Neutral Citation Number: [2019] EWHC 67 (Fam)

Case No: FD19F00097

IN THE HIGH COURT OF JUSTICE
FAMILY DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 13/11/2019

Before :

MRS JUSTICE LIEVEN DBE

- -

Between :

JK	**Applicant**
- and -	
A LOCAL HEALTH BOARD	**Respondent**

- -
- -

Mr Michael Mylonas QC and Ms Emma Sutton (instructed by **NHS Wales Shared Services Partnership - Legal & Risk Services**) for the **Applicant**
Mr John McKendrick QC (instructed by **Bindmanns LLP**) for the **Respondent**

Hearing dates: 4th November 2019

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Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

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MRS JUSTICE LIEVEN DBE

This judgment was delivered in private. 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 children and members of their family must be strictly preserved. All persons, including representatives of the media, must ensure that this condition is strictly complied with. Failure to do so will be a contempt of court.

Mrs Justice Lieven DBE :

1. This is an application by A Local Health Board (the Health Board) in respect of possible future treatment of JK. The original application was for: (1) a declaration that it is lawful for treatment to be provided pursuant to s.63 of the Mental Health Act 1983 (MHA) that JK can be force fed; (2) in the alternative, a declaration under the inherent jurisdiction that such treatment is lawful; and (3) a declaration under the Mental Capacity Act 2005 (MCA) that an advance decision could be disregarded as a result of actions by P that were inconsistent with it.

2. JK is a 55-year-old man with a diagnosis of Autism Spectrum Disorder (ASD) made late in life. He is currently on remand for the alleged offence of having murdered a close relative, the index offence having taken place in recent weeks. He was transferred from A Prison to A Hospital, a medium secure psychiatric hospital on 23 October 2019 under s.48 of the MHA.

3. The application came before me on 23 October 2019 in the High Court in London. Ms Sutton represented the Health Board, and she had her instructing solicitor and two clinicians, Dr L and Dr J on the phone. JK was not represented, having been assessed to have litigation capacity, and having declined representation (as told to me by the Health Board). JK had told Dr J that he did not wish to speak to me by phone, but did wish to participate in the hearing. As I will explain further below the issue appeared at that stage to be extremely urgent, given that JK had been refusing to eat for a fairly prolonged period and, in those circumstances, I decided that the best course was to adjourn the hearing and continue the hearing the following day at A Hospital. However, on 24 October 2019 when I met JK at A Hospital, JK told me that he did want representation and that he would eat up to the next hearing, as long as that was the following week. Given the importance of the issue, and the legal complexities, I therefore adjourned the application again in order for JK to instruct a solicitor and counsel.

4. The matter then came back before me on 4 November 2019. JK is now represented by Mr McKendrick QC, and the Health Board by Mr Mylonas QC with Ms Sutton. I am very grateful to them all for their assistance in this very difficult case.

5. I heard evidence from Dr L, a consultant psychiatrist who had assessed JK after two meetings with him and Dr J, a consultant psychiatrist and the clinician responsible for JK's care at A Hospital. I have a witness statement from JK, which was drawn up in some haste but contains a very moving account of his family background and his perception of his current situation, and JK gave oral evidence.

JK's background history

6. JK was born in 1964 and has one sister, from whom he has been estranged for very many years. It is apparent that he had a very unhappy childhood and describes his father having been highly controlling and at times violent to JK, and probably his mother. JK had a long-standing partner for 24 years and has 2 step children and 5 children with his ex-partner. The relationship with his partner broke down around 2 years ago. This seems to have been, although I cannot be sure, a defining event in his

life. He was for a period homeless before moving in with his father. The relationship with his father had been strained for many years. He is now estranged from his children, although he said he would like to see at least one of them to explain his wish to starve himself to death. It has not been possible for any of the professionals now involved in the case to speak to any of JK's family.

7. JK had worked as a carpenter but had had problems over the years with chronic fatigue syndrome and ASD. It seems that a significant cause of difficulty for him, and something that has caused him great anxiety and frustration, has been his interactions with the Department for Work and Pensions (DWP) and the assessments that he had to undertake over many years. He reports that problems with the DWP, both for him and his ex-partner, contributed to the breakdown in his relationship.

8. JK's history in terms of mental disorder is described by the experts as being highly unusual. JK had had some interactions with psychiatric services since 2016. He has reported that he has made five suicide attempts over the years, with one resulting in hospitalisation. There is no reported history before the index offence of anti-social behaviour or violence. There is a record of being prescribed Sertraline for depression in the past, but according to JK this had little or no benefit. In October 2018 he was diagnosed with ASD. JK had no support for his autism before the diagnosis, and it may well be that this was a strong contributing factor in many of the problems and frustrations he had with governmental agencies and decision making over the years. It was notable that when he gave his oral evidence he was still preoccupied with problems that he had had with the DWP and his view was that if he now returned to the community he could not cope with dealing with that and other governmental agencies.

