Neutral Citation Number: [2020] EWCOP 40

Case No: COP13630725

IN THE HIGH COURT OF JUSTICE

COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 16/08/2020

Before :

THE HONOURABLE MRS JUSTICE ROBERTS

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Between :

NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST	**Applicant**
- and -	
AB	**Respondent**

- -
- -

Vikram Sachdeva QC (instructed by Hempsons) for the Applicant NHS Trust
Katie Gollop QC (instructed by Bindmans) for the Respondent

Hearing date: 14 August 2020

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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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THE HON. MRS JUSTICE ROBERTS

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 respondent and members of the 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 Roberts :

1. AB is a 28 year-old woman who has over many years suffered from anorexia nervosa. She was first diagnosed when she was a teenager of 13 and now has a formal diagnosis of a Severe and Enduring Eating Disorder ('SEED'). She has lived for more than half her life with the increasing and catastrophically debilitating effects of this illness. All of those treating her recognise that her illness is both chronic and severe. It is one which has proved impossible to treat with any lasting benefit. AB's weight is now so low and her physical state so fragile that she is at serious risk of death. She could die at any time from cardiac arrest as a result of the ravages caused to her body by the illness and/or any attempts to deliver the only form of life-sustaining treatment which is now available to her in the form of tube feeding using physical restraint or chemical sedation.

2. The NHS Trust and the team of treating clinicians who have been responsible for providing care for AB now apply to this court for declaratory relief pursuant to ss 4 and 15 of the Mental Capacity Act 2005 in these terms:

    (i) it is in AB's best interests not to receive any further active treatment for anorexia nervosa; and that

    (ii) AB lacks capacity to make decisions about treatment relating to anorexia nervosa; and

3. In essence, there is only one treatment option available to AB given the significant deterioration in her health and that is to undergo forced nasogastric feeding through the insertion into her stomach of a tube through which liquid nutrients can be delivered. AB would probably not tolerate this treatment and would probably resist as forcefully as her weakened resources would allow thereby exposing her to a very significant risk of injury given the degree of physical restraint which would be required. If such physical restraint is to be avoided, AB would need to be heavily sedated throughout the procedure. Dr B, a consultant psychiatrist who leads the team of treating clinicians caring for AB, told me that if this regime were to have any prospect of success, she would need to be hospitalised as an in patient over at least six months and, because of the risk that AB might pull out the tube, this procedure might need to be undertaken at least twice a day. It is properly described by her leading counsel, Ms Katie Gollop QC, as a horrific scenario which AB herself cannot contemplate. Her doctors agree it is not in her best interests. Whilst I will need to be satisfied that it is not in AB's best interests to receive further treatment of this nature before I can grant the declaration which is sought, no one in this case is asking me to impose such a treatment regime on this young woman. For reasons which I shall explain, and as I assured AB at the conclusion of the hearing last Friday, I am entirely satisfied that it would not be in her best interests to undergo further treatment of this nature.

4. An important point needs to be made at the outset. AB accepts and understands that her life is at risk and that she could die at any point as a result of cardiac arrest, if not eventually of starvation. She currently weighs only 4 stone (or 25.8 kg). Her potassium levels are dangerously low and she suffers from a number of different

presenting conditions as a result of severe and chronic malnutrition. These include osteoporosis, oedema (painfully swollen legs), anaemia (low blood count leading to extreme fatigue and tiredness) and unstable blood salts (the result of low potassium levels which expose her to possible heart complications and the risk of a cardiac arrest as well as adding to her debilitating fatigue). Yet despite all of this, AB sees reason and purpose in what remains of her life. She is cared for in the home which she shares with her devoted and loving parents. She acknowledges that her illness is a part of her but she is clear in her written statement which was read to the court that she does not regard it as defining the essence of who she is. Life, even in the context in which she currently experiences it, continues to bring some pleasure to this young woman. She is surrounded by those she loves and those who love her (principally her parents, her brother and sister, and their children). She leads her life one day at a time and she makes the most of each day knowing that one day she may simply not wake up. Whilst much of her waking day is spent engaging with her treating team both as an out-patient and within the community, there are still activities which bring her much pleasure on a day to day basis. She places enormous value on the time she spends with her parents even when they are doing simple activities such as watching favourite television programmes together. She has a number of pets with whom she continues to engage.

5. AB is clear in her evidence to me that her wish to stop further treatment for her illness is a decision which she has made independently of her treating clinicians. It is one which she wishes to own as an aspect of her personal autonomy. She said this in her statement:

> "Some people might think that it is a life limited in quality as well as quantity, and, in some ways it is, but in so many others, it is not; in many ways, I have what others do not, and finally, as I have said – it is mine. Many, many aspects of it are aspects that I have chosen for myself. That is what I mean when I say that it is a decision made by me as opposed to my illness.
>
> I don't feel that to ask anything else of me is fair. But it is more than that. I believe in fact that to ask anything else of me would make me worse: both physically and mentally. It would be like being punished twice: once by having the illness, and once in an attempt to 'treat' it (whatever that means)."

