have any evidence as to what his understanding was of the Official

Solicitor's preliminary views. It might have been possible to clear up the confusion that had evidently arisen through correspondence with the Official Solicitor's office. I have not seen any evidence that the suggestion of further liaison with the Official Solicitor to clarify her position was made by the Trusts to the local authority at the time, or that the Trusts themselves tried again to ascertain the Official Solicitor's position prior to issuing their application. I am not surprised by that, as neither the local authority nor the Trusts would have had particular reason to think that Mr Z had fundamentally misunderstood or misreported the Official Solicitor's views.

33. While it is no doubt correct that had the Official Solicitor's position as set out at this hearing been provided to the statutory bodies at an earlier stage, this application would not have been needed, I am not persuaded that either the local authority or the Trusts can properly be criticised for not having attempted to obtain further clarification in the circumstances. Nor can I see a basis for blaming the local authority for the confusion that arose in respect of the preliminary view of the Official Solicitor as to the necessity of a court application in respect of a medical treatment decision.

34. It seems to me that the fair order in the circumstances is that the statutory bodies share the costs of bringing these proceedings. This was an unusual case with a complex procedural background, which resulted in a stalemate that had to be broken, to further KAG's interests. An application to the court was the most obvious way to achieve that goal given what Mr Z had reported was the position of the Official Solicitor on 27 June 2024. All the statutory bodies necessarily needed to be parties to that application given their roles in respect of KAG's care and treatment and having regard to the framework of the MHA. The local authority has already agreed to pay 50% of the applicants' 50% contribution to the Official Solicitor's. I will order that the local authority should also pay 50% of the costs of the Trusts occasioned by this application. I am treating both Trusts as one for the purpose of sharing the costs burden, as the Trusts have been jointly represented throughout.