9. According to Dr L's report, SG has said that he has made five serious suicide attempts. It is not clear when these occurred, but it seems that they have been in recent years. He had a history of heavy drinking at times, but not in the recent years. It is reported that since he has been in healthcare at prison, he has presented with symptoms consistent with ASD, including rigidity of thinking, liking of routine and a difficulty with dealing with the unexpected.

10. The index offence took place in recent weeks. It is described in the reports as a frenzied attack using a knife or screwdriver. JK called the police after the index offence and admitted to it. He was arrested and remanded in custody at A Prison on 14 September 2019. Perfectly appropriately he was advised by his legal team to say nothing in evidence to me about the index offence. He was assessed by two medical practitioners on 10 October 2019 as suffering from a mental disorder which makes it appropriate for him to be detained under the MHA. A transfer direction was made by the Secretary of State for Justice on 21 October 2019 and he was transferred to A Hospital on 23 October, pursuant to s.48 of the Mental Health Act 1983. He has been resident at A Hospital since, under the clinical care of Dr J and her team. He was very unhappy about the way that he had been transferred, and felt that it had been deceitful. However, as far as I could tell the way the transfer was done was intended to minimise the impact upon him.

11. Since shortly after arriving at A Prison JK has been saying consistently that he wants to die and that he intends to starve himself to death. Between 10 September 2019 and 2 October 2019 (i.e. 23 days) he refused food. He then ate limited food for a few days, because he was concerned that he might be found not to have capacity to make the decision if he was in a weakened state. After 2 October 2019 he has largely been refusing food, but he has started eating again at A Prison because he wished to be able to attend and give evidence before the court.

12. His clinical team, including those at A Prison and at the hospital were very concerned about the impact of his refusal to eat. He is at severe risk of re-feeding syndrome, even if he does decide to eat at some later point. This would include hypophosphatemia, with increasing weakness leading to collapse, hypoglycaemia and cardiac arrest. If he chooses to continue not to eat then he will die, although as he is continuing to drink this may take some time. It is not possible to give specificity regarding life expectancy however the Guidelines for the clinical management of people refusing food in immigration removal centres and prisons (January 2010) produced by the Department of Health states that if a person is well nourished at the beginning of the fast and is prepared to take adequate fluid, they are usually at little risk of dying from malnutrition for at least six to eight weeks.

13. On 28 September 2019 JK made an Advance Decision stating that he does not wish for any medical intervention to occur even if his life is at risk. There was originally an issue raised by the Health Board that this advance decision was not valid. However, the Health Board now accept that it is valid, and in any event JK has made a fresh advance decision in effectively the same terms dated 31 October 2019. Therefore, there is a lawful advance decision in place, subject to the findings I make below about JK's capacity.

14. On 27 September 2019 Dr S, the resident psychiatrist at A Prison and Dr J, both assessed that JK had capacity at that time to make the decision not to eat. Dr L met JK on 16 October 2019. He has also reached the view that JK has capacity to make the decision to refuse food and medical treatment. His report is detailed and careful. He goes through each stage of the criteria in the Mental Capacity Act 2005 for assessing capacity. JK has been given the relevant information as to how his condition is likely to deteriorate if he continues to refuse food, the risks associated and the likely mode of death. He concludes that JK has capacity to refuse food and to refuse medical treatment including palliative care. Dr L also considered whether JK had litigation capacity and concluded that he did.

The Evidence

15. Dr L is a consultant psychiatrist with a specialism in the diagnosis, assessment and treatment of ASD. He has met JK on two occasions and produced two reports to the court. He gave detailed oral evidence in court and was cross examined.

16. In his written report he records that JK has a history of sensitivity to noise and of secretive obsessions/rituals around food which means that he cannot eat in front of other people. He describes JK as being rigid in his thinking, needing control and liking routine. Misunderstandings due to miscommunications have occurred on a

number of occasions since his detention. Dr L explained that all of this is common in people with ASD. He also described JK as being someone who wanted to do the right thing. All of this accords very strongly with my impression of JK when he gave evidence, and when I met him on 24 October at A Hospital.

17. He recorded JK saying to him "*my goal is that I don't want to live and starvation is my chosen method or tool."* JK had told him that he felt worthless, did not fit into society and was not able to meet his own targets for himself. Dr L had talked through with JK the consequences of starving himself, in terms of physical impacts such as weakness, pressure sores and organ failure. He also discussed refeeding syndrome which can affect the brain and the heart. JK was aware of these impacts and discussed them quite coherently with Dr L.

18. Dr L was of the view that JK had capacity both to litigate and in respect of decisions as to whether to eat and whether to accept forcible feeding. In his reports he carefully went through the various stages under the MCA in order to assess whether JK had capacity, and was satisfied that he did in respect of all decisions relevant to this application. He said that JK fully understood and retained the information about refusing food and medical treatment, and could communicate back his decision. In relation to weighing up the information Dr L thought JK's decision was heavily influenced by his perception of his family and social circumstances. He said that there was no reason to think any of this information is false. He said that JK's evaluation of his situation is that it is hopeless and unbearable, but that was a capacitous decision. He also took the view that depression is not a prominent feature of JK's case, although he did suggest that JK may have suffered from chronic depression for a long time.