6. This resonates with the clear evidence I had from Dr B that a coercive feeding regime is now the only treatment option available for AB in the circumstances in which she now finds herself. The only purpose of such an option would be to re-nourish AB's body to the point where she is well enough to engage in psychiatric or psychological therapies. Her treating team agrees that the advanced effects of her illness are now such that she would not be able or willing to engage in this next stage. Because of the physical and psychological trauma which would be inflicted on this young woman were she to be subjected to a further trial of nasogastric feeding, both they and she are in agreement that she should not receive any further active treatment for her anorexia nervosa. Each of her parents have agreed that their beloved daughter should not receive any further treatment. Their love for their daughter is too great to watch her suffer despite the fact that they are aware of the inevitability of the outcome given the path which her illness has taken to date.

The remaining issue for this court

7. It is now agreed that AB has litigation capacity for the purposes of these proceedings. Both she and her clinical team agree it would not be in her best interests to receive further medical treatment beyond that in which she voluntarily participates through regular health checks and visits to the hospital and her GP in addition to palliative care when that proves necessary. The single remaining issue for this court is whether AB has capacity for the purposes of making this decision in relation to her own treatment. If she does, there is no further role for the Court of Protection.

8. This flows from the fundamental principle that a person who has capacity is entitled to decide for himself or herself whether or not to accept or decline medical treatment. Even treatment which has the potential to save life is subject to that absolute principle and basic human right once a court is satisfied that the person concerned has the capacity to make the decision. This fundamental right to choose is not limited to situations and decisions which others might regard as sensible. It matters not that the reasons for making the choice are "rational, irrational, unknown or even non-existent": see *Re T (Adult: Refusal of Treatment)* [1993] Fam 95 at 102 per Lord Donaldson.

9. During the course of argument, I was referred to several authorities in which the court was confronted with similar issues arising in cases where the chronic and long term effects of anorexia nervosa have brought those affected to a potentially critical end of life stage. In each case, the individuals concerned have been found to lack both litigation and subject matter capacity: see, for example, *A Local Authority v E (by her Litigation Friend, the Official Solicitor) & Others* [2012] EWHC 1639 (COP), *The NHS Trust v L (by her Litigation Friend, the Official Solicitor) & Others* [2012] EWHC 2741 (COP), *A NHS Foundation Trust v Ms X* [2014] EWCOP 35, *Betsi Cadwaladr University Local Health Board v Miss W (by her litigation friend, the Official Solicitor)* [2016] EWCOP 13 and *Cheshire & Wirral Partnership NHS Foundation Trust v Z* [2016] EWCOP 56.

10. In this case, it is accepted that AB has *litigation* capacity. She instructs specialist solicitors on her own account and the Official Solicitor has no role to play in these proceedings.

11. This development is recent and I need to explain the course which this litigation has taken since 3 August 2020 when the applicant NHS Trust issued its application for the relief which is now sought.

12. The application was sent to me whilst I was sitting during the vacation in order to deal with the Urgent Applications list in the Royal Courts of Justice. I listed an urgent hearing the following day. Mr Jack Anderson appeared on that occasion to represent the applicant. On that occasion I joined AB as a party to the proceedings and invited the Official Solicitor to consider whether she should act as her litigation friend. Conscious of the need for expedition in this case, I listed a further on notice hearing on 7 August, some three days later.

13. On that occasion, Mr Anderson appeared again to represent the applicant. Ms Katie Gollop QC appeared on behalf of the Official Solicitor, AB and her father, both of whom were in attendance at the remote hearing which was conducted via a video link.

The issue of litigation capacity was raised. The applicant's position was that AB may lack litigation capacity and thus the threshold for the involvement of the Official Solicitor on an interim basis was met although she had not yet formally accepted the invitation to act. Having spoken to AB prior to the hearing, Ms Gollop QC reported that she was well able to communicate her views about the proceedings in a manner which was thoughtful, intelligent, articulate and insightful. She was able to appreciate the difference between her ability to instruct a solicitor to represent her views in proceedings about her future treatment and whether or not she should have treatment. I was told that she had instructed her own solicitor in previous tribunal proceedings concerning her mental heath and had been successful in achieving the discharge of a compulsory treatment order. She had been judged to be competent to give her consent to the instruction of a medical second opinion and had consented to the disclosure of her medical records for these purposes. The applicant Trust's own evidence in relation to capacity was narrow and restricted. It is accepted that AB has the capacity to understand, retain and communicate information relating to her condition. Dr B's evidence related only to her inability to weigh and use information in the limited sphere of decisions relating to her need to put on weight. It was accepted that in all other medical decisions, she had capacity. She was accepting and compliant of the need to attend weekly blood tests, observations and hospital appointments. In circumstances where there was no evidence of a related condition such as body dysmorphia or schizophrenia, the Official Solicitor was concerned that the applicant may be making assumptions about AB's inability to instruct her own solicitor for the purposes of a final determination of its application.

14. It was agreed that Dr B would prepare a supplementary report on the issue of litigation capacity and, in the absence of opposition from the Trust, AB would consult specialist solicitors who had been approached with a view to assisting her.

15. Dr B has since provided the court with a further statement in which he confirms that at the present time AB has capacity in respect of all day to day decisions, including the ability to instruct solicitors and participate in proceedings. Whilst this capacity might fluctuate were she to become more gravely ill, he considers that she does not need a litigation friend at the present time.

16. Thus it was that, when the matter was before the court for final determination of the Trust's application last Friday (14 August 2020), Ms Gollop QC appeared again on behalf of AB instructed by Bindmans. Mr Vikram Sachdeva QC was instructed by the applicant Trust.

17. The submissions from both leading counsel on that occasion were directed towards the single remaining issue between them: does AB have capacity to make decisions in relation to her ongoing medical treatment ?

The Law

18. The law in relation to capacity is set out in the Mental Capacity Act 2005 ("the 2005 Act"). The relevant sections are set out below.

1. The principles

(1) The following principles apply for the purposes of this Act.

(2) A person must be assumed to have capacity unless it is established that he lacks capacity.

(3) 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.

(4) A person is not to be treated as unable to make a decision merely because he makes an unwise decision.

2. People who lack capacity

(1) For the purposes of this Act, 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.

(2) It does not matter whether the impairment or disturbance is permanent or temporary.

(3) A lack of capacity cannot be established merely by reference to -

(a) a person's age or appearance, or

(b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about his capacity.

(4) In proceedings under this Act or any other enactment, any question whether a person lacks capacity within the meaning of this Act must be decided on the balance of probabilities.

3. Inability to make decisions

(1) For the purposes of section 2, 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).

(2) A person is not to be regarded as unable to understand the information relevant to a decision if he is able to understand an explanation of it given to

him in a way that is appropriate to his circumstances (using simple language, visual aids or any other means).

(3) The fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him from being regarded as able to make the decision.

(4) The information relevant to a decision includes information about the reasonably foreseeable consequences of –

(a) deciding one way or another, or

(b) failing to make the decision.

19. Thus, one starts with a statutory presumption that a person has capacity unless and until it is established on the balance of probabilities that he or she lacks capacity. The burden of establishing a lack of capacity lies on the person or party asserting a lack of capacity (here, the applicant Trust).

20. Next, determination of capacity under Part I of the 2005 Act is always 'decision specific': see *PC v City of York Council* [2014] 2 WLR 1 at para 35. In this context I must assess AB's capacity in relation to the specific decision as to whether or not she has capacity in relation to treatment for her anorexia at this point in time when the decision needs to be made. I am not making a decision about her capacity to make decisions generally. In relation to decisions which concern her treatment, I cannot treat AB as unable to make a decision unless I am satisfied that all practicable steps have been taken to help her but these attempts have been unsuccessful.

21. Importantly in the context of this case, I cannot treat AB as being incapacitous in relation to decisions about her medical treatment merely because she has made a decision which is unwise. In this context, I bear in mind the observations made by Peter Jackson J (as he then was) in *Heart of England NHS Foundation Trust v JB* [2014] EWHC 342 (COP) at para [7]:

> "The temptation to base a judgment of a person's capacity upon whether they seem to have made a good or bad decision, and in particular on whether they have accepted or rejected medical advice, is absolutely to be avoided. That would be to put the cart before the horse or, expressed another way, to allow the tail of welfare to wag the dog of capacity. Any tendency in this direction risks infringing the rights of that group of persons who, though vulnerable, are capable of making their own decisions. Many who suffer from mental illness are well able to make decisions about their medical treatment, and it is important not to make unjustified assumptions to the contrary."

22. The *outcome* of the decision in respect of which capacity is in issue is not relevant to the specific enquiry into capacity per se for the purposes of the 2005 Act: see *R v Cooper* [2009] 1 WLR 1786 at para 13 and *York City Council v C* [2014] 2 WLR 1 at paras 53 and 54. Thus, in determining AB's capacity to make her own decisions in relation to medical treatment for her anorexia, I cannot take into account that a decision not to undergo *potentially* life-saving treatment through nasogastric tube feeding might be seen as an unwise decision with potentially fatal consequences. To

do so would risk the introduction into the test of "elements which risk penalising individuality and demanding conformity at the expense of personal autonomy in the context of a diverse, plural society which tolerates a range of views on the decision in question (see *Mental Incapacity* (1995) (Law Comm No 231) (HC 189), para 3.4)": per MacDonald J in *Kings College Hospital NHS Foundation Trust v C and V* [2015] EWCOP 80 at para 30. In that case, his Lordship said this in relation to the issue of 'impaired thinking' (see para 31):

> "It does not matter whether the impairment or disturbance in the functioning of the mind or brain is permanent or temporary (Mental Capacity Act 2005, s. 2(2)). It is important to note that 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 (see *Re SB (A Patient: Capacity to Consent to Termination)* [2013] EWHC 1417 (COP) at [38])."