19. Dr L was careful to draw a distinction between the test for capacity in the MCA, which is necessarily a relatively low one, and the question of whether JK's decision not to eat was a manifestation of his ASD, for the purposes of the MHA. Dr L's evidence is that it was such a manifestation and that there was potentially treatment available which could alleviate that disorder. Dr L referred to the fact that JK's diagnosis of ASD came very late in his life, and prior to that he had had no support for the condition, and many of the problems that he had faced with the DWP and other authorities may have stemmed at least in part from the ASD. Dr L explained that for many people with autism when they face a crisis situation they become overwhelmed and effectively choose 'demand avoidant' behaviour when facing a crisis. He phrased this as being "demand avoidant" and that being a characteristic feature of ASD. At that stage they may pass through the crisis, or in some cases try to commit suicide. However, JK has very limited choices, because he is detained and this has led to him seeking control through the decision not to eat and end his life by that means. In Dr L's view JK's decision not to eat is his response to the crisis he finds himself in, and as such is a manifestation of his autism.

20. Dr L said in cross examination that JK's reactions to his situation were fairly characteristic of autism, albeit unusual in the extremity both of the situation and of the response. People with ASD often present in a demand avoidant way, e.g. by refusing to eat or trying to commit suicide. He said that JK was an intelligent thoughtful man, and it was possible that given time and appropriate interventions, his rigid thought processes could be overcome. He gave the example that when JK first transferred to A Hospital he was entirely negative about it and could not contemplate interacting with

others, but 10 days later he was managing to interact. Much of Dr L's evidence focused on JK's lack of emotional understanding or response, particularly on issues around his family. He felt that with time and professional support JK could be assisted to understand wider concerns, including the impact of his actions on his family, and to consider this further before making an irrevocable decision.

21. The treatment being proposed is effectively in two distinct parts. Dr L explained the treatment plan that he would recommend, involving a process of discussion and explanation with JK. He also said that the treatment plan would consider JK's depression, which Dr L thought could have been a long term and chronic condition.

22. Dr L gave evidence on the issues that would arise with force feeding, the second part of the treatment. He was completely straightforward in accepting that it would be a distressing and unpleasant process which would be likely to be harmful (although not necessarily fatal) to any therapeutic relationship with JK. He said that there was often a process of negotiation with a patient as to how any feeding took place. The practicalities of force feeding in terms of the sedation that would be required, and the steps to ensure that the tube could be placed and removed safely was a matter for other expert clinicians.

23. Dr J made clear that neither she, nor A Hospital, were specialists in treating patients with ASD; nor did she have experience of force feeding. She said that efforts had been made to find a secure unit which had specialism in autism, but the only such facilities were not prepared to take JK given the issue of his refusing food and potentially needing to be force fed.

24. She accepted that the proposed treatment plan was at a fairly outline stage, but that meetings had been set up with specialist clinicians and further work was underway to provide more detail in the treatment plan. It was clear from her evidence that a clinical decision that it was in JK's best interests to force feed him if he continued to refuse food had not yet been made, and would only be made once a full treatment plan had been drawn up, and JK's situation at that date fully considered.

25. JK made a witness statement and gave oral evidence. He appeared to me to be an intelligent and thoughtful man, who was greatly troubled by his situation. He was very rigid in his thinking, and in particular in respect of how he responded to his current position and to thoughts about the future. He took a wholly fatalistic view of the future, and thus saw it as hopeless. He was unwilling and probably unable to contemplate that matters could change. For example, his first response when asked why he wanted to end his life was that he could not cope with the DWP again if he was released into the community in the future. He could not envisage that by getting help with his ASD and practical help with dealing with public bodies this issue might be mitigated. He was also completely rigid in his thinking about his family, and the possibility that he or they might shift their position.

26. He struck me as being highly motivated by a desire to "do the right thing", and his current view is that that involves him ending his life. This ties back into a belief that his life is worthless. I suspect that he was seeking to control a situation which since the index offence had been wholly out of his control, by refusing to eat and trying to end his life.

The Law

27. The primary issue in this case is whether the terms of s.63 are met, because JK's consent to force feeding is not required. On the facts of the case this raises the interaction between the Mental Capacity Act 2005; the Mental Health Act 1983 and the High Court's inherent jurisdiction, although some of the issues have narrowed during the hearings. As I analyse the case the following issues potentially arise, although some have become less important, and (e) does not yet arise;

    a) Does JK have capacity to make a decision to refuse food?
    b) Where the court is invited to make a declaration that a proposed course by the Health Board is medical treatment under s.63 MHA, what legal test should the Court apply?
    c) Is the proposed treatment, i.e. force feeding, treatment that falls within s.63?
    d) If the proposed treatment does not fall within s.63 can the court authorise the force feeding pursuant to its inherent jurisdiction? this raises two sub-issues;
        i. Is there a lacuna in the statutory scheme which the inherent jurisdiction can appropriately fill?
        ii. Is JK a vulnerable person within the meaning of *SA (Vulnerable Adult with Capacity: Marriage)* [2006] 1 FLR 867?
    e) Is it appropriate on the facts to order that JK can be force fed?