23. Finally, s 3(1) (a) to (d) of the 2005 Act (often referred to as the 'functional test') provides that an inability to undertake any one of the requirements set out in those sub-paragraphs will be sufficient for a finding of incapacity provided that the person concerned is unable to satisfy any one of the individual component elements because of an impairment of, or a disturbance in the functioning of, the mind or brain: see *RT and LT v A Local Authority* [2010] EWHC 1920 (Fam) at para 40. This, as we shall see, is important in the context of AB's submissions in relation to capacity. The applicant Trust relies on s 3(1)(c) to establish incapacity in this case. Dr B's professional opinion, which is relied on by the Trust for these purposes, is that AB cannot make a decision for herself about her medical treatment because the effect and chronic nature of the severe disease from which she suffers has so infected her ability to use or weigh information as part of the decision-making process that it has disturbed, or impaired, the functioning of her mind or brain in such a way as to render her unable to reach a capacitous decision. Whilst the Trust accepts that she is perfectly capacitous in relation to some other aspects of decision-making, including her acknowledged ability to instruct her own solicitor, in decisions relating to her anorexia and her obsessive and overriding fixation on reducing her calorific intake to the barest minimum, she has elevated that imperative and those beliefs into "an overvalued idea". She now follows that imperative to such an extreme level that she is compelled to attach to it an extreme and undue level of weight with the result that she has lost the ability to properly weigh in the balance other factors. As he explained it to me during the course of his oral evidence,

> "It is the *degree* to how much it affects her thinking that puts it outside her ability to weigh and consider information [about her medical treatment]. There is an attempt on her part to balance [information] but undue weight is put on avoidance……. It is the interference of the anorexia which affects her ability to think. It is the direct overvalued idea which creates the imbalance."

24. Whilst I have strayed into the territory of the evidence, it is important in the context of the issues raised in this case under the 2005 Act to provide some context for the narrow basis of the challenge made by the Trust to AB's assertion of subject matter capacity before turning to a wider survey of the evidence which is before the court.

25. In the context of s 3(1)(c) it is not necessary for the court to find that AB has the ability to use and weigh every aspect and detail of the available options, merely the salient factors: see *CC v KK and STCC* [2012] EWHC 2136 (COP) at para 69. Further, if the court finds that AB is able to employ the relevant information in the decision making process and determine what weight to give it relative to other information required to make the decision, the weight to be attached to that information is a matter for AB as the decision maker. Provided she is able to use and weigh the relevant information, a choice on her part to give the information no, or minimal, weight in reaching a decision will not be enough to bring that decision making within the terms of s 3(1)(c) of the 2005 Act. As MacDonald J said in *Kings College Hospital NHS Foundation Trust v C and V* (supra) at para 38:

> "… a person cannot be considered to be unable to use and weigh information simply on the basis that he or she has applied his or her own values or outlook to that information in making the decision in question and chosen to attach no weight to that information in the decision making process."

26. It seems to me that therein lies one of the tensions in relation to the issue of capacity in this case. Dr B's evidence speaks to the existence of "an overvalued idea" or fixation which arises as a direct result of AB's illness and which overwhelms her thought processes so as to *prevent*, or disable, her from conducting the sort of weighing and balancing exercise required by s. 3(1)(c). This seems to me to go beyond the application of her individual subjective 'values or outlook' which she is perfectly entitled to bring to that decision making process.

27. In this context, I remind myself that whereas the expert evidence of a treating consultant psychiatrist is likely to be determinative of whether there is an impairment of mind for the purposes of s 2(1) of the 2005 Act, the decision as to the capacity of an individual is a judgment which is entrusted to the court. In *PH v A Local Authority* [2011] EWHC 1704 (COP), Baker J (as he then was) said this at para 16:

> "In assessing the question of capacity, the court must consider all the relevant evidence. Clearly, the opinion of an independent-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. ….in cases of vulnerable adults, there is a risk that all professionals involved with treating and helping that person – including, of course, a judge in the Court of Protection – may feel drawn towards an outcome that is more protective of the adult and thus, in certain circumstances, fail to carry out an assessment of capacity that is detached and objective."

28. Finally, I must, as I do, direct myself that each case has to be determined on the basis of its own specific facts. AB and her interests lie at the very heart of this case and her individual circumstances must throughout remain my focus both in relation to the issues of capacity and, insofar as it is necessary for the court to express its view, best interests. The fact that similar cases which have come before the courts have been decided on the basis of different outcomes does not, and must not, influence me one way or the other. Just because they may have involved a similar 'risk matrix' in terms

of the underlying facts does not, and cannot, lead me into conclusions based on a comparative analysis with case law: see *Cheshire & Wirral Partnership NHS Foundation Trust v Z* [2016] EWCOP 56 per Hayden J at para 18.

The evidence

29. Thus I turn now to the evidence which has been put before the court, on some of which I have already touched in the context of the law which I must apply.

30. By way of introduction, I can do no better than to repeat what Peter Jackson J (as he then was) said about the illness from which AB suffers in *Betsi Cadwaladr University Local Health Board* case (cited above):

> "*Anorexia nervosa* (from the Greek *an-/without -orexia/appetite*) is a pernicious condition. In its severe form it is life-governing and potentially fatal. In order to stay alive, a human being needs air, water and food. The normal energy intake for an adult woman is about 2,000 calories a day. A healthy Body Mass Index (BMI) is between 18.5 and 25. If the body uses more energy than it gains over a prolonged period, the result is malnutrition, with a global effect on well-being. The physical consequences can include endocrine disorder preventing the onset of puberty, slow heart rate, low blood pressure, hypothermia, anaemia, reduction in white blood cells, reduction in bone density and reduced immune system functioning. The social consequences for individuals and their families can be devastating, as they damage or destroy normal social development. The psychological consequences for the sufferer include a mental life dominated by thoughts of food. The act of eating is all too easy for most people in developed societies. But for the sufferer, whose life would be utterly transformed by the most modest food consumption, the ability to eat is seemingly overpowered. Years are spent thinking and talking about eating, but talking about eating is not the same thing as eating." (para 1)

31. This passage is not, of course, evidence for the purposes of the decision I must reach but it provides a helpful and succinct context by way of introduction to the evidence which I did hear.

32. As the expert evidence in a number of the cases to which I have referred reveals, the psychological overlay common to the emergence of anorexia nervosa is the development of a profound and illogical fear of weight gain. A sufferer may otherwise appear perfectly rational and may well be able to make entirely appropriate capacitous decisions in relation to a whole range of issues affecting his or her daily life. As the illness takes a grip on an individual over what may be a number of years, it can, and often will, cause a deficit in capacity specific to issues relating to food and an inability to consume what the body needs because of this fundamental fear. In a serious case, a sufferer may have a full appreciation that he or she is putting their life at risk; he or she may understand what is required to redress progressing malnutrition; but unless treating clinicians are able to address the underlying psychological causes, the illness and its effects on the sufferer can be completely overwhelming.

33. I can see from the evidence before me the insidious progress of the disease in AB's case. Dr B has set out a full clinical history in his first statement. He has been AB's treating psychiatrist for nearly ten years and he knows her well. Her first engagement

with psychiatric services occurred when she was 13 years old when she was diagnosed with an eating disorder and obsessional behaviour. Nasogastric (NG) tube feeding against her will followed a matter of weeks later, such was the concern about her weight loss. Over the years which followed between January 2007 and October 2019, AB has been admitted for lengthy periods of treatment as an in-patient on no fewer than eleven occasions. Several of those admissions were detentions pursuant to s 3 of the Mental Health Act 1983. By July 2014 she weighed just 35.4 kilograms. By March 2019 her weight had dropped to 31.3 kilograms. In January 2019 she was discharged after two months in hospital on the basis of a compulsory treatment order (CTO). In June last year, she was recalled to hospital on a further compulsory detention when the CTO was revoked. By August 2019 it was clear the degree of distress she was suffering when further attempts were made to feed her via a nasogastric tube. By February this year, she was in significant pain and had been diagnosed as suffering from osteoporosis. There were concerns regarding her skin integrity which was breaking down. In May 2020, she was struggling with oedema in her legs which was causing significant pain and affecting her mood, sleep and mobility. By June 2020, shortly before this application was issued, her weight had dropped to 28.5 kilograms (a BMI of 9.7).

34. The detailed chronology which Dr B has exhibited to his first statement sets out the detail of the interventions which have occurred over the last fourteen years in this young woman's life. The stark reality as he records in paragraph 8 is that,

> "[AB] is unable (due to her fear of food and weight gain) to meaningfully increase her weight by eating more and most of the hospital admissions have involved feeding via NG tube or consideration of this. [AB] finds this incredibly distressing."

35. Whilst she is currently cared for in the community and from her home, she remains under the care of a multi-disciplinary team consisting of Dr B, a consultant psychologist, Dr R, clinical specialists nurses and her GP. A full capacity assessment was undertaken on 22 July 2020.

36. In May 2019, a second opinion in relation to AB's capacity to make decisions about her treatment was obtained from Dr S, a consultant psychiatrist who specialised in the treatment of adult eating disorders. His report is within the bundle of material which I have read for the purposes of this hearing. He had been asked by AB's treating team to review the case and to advise in relation to both capacity and treatment options. It is a detailed report and its contents reveal that AB was able to engage fully in a dialogue with Dr S about her medical history and her experience of treatment to date. It records that she had been doing her "absolute best" to increase her calorie intake. *"However, logically you know that you are not eating enough food to be able to survive."* Her weight at that stage was sufficiently low (30.8 kilograms) that she was not making herself sick after eating or using laxatives as she had before but she was expressing a concern that these behaviours would return if she started to put on weight.

37. I gain some insight into AB's approach to her illness as at May 2019 from the following passage of Dr S's report.

> "I wondered about the underlying functions of the eating disorder. The most important for you is that it keeps you safe. It gives you a sense of achievement, being good at something, which helps when you feel down on yourself. It numbs your emotions. I wondered about interpersonal functions of the illness. You did not think that it communicates distress to others, nor that it brings others closer. I explained that nobody plans to have anorexia for the functions that it provides, these happen as a consequence of living with the illness. Moreover, the functions are not always helpful, but the fear of living without them can make it very difficult to consider recovery. … I asked what you fear you would lose if you get better. The most important of these is that you fear that you would not be able to cope with what life will bring you without anorexia, the demands of normal life. It is understandable to feel like this when you have been unwell for such a long time as you have."