28. The starting point is, in principle, every citizen who is of age and of sound mind has the right to harm or (since The Suicide Act 1961) to kill himself, and is entitled to make decisions about his treatment, even if those decisions bring about his death.

29. As Lord Goff observed in *Airedale NHS Trust v. Bland* [1993] AC 789 at [864];

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

30. This right applies equally to detained citizens. In *Home Secretary v Robb* [1995] 1 FLR 412 Thorpe J stated that

> *'... every person's body is inviolate and proof against any form of physical molestation .... The right of the defendant to determine*

his future is plain. That right is not diminished by his status as a detained prisoner'.

31. In *Newcastle Upon-Tyne-Hospitals Foundation Trust v LM* [2014] EWHC 454 (COP), a gravely ill 63-year-old female Jehovah's Witness urgently needed a blood transfusion but had told doctors that she was adamant that she would not want treatment with any blood products. Jackson J declared that it was lawful for the doctors treating her to withhold blood transfusions or the administration of blood products notwithstanding that such treatments would reduce the likelihood of her dying and might prevent her death. He held at [**24**] that *'there is no obligation on a patient with decision-making capacity to accept life-saving treatment, and doctors are neither entitled nor obliged to give it'.*

32. There are three circumstances in which adults can have treatment imposed upon them without their consent- if they lack capacity under the Mental Capacity Act 2005; if they are detained under the Mental Health Act 1983 and the treatment falls within the terms of s.63 (or s.58); or if they can be categorised as "vulnerable" under the High Court's inherent jurisdiction.

Mental Capacity Act 2005

33. A person must be assumed to have capacity unless it is established that they lack capacity (section 1(2) MCA). The burden of proof lies on the person asserting a lack of capacity and the standard of proof is the balance of probabilities (section 2(4) MCA, *KK v STC and Others* [2012] EWHC 2136 (COP) at [**18**]).

34. Determination of capacity is always 'decision specific' having regard to the clear structure provided by sections 1 to 3 of the MCA. Capacity is required to be assessed in relation to the specific decision at the time the decision needs to be made and not to a person's capacity to make decisions generally.

35. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success (section 1(3) MCA) and a person is not to be treated as unable to make a decision merely because they make a decision that is unwise (section 1(4) MCA and *Heart of England NHS Foundation Trust v JB* [2014] EWHC 342 (COP), Peter Jackson J at [**7**]).

36. Pursuant to section 2(1) MCA 2005, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain (the so called 'diagnostic test'). It does not matter whether the impairment or disturbance in the functioning of the mind or brain is permanent or temporary (section 2(2) MCA).

37. The question for the court is not whether the person's ability to take the decision is *impaired* by the impairment of, or disturbance in the functioning of, the mind or brain but rather whether the person is rendered *unable* to make the decision by reason

thereof (*Re SB (A Patient: Capacity to Consent to Termination)* [2013] EWHC 1417 (COP) at [**38**]).

38. Pursuant to section 3(1) MCA 2005 a person is 'unable to make a decision for himself' if he is unable (a) to understand the information relevant to the decision, (b) to retain that information, (c) to use or weigh that information as part of the process of making the decision, or (d) to communicate his decision whether by talking, using sign language or any other means (the so called 'functional test'). An inability to undertake any one of these 4 aspects of the decision-making process set out in section 3(1) MCA will be sufficient for a finding of incapacity provided the inability is *because* of an impairment of, or a disturbance in the functioning of, the mind or brain. There must be a causal connection.

39. The information relevant to the decision includes information about the reasonably foreseeable consequences of deciding one way or another (section 3(4)(a) MCA). In *PCT v P, AH and The Local Authority* [2009] COPLR Con Vol 956 at [**35**] Hedley J described the ability to use and weigh information as *'the capacity actually to engage in the decision-making process itself and to be able to see the various parts of the argument and to relate one to another'.*

40. Within the context of section 3(1)(c) MCA, it is not necessary for a person to use and weigh every detail of the respective options available to them in order to demonstrate capacity, merely the salient factors (*CC v KK and STCC* [2012] EWHC 2136 (COP) at [**69**]).

41. Even though a person may be unable to use and weigh some information relevant to the decision in question, they may nonetheless be able to use and weigh other elements sufficiently to be able to make a capacitous decision (*Re SB* [2013] EWHC 1417 (COP)).

42. Whilst the evidence of psychiatrists is likely to be determinative of the issue of whether there is an impairment of the mind for the purposes of section 2(1) MCA, the decision as to capacity is a judgment for the court to make (*Re SB* [2013] EWHC 1417 (COP)). In *PH v A Local Authority* [2011] EWHC 1704 (COP) Baker J observed at [**16**] that *'in assessing the question of capacity, the court must consider all the relevant evidence. Clearly, the opinion of an independently-instructed expert will be likely to be of very considerable importance, but in many cases the evidence of other clinicians and professionals who have experience of treating and working with P will be just as important and in some cases more important. In assessing that evidence, the court must be aware of the difficulties which may arise as a result of the close professional relationship between the clinicians treating, and the key professionals working with, P ….".*

Mental Health Act 1983

43. JK has been transferred to mental hospital under s.48 MHA. The Health Board proposes treating him pursuant to s.63, which states:

> *"The consent of a patient shall not be required for any medical treatment given to him for the mental disorder from which he is suffering, not being a form of treatment to which section 57, 58 or 58A above applies, if the treatment is given by or under the direction of the approved clinician in charge of the treatment".*

44. Section 145(4) of the MHA provides:

> *"Any reference in this Act to medical treatment, in relation to mental disorder, shall be construed as a reference to medical treatment the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations."*

45. In *B v Croydon Health Authority* [1995] 1 ALL ER 683 it was held by the Court of Appeal that the feeding by nasogastric tube of a patient who was suffering from borderline personality disorder was treatment which fell within the scope of section 63 MHA 1983 because such treatment was aimed at treating a symptom of the disorder which was a compulsion to self harm. Therefore, the basic proposition that force feeding can be treatment within the meaning of s.63 is established, and not in issue.

46. In *R v Collins ex p ISB* [2000] Lloyd's Rep. Med. 355, Mr Justice Maurice Kay was considering an application for judicial review by Ian Brady, challenging a decision by the clinicians at Ashworth Hospital to force feed him. Mr Brady had been diagnosed as having a psychopathic disorder and had decided to refuse food in part as a protest against events in Ashworth. The Judge's conclusion is at [44];

> *'On any view, and to a high degree of probability, section 63 was triggered because what arose was the need for medical treatment for the mental disorder from which the Applicant was and is suffering. The hunger strike is a manifestation or symptom of the personality disorder. The fact (if such it be) that a person without mental disorder could reach the same decision on a rational basis in similar circumstances does not avail the Applicant because he reached and persists in his decision because of his personality disorder'.*

47. A similar issue arose before Baker J in *A NHS Trust v Dr A* [2014] Fam 161. In that case the patient had been diagnosed as suffering from a delusional disorder and was refusing to eat, at least in part in protest about being placed in immigration detention. He was found under the MCA not to have capacity and had been detained under s.3 of the MHA. The Judge found, when considering the MCA, that it was in A's best interests to force feed him, but there was a significant problem in determining by what power the Court could so order. The Judge considered s.63 but found that its terms were not met. He said at [79] that he;

> *'found the views articulated by the treating clinicians, and in particular Dr. WJ, persuasive. She does not consider that the administration of artificial nutrition and hydration to Dr. A. in the circumstances of this case to be a medical treatment for his mental disorder, but rather for a physical disorder that arises from his decision to refuse food. That decision is, of course, flawed in part because his mental disorder deprives him of the capacity to use and*

> *weigh information relevant to the decision. The physical disorder is thus in part a consequence of his mental disorder, but, in my judgement, it is not obviously either a manifestation or a symptom of the mental disorder. This case is thus distinguishable from both the Croydon case and Brady'.*

48. The Judge went on to hold that A could not be force fed under the MCA, even though he did not have capacity, because the MHA had primacy over the MCA when a person is detained in hospital under the hospital treatment regime. Baker J however, went on to find that the Health Board could be authorised to force feed A pursuant to the inherent jurisdiction, because there was a lacuna in the statutory schemes, between the MCA and MHA on the facts of the case, and Dr A was a vulnerable person.

49. In *Nottinghamshire Healthcare NHS Trust v RC* [2014] EWCOP 1317 Mostyn J observed at paragraph 24 that the extent to which a condition is within the ambit of section 63 read with section 145 can be difficult to ascertain:

> *The cases have drawn a distinction between a condition which is, on the one hand, a consequence of the disorder, and, on other hand, a condition which is a symptom or manifestation of it. The former is not within section 63 , the latter is. I confess to finding the distinction intellectually challenging. At all events a wide (but not always consistent) interpretation has been given to section 145(4). Thus the decision to force-feed Ian Brady was held to be within section 63. His hunger strike, ostensibly in protest at the decision to move him to another ward, was held to be a manifestation or symptom of his very profound personality disorder (he was additionally found to be incapacitated): see Ex parte Brady [2000] Lloyd's Rep Med 355. In B v Croydon Health Authority [1995] Fam 133 the court declared that it was lawful to force-feed a patient who would otherwise die from self-starvation which was the result of her borderline personality disorder. By contrast in A NHS Trust v Dr A [2014] 2 WLR 607 a hunger strike by a detained Iranian doctor protesting about the impoundment of his passport was held to be not a manifestation or symptom of his mental disorder. In Tameside and Glossop Acute Services v CH [1996] 1 FLR 762 it was held that section 63 could be used to restrain a patient to enforce a Caesarean section upon her; while in St George's Healthcare NHS Trust v S the opposite conclusion was reached.*

The Inherent Jurisdiction

50. The Health Board originally put its application to the Court on the alternative basis of either seeking a declaration under the section 63 of the MHA, or that if the Court found there was no power to force feed under s.63 then there was such power under the inherent jurisdiction. However, by the time of the hearing on 4 November 2019

the Health Board had accepted that there was no power under the inherent jurisdiction on the facts of this case to grant a declaration that JK could be force fed. The basis for this concession was that JK was not "vulnerable" within the meaning of *SA (Vulnerable Adult with Capacity: Marriage)* [2006] 1 FLR 867 and as further considered by the Court of Appeal in *A Local Authority v DL* [2012] 3 All ER 1064.