38. In relation to capacity to make decisions about treatment for her illness, Dr S noted that AB at that stage did not believe she was likely to die. Whilst logically she understood that she was not eating enough to survive, she dismissed firmly the risk she might die. Dr S said this to her (as recorded in his report):

> "You have an impairment of mind, anorexia nervosa. While you understand information given to you regarding the risk to your life and the severity of your illness, you do not believe this information. Your fear of weight gain affects your ability to weigh up information, dismissing all information that would points *[sic]* towards the severity of your illness and in favour of weight restoration. It is my opinion that you do not have capacity to make decisions about your treatment at this time."

39. In paragraph 20 of his first statement made in support of the current application just over a week before this hearing, Dr B expressed his professional view of AB's capacity in this way:

> "I have concern that [AB]'s anorexia nervosa may interfere with her ability to make a reasoned decision regarding the non-acceptance of life-saving in-patient treatment. She clearly understands the gravity of her situation, is accepting and believing of this and is able to communicate her wishes to us. However her reasoning around the aversive nature of being forced to do something that she does not wish to do i.e. have an NG feeding tube, is likely to be partly or wholly as a result of not being able to allow herself to have an increase in nutrition which is a direct consequence of her mental disorder."

40. He explained that, as a treating team, the professionals had decided that long-term admission to a residential unit was not an option because it was not likely to be successful unless AB was prepared to engage in a regime whereby her dramatic weight loss was addressed. She had shown over several years that she was unable to sustain any weight gain in the community and her weight was now so low that a residential unit would be unlikely to accept her. Her best option now lay in the support provided by a close and loving family which is what she currently has. In Dr B's professional judgment, there was no prospect of a recovery from anorexia and the focus should now be on giving her the best quality of life for as long as possible in the community. Since she was happy to see nurses, dieticians, doctors and other members of the eating disorders team on an outpatient basis, he was satisfied that this

was entirely in line with what are now her best interests. He acknowledges that she is bright and intelligent and has been able to engage fully in discussions about her treatment and whether further inpatient admissions should be attempted.

41. Two best interest meetings have been convened, the last on 22 July 2020. These have left undisturbed the unanimous professional view that further treatment is not in AB's best interests. I have seen the detailed plan for palliative care and the support which will be put in place for AB as and when it is required. The views of her treating team are completely aligned with the wishes of AB and her family. The decision to bring the matter before the Court of Protection was taken from a clear appreciation of the potential early consequences of following that course.

42. In relation to AB's capacity in relation to treatment, the multi-disciplinary best interests meeting held on 22 July 2020 concluded that, whilst she had the ability to use and assess information about her condition, AB's anorexia affected her ability to make a choice to accept enough calories in order to stay alive. Dr B concluded that this interfered with her ability to make a reasoned decision as to the level of input she was willing to accept in terms of calorific intake. In his professional judgment, this was likely to play a significant part in her reasoning and her refusal to engage in the potential treatments then on offer. She accepted this refusal was putting her life at immediate risk but "finds the treatments so aversive this risk is accepted by her". This was the basis for his, and the other professional conclusions, that her capacity was impaired. Whilst she was trying to follow some active treatment for her eating disorder, and although she did not wish to die, she then had a stronger wish to avoid traumatic treatment which had always failed to work. That meeting concluded with an agreement that, in terms of a time frame, AB's condition was deteriorating and an agreed way forwards was "time sensitive".

43. AB was a part of that meeting. Her contribution is recorded in these terms:

> "[AB] said her illness is very powerful over her like a bully. Bullying her constantly in everything she does. [She] is 'still in there' somewhere but the Anorexia is stronger."

44. Dr B explained to her parents during that meeting that her illness had had a significant impact on her decision making. She had suffered from the illness for so long that her anorexia was now likely to be having a significant impact on how she was making decisions. Since this was now a life-threatening decision, it was necessary to refer her case to the Court of Protection for a ruling on capacity and best interests. By the time she saw her GP on 10 August 2020 very shortly before this hearing, AB's weight had dropped to 25.4 kilograms. Such was the level of her frailty and fatigue that she needed a wheelchair.

45. I have already recorded the oral evidence which Dr B gave when he attended the hearing on Friday of last week. He admitted, frankly, that they had run out of options in terms of anything over and above palliative care when that became necessary. There was a clear medical consensus that a regime of nasogastric feeding against AB's will was entirely contrary to her best interests. It was, quite simply, physically and psychologically too traumatic for her and there was a clear risk that she may suffer a cardiac arrest as a result of "refeeding syndrome". Even the suggestion of re-implementing this regime was producing acute panic attacks in AB. She was

exhibiting signs of anorexic hepatitis. Given the extent of her osteoporosis, there would be an inevitable risk of broken bones if she were to be forcibly restrained during such a process. Chemical sedation remained an option but was completely impractical given the length of time she would need to remain an in-patient.