51. In these circumstances it is not appropriate to give an extensive judgment on the inherent jurisdiction. However, I should make clear why I agree with the Health Board's concession.

52. In my view there are two interrelated reasons why the inherent jurisdiction is not applicable in this case. As is explained by Munby J (as he then was) in *Re SA* the inherent jurisdiction can be used by the High Court to protect vulnerable adults, in circumstances where there is a gap or lacuna in the statutory scheme. As to who is 'vulnerable', there is no '*finite limit'* on those who may, or may not, attract the court's protection (*DL v A Local Authority & Ors* (supra), McFarlane LJ [**64**]) and as held by Munby J (as he then was) in *Re SA (Vulnerable Adult with Capacity: Marriage)* (supra) at [**77**])

> *'it would be unwise, and indeed inappropriate, for me even to attempt to define who might fall into this group in relation to whom the court can properly exercise its inherent jurisdiction. I disavow any such intention'.*

53. Guidance was however provided in *Re SA* at [77] that the inherent jurisdiction can be exercised (but is not limited to) persons:

1) Under constraint;
2) Subject to coercion or undue influence;
3) For some other reason deprived of the capacity to make the relevant decisions, or disabled from making a free choice, or incapacitated or disabled from giving or expressing a real and genuine consent.

54. In relation to (3) above, at [**78(iii)**] in *Re SA*, Munby J described other disabling circumstances as:

> *'the many other circumstances that may so reduce a vulnerable adult's understanding and reasoning powers as to prevent him forming or expressing a real and genuine consent, for example, the effects of deception, misinformation, physical disability, illness, weakness (physical, mental or moral), tiredness, shock, fatigue, depression, pain or drugs. No doubt there are others'.*

55. Very recently Cobb J has analysed the use of the inherent jurisdiction in two cases; *Wakefield MBC v DN* [2019] EWHC 2306 and *Redcar and Cleveland BC v PR* [2019] EWHC 2305. I adopt with gratitude what he said at [24] in *Wakefield*;

> *"24. The arguments presented to me on these facts have caused me to consider with care the circumstances in which the inherent jurisdiction can indeed be deployed for someone who is 'vulnerable'. The evolving caselaw was neatly and helpfully summarised neatly by Baker LJ when refusing permission to appeal in the case of Southend-on-Sea v Meyers [2018], and reproduced by Hayden J in his later judgment at [2019] EWHC 399 (Fam) at [28]. I do not propose to reproduce that summary once again here, but it plainly a most useful reference point in cases of this kind. For the purposes of deciding this case, on these facts, I have focused on some of the key messages from the Court of Appeal's decision in Re DL ,and the predecessor authorities, thus:*
>
> *(i) "[T]he inherent jurisdiction can be exercised in relation to a vulnerable adult who, even if not incapacitated by mental disorder or mental illness, is, or is reasonably believed to be, either (i) under constraint or (ii) subject to coercion or undue influence or (iii) for some other reason deprived of the capacity to make the relevant decision, or disabled from making a free choice, or Particularly citing Singer J in Re SK [2004] EWHC 3202 (Fam)*
>
> *(emphasis by underlining added) (Munby J in Re SA at [77]: this description was expressly endorsed by McFarlane in Re DL at [53]);*
>
> *ii)The inherent jurisdiction should be "targeted solely at those adults whose ability to make decisions for themselves has been compromised by matters other than those covered by the 2005 Act" (McFarlane LJ in Re DL at [53])*
>
> *iii)The inherent jurisdiction can be used to "supplement the protection afforded by the Mental Capacity Act 2005 for those who, whilst 'capacious' for the purposes of the Act, are 'incapacitated' by external forces—whatever they may be—outside their control from reaching a decision" (Macur J as she then was in LBL v RYJ [2010] EWCOP2665 [2011] 1 FLR 1279 at [62]). Macur J added (op cit.), materially: "...the relevant case law establishes the ability of the Court, via its inherent jurisdiction, to facilitate the process of unencumbered decision-making by those who they have determined have capacity free of external pressure or physical restraint in making those decisions" (also at [62]: emphasis added).*

56. In my view, relying on what McFarlane LJ said at [53] in *DL* some caution needs to be exercised over the extent of the category set out at [78iii] of *SA*, given that some of those matters would go directly to mental capacity under the MCA and therefore are covered by that Act. In *DL* the gap in the statutory scheme was that the MCA covered those who lacked mental capacity to make the decision in issue, but not those whose

will had been overborn in making that decision by reason of their vulnerability, for example by coercion.

57. The inherent jurisdiction cannot be used to simply reverse the outcome under a statutory scheme, which deals with the very situation in issue, on the basis that the court disagrees with the statutory outcome. Here the vulnerability which the Health Board originally relied upon was JK's mental disorder, namely his ASD. Despite his ASD JK undoubtedly has capacity, so he cannot be compulsorily treated under the MCA. If I had found that his decision not to eat was not a manifestation of his mental disorder, then he could not have been compulsorily treated under the MHA. In my view that would have been the end of the matter, because the two statutory schemes deal precisely with someone in JK's situation, and there is no factor such as coercion which lies outside those considerations.

58. Therefore, either it can be said that there is no lacuna in the statutory scheme which would leave space for the inherent jurisdiction; or alternatively, as the Health Board now accept, JK is not "vulnerable" within the meaning of *SA*. He is not "vulnerable" because this is not a case of JK's will being overborn by some factor outside the scheme of the statutes, but rather his decision having been made in circumstances entirely contemplated by the statutes. These two analyses reach the same end result, that JK's situation either allows treatment without consent under the MHA, or not at all.

The Submissions

59. Mr Mylonas accepted that JK has capacity in all relevant regards. He also accepted that he could not seek an order under the inherent jurisdiction that JK can be force fed, because JK is not vulnerable within the meaning of *SA.*

60. However, he did submit that JK's refusal to eat (or as the situation stands at present his intention to refuse eat) is a manifestation of his mental disorder, namely ASD. He relied on the evidence of Dr L, as I have set it out above.

61. Mr Mylonas explained that he was not seeking an order that JK should be forcibly fed, but rather a declaration that it would be lawful for the clinical team to do so within the terms of s.63. After hearing the evidence, he accepted that that the treatment plan and the evidence were not, at present, sufficient for the court to be able to tell whether it was in JK's best interests to be force fed, and whether such treatment would be appropriate and necessary, and not a breach of article 3. He thus accepted that if I made the declaration that under s.63 that JK's consent could be dispensed with, the clinicians would then need to make a subsequent decision as to whether they intended that such treatment should be given. Any decision to feed JK under s63 would also raise issue of necessity under Article 3. That decision would be amenable to judicial review, or alternatively be a matter that should be restored to court (if challenged by JK) in these proceedings. Any judicial review would on the authority *R (JB) v Haddock* 2006 EWCA Civ 961 at [13] be a full merits review.

62. Mr McKendrick argued that JK's decision not to eat was not a manifestation of his autism, but rather a response to the situation he found himself in. Mr McKendrick said that it was not possible to conclude that the decision was primarily a consequence of his autism, without "longitudinal" evidence, by which he meant evidence of JK's

presentation over time and before the index offence and detention. He argued that JK's desire to starve himself to death, although potentially having some link to his autism, was not primarily a manifestation of that condition. Although Mr McKendrick accepted that there was a legal difference between a finding that JK had capacity to decide to refuse to eat, and whether the test in s.63 was met, he did submit that the fact JK had capacity was a strong indicator that the decision was not primarily caused by his autism.

Conclusion

Capacity

63. I will deal with the issues in the order set out above. The first is whether JK has capacity to litigate and to make a decision to refuse food and subsequent treatment. Dr L's assessment is that he has capacity in respect of both matters and this is supported by the earlier assessments of the other consultant psychiatrists. I heard JK give evidence and I have no reason to doubt Dr L's assessment. Dr L explains that JK understands the information that he has been given, can process it and understand the consequences. In relation to litigation capacity, the very fact that JK decided he did want representation indicates that he had weighed up the material and the choices and could come to a decision.

64. In relation to the decision around eating, the evidence both written and oral, suggested that he fully understood the consequences of the decision both in terms of ultimately dying and what he might go through during the period he did not eat. He could weigh up that information and reach a capacitous choice. It must always be remembered that the fact someone makes an unwise decision or one that a large majority of people might not agree with, does not mean the individual does not have capacity.

65. I therefore have no hesitation in finding that JK does have capacity in both regards.

Legal test under s.63

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, as happened in *R v Collins ex p ISB*. However, in the present case what is in issue is a proposed future treatment where the clinicians have not yet drawn up a treatment plan, and not yet weighed up the factors for and against force feeding. In *A NHS Trust v A* Baker J at [80] said; that in cases of uncertainty under s.63 MHA "*where there is doubt whether the treatment falls within section 145 or section 63, the appropriate course is for an application to be made to the court to approve the treatment"*. Baker J did not explain what jurisdiction the Court would be exercising in order to make any such

declaration and judicial review would not be apposite at this stage as an actual decision to treat has not yet been made. However, the inherent jurisdiction can be used to make declaratory orders, and I can see no reason why a similar principle would not apply here. I therefore will consider the making of declaratory relief.