46. This heart-rending exposition of AB's medical history does not properly reflect the many and obvious attributes which I was able to observe for myself on the two occasions when I had the privilege of meeting AB in the hearings on the 7 and 14 August this year. We were able to speak to one another over the remote link which enabled me to see and hear her as clearly as if we had been sitting in the same room together. I hope we built up something of a rapport on those occasions. I share with Ms Gollop QC the clear impression that AB is an intelligent and emotionally responsive young woman who is both thoughtful, articulate and insightful in terms of the position in which she now finds herself. The depth of her emotional attachment to, and love for, her parents and close family is transparently clear. She has a voice and views which she is keen the court should hear. At the hearing on 7 August, she had prepared a short statement which she wanted to read to the court. I made a careful note of what she told me. She read her statement to me sitting next to her father in her family home into which they had both invited me along with Ms Gollop QC and Mr Anderson.

47. This is what she told me:

> "I know that I do not have capacity about eating enough to gain weight. I do have mental capacity in knowing the risks and what I am doing to my body. I know the consequences of what could happen. I have full capacity in terms of getting my observations checked and that sort of thing. I engage with my Northamptonshire team every week. I have a very supportive team around me and I have my family. This is my decision to stay at home with my family. I will always carry on seeing my GP. I know about the consequences of death but I just cannot go through any more [hospital] admissions. Everyone decided at the best interests meeting in July this year that palliative care was better for me. I know my health will decline. It is just cruel to keep putting me through this [i.e. further hospital admissions for nasogastric tube feeding]."

48. AB prepared a further written statement which was read to the court by her solicitor at the final hearing last Friday. She confirmed the history of her ten years of treatment as Dr B has described it. She acknowledged that she suffered from obsessive compulsive disorder and was prone to frequent panic attacks. Of her experiences in hospital, she said this:

> "4. To say however simply that I have had 11 in-patient admissions doesn't in and of itself convey what happened during those admissions. It couldn't. I have been held down by my legs with a tube thrust forcefully and forcibly up my nose. I have had food inserted through a syringe so quickly and violently that I was sick. I have had my mobile phone removed from me so that I couldn't call my friends or my family, and they couldn't contact me. I have been restrained and force fed in front of other patients. I have been left covered in bruises and scratches. I have been thrown down on to a bed because I refused to sit in a chair. I have had my feet stamped on when being manhandled. I have been lied to, blackmailed, promised that something would happen, only then to be told that it

won't, and threatened. I have been searched on returning from leave, as have my parents. I have been helpless – and watched helplessly – as every aspect of my life, every aspect of my being, has been controlled by those with the power to do so. In turn, I have kicked and screamed until I've been hoarse.

5. I have tried in the past to 'get better', but never have. During each admission, the focus has been on me putting on weight, and I have. But I have been admitted, gained weight, been discharged, and lost weight. Circular or cyclical, there has never been an endpoint. What is different now is that I have identified for myself a path. I know what the end of that path is likely to be, but it is a path nonetheless, and a path of my choosing.

6. My illness is a part of me, but it is not all of me; it does not define me, and that is where I think [Dr B] is wrong. I do understand that my weight is dangerously low, and that the consequence of not eating enough to gain weight is death. I do not want to die, and I do understand what the illness is doing to me, and the consequences of continuing down the path that I am on. Similarly, though, I also understand what the physical risks, as set out by [Dr B] or forcibly feeding me now are, and I wonder in addition whether in fact the mental stress of being treated against my will would kill me.

7. When I was 13, I was picked on at school by children who would call me ugly, throw things at me, and say that I shouldn't eat certain foods, as I would become fat. It was those same children who then picked on me when I lost too much weight. I couldn't win. In a way, the illness is like those bullying voices. Ultimately, I know that again, I probably won't 'win'.

8. But the decision not to undergo further inpatient treatment is mine. The illness is a part of me, yes. It is a voice, yes. It is a bullying and powerful voice, yes. But the voice making this particular decision is mine. It is a voice made hoarse by screaming, and tearful by the prospect of being forcibly treated against my will – knowing all the while both that any such treatment may cause my death in any event, and that, even were it not to, the likelihood of it 'working' is minute. I do not believe that anyone would agree to undergo further inpatient treatment knowing what it entails, and if told, as I have been, that the chances of 'success' – whatever that actually means – are so low."