67. In *R (JB) v Haddock* [2006] EWCA Civ 961 the Court of Appeal considered a challenge to a decision of Ashworth Hospital to administer anti-psychotic medication under s.58 of the MHA. The Court said at [13];

> *This Court, in R (Wilkinson) v Broadmoor, held in judicial review of an RMO's decision to treat a detained mentally ill hospital patient without his consent pursuant to section 58(3)(b), that the court should conduct a "full merits review" as to whether the proposed treatment infringed his human rights, and that, to that end, he is entitled to require the attendance of witnesses to give evidence and to be cross-examined. As appears later in this judgment, the rigour of that ruling may be qualified to the extent that resolution of challenges to section 58(3)b) decisions may not always or even mostly require oral evidence. However, it is authority for the proposition that a court, albeit exercising a judicial review function, does so, not on a Wednesbury basis, but by deciding the matter for itself on the merits after a full consideration of the evidence whether oral or in writing. The importance of this is the further safeguard it provides to vulnerable, detained mental patients in addition to that of the independently appointed SOAD for scrutiny of medical decisions with a potential to violate their human rights.*

68. It therefore must follow that any 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 also involve a full merits review.

Is the refusal to eat a manifestation of JK's mental disorder?

69. The next issue is whether the proposed force feeding does indeed fall within s.63 on the facts of the case. As I have just said this must be a question for the Court to determine, as did Maurice Kay J and Baker J in their respective cases. However, it is necessarily a matter on which the Court will be heavily reliant upon medical, and in particular, psychiatric 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.

70. It is Dr L's clear view that JK's refusal to eat is a manifestation of his autism. Dr L is not only a consultant psychiatrist but also one with a particular expertise in the assessment and treatment of patients with autism. Dr L appeared to me to be a measured, highly knowledgeable and careful witness, whose evidence I can give the maximum weight to. He had met JK twice, once for quite a prolonged interview, and had clearly listened carefully to what JK had said and the information he had

gathered. It is true that Dr L and the court, have relatively little information about JK's mental health before the index offence and the fact that none of the clinicians have been able to speak to JK's family limits their understanding of his presentation outwith the highly traumatic recent circumstances. However, I do not accept Mr McKendrick's submission that without such "longitudinal evidence" it is not possible to conclude that the refusal to eat is not a manifestation of JK's autism.

71. I take in particular from Dr L's evidence that JK's rigid and "shutting down" response of saying that he has nothing to live for and refusing to eat, is a not uncommon approach from a person with autism dealing with a crisis situation. JK has been through a quite exceptionally difficult and traumatic few weeks, and it should not be forgotten that the index offence only took place two months ago. It is hardly surprising given his mental disorder perhaps exacerbated by chronic depression, that his response is suicidal. Issues around food and eating appear to have been a feature of his autism, and possibly also OCD, and a refusal to eat therefore has an obvious relationship to his mental disorder.

72. I do accept that with a condition such as autism which is a fundamental part of JK's personality, it is exceptionally difficult to see how any decision making is not a manifestation of that disorder. I also accept that it is possible that many people faced with JK's situation would feel despair and potentially be suicidal. However, I do not think the task for me is to try to compare JK's response to his situation with that of a hypothetical person without autism. It is rather, to try to analyse the degree to which JK's own response relates to his condition, and the way his mind works because of that condition.

73. In my view his refusal to contemplate any alternative paths, and his rigid belief that refusing to eat is his only way forward, is a consequence of his autism and as such falls within s.63. The proposed force feeding is therefore certainly capable of being treatment for the manifestation of his mental disorder.

74. However, that does not mean that I by any means accept that force feeding JK would be in his best interests, or critically would be "treatment" that falls within the definition in s.145(4) of the MHA, as being "to alleviate or prevent a worsening of the disorder…". It is apparent that force feeding is a highly intrusive process, which involves sedating the patient whilst the naso-gastric tube is inserted and potentially having to restrain the patient for fairly prolonged periods. This process would be extremely upsetting for any patient, but for JK with his ASD and his aversion to eating in front of other people, the process would be even more traumatic. JK said in oral evidence that he viewed the possibility as abhorrent, and it was clear from that response how incredibly upsetting for all concerned having to go through that process would be. If it came to that stage close consideration would necessarily have to be given to the terms of article 3 ECHR and the caselaw such as Herczegfalvy v Austria [1993] 15 EHRR 437 and the test of medical necessity.

75. The position at the moment is that the Health Board are drawing up a detailed treatment plan and are in discussions with appropriate clinical experts. If JK reverts to refusing to eat, and the Health Board decide pursuant to s.63 that he should be force fed, then the matter will need to be restored to court. This could be done by way of a judicial review of the Health Board's decision at that stage, that force feeding is treatment which falls within s.145(4), the decision having already been made by the

court that it is capable of being treatment within s.63. However, given that this is a full merits review, and Baker J said that in cases of uncertainty it was appropriate to bring the matter before the court, it seems to me that the most straightforward route is to give JK liberty to apply to bring the matter back before me sitting in the Family Division, if needed. There is no benefit, and potentially additional cost and complication, by requiring a judicial review action to be commenced.