Submissions in relation to capacity

The applicant's submissions

49. On behalf of the applicant Trust, Mr Sachdeva QC relies on Dr B's evidence in support of his submission that the nature of AB's illness is such that she lacks capacity in relation to decisions concerning the treatment options for her anorexia. He stressed to me that it was *not* the Trust's case that the medical advice it had offered to AB was not being accepted. Further, this was not a case where the wisdom of AB's decision to refuse further tube feeding was the focus of its approach to capacity. What the Trust relies on in this context is the fundamental impairment of, or disturbance in the functioning of, AB's mind or brain. It is her inability to properly

use or weigh information which this impairment or disturbance causes which engages s 3(1)(c) of the Mental Capacity Act 2005. AB's anorexia is thus the causal connection between that functional element of the test and the impairment or disturbance required by s 2(1) of the Act. The root of her incapacity is her inability to properly weigh the importance of consuming calories as a life sustaining imperative in circumstances where her illness prevents her from accepting the necessity of eating and putting on weight. Whilst she understands clearly the consequences of what is likely to happen to her and has clearly expressed a wish to continue to live, she is overborne, in effect, by the stronger and much more powerful need to control the nourishment which she allows to enter her body. It is this inability to carry out any real or effective balancing exercise which renders her incapacitous in relation to issues of feeding, forcible or otherwise. Mr Sachdeva QC submits this impairment or disturbance in the functioning of her mind or brain goes way beyond using her personal values or outlook when she considers her options. It strikes at the very heart of her ability to undertake that task. This, he submits, is what Dr B was referring to when he says in his most recent statement that:

> "5. This extreme aversion to adequate nutrition is part of her mental disorder of anorexia nervosa. She shows the overvalued ideas that are typical of this disorder – an over evaluation that being low weight is desirable and that being considered fat is so aversive it is to be avoided at all costs. The avoidance of this becomes extreme and out of all proportion to biological norms.
>
> 6. The weight that [AB] places on this desire to be thin and avoidance of being fat is therefore out of proportion to the situation and she places undue weight on the need to achieve this goal. In my opinion this undue weighting on the need to be thin above all else is what sets [AB's] decision-making ability apart from that of someone who has capacity."

50. Whilst every case turns on its own facts, similar expert views expressed in *A NHS Foundation Trust v X* [2014] EWCOP 35 140 BMLR 41 and *In Re W (Medical Treatment: anorexia)* [2016] EWCOP 13 151 BMLR 220 persuaded respectively Cobb J and Peter Jackson J (as he then was) that each of the individuals in those cases lacked capacity in relation to decisions about their illness and treatment.

Submissions made on behalf of AB

51. On behalf of AB, Ms Gollop QC accepts that the applicant Trust acted perfectly properly in bringing its application seeking clarity in relation to AB's treatment. Clarity was plainly required although there are other issues in relation to the timing of its application and the speed at which representation has had to be arranged. However, she submits that the issue for the court to determine is: *'Does AB have capacity to decide whether or not to be tube fed ?'* and not *'Does AB have capacity to make decisions about treatment relating to anorexia nervosa ?'*. She argues that to frame the question more widely in the second way may be disproportionately restrictive of her personal autonomy. It would, for example, remove her ability or agency to make decisions about whether to undergo therapy or counselling, or admission to hospital for these purposes as opposed to forcible feeding, or whether to accept injections of dextrose or intravenous nutrition or hydration.

52. In terms of the court's approach to the issue of capacity, Ms Gollop QC urges me to consider the extent to which the applicant Trust's approach has an element of circularity in terms of the thought process it has adopted. She points to its failure specifically to address the issue of litigation capacity (which is now agreed) before involving the Official Solicitor. As she says in her written skeleton argument, *"The risk that all people suffering from anorexia may be treated as or assumed to be lacking capacity in both regards is real and not theoretical: the applicant's initial assumption about litigation capacity demonstrates this…"* (para 21).

53. Whilst Ms Gollop QC accepts that the way forward in respect of treatment is not finely balanced since the evidence all points in the same direction, she submits that the issue of capacity and AB's ability to determine her own future path is a more difficult issue where the balance is not as clear. There is a concern that, whilst her current treating team will not force her to have treatment if she does not consent to it, this might not be the position if she were to be admitted to a different hospital on an emergency basis.

54. She recognises that the application has the potential to provide AB with an important benefit. In the event that the court determines that AB does indeed have capacity to make decisions about whether or not to undergo tube feeding with the necessary restraint which will inevitably need to accompany it, she will be in a position to make an Advance Decision which will provide her with legal assurance that she will not have to endure that process again against her wishes.

55. Ms Gollop QC submits that I should attach little weight to Dr S's earlier capacity assessment in May 2019 because AB did not have any real insight at that stage of her illness into the imminent risk of death even though she knew she was not eating enough to stay alive. She points to the fact that, more than a year on, she is now accepting that death will be the inevitable consequence of neither eating enough to gain weight nor having tube feeding to produce weight gain.

56. Of Dr B's most recent assessment of capacity, she points to its potential circularity of reasoning. I quote from her skeleton (para 64):

- "Anorexia interferes with AB's ability to accept enough calories to stay alive;
- That adversely affected ability interferes with her ability to make a reasoned decision about tube feeding;
- Although AB understands, retains and can communicate information relevant to the decision about tube feeding to gain weight, and understands and accepts that the consequence of not being tube fed to gain weight is her death, nevertheless her decision not to have more tube feeding is incapacitous because she cannot use and weigh the information because her ability to accept enough calories to gain weight and stay alive is interfered with by anorexia."

57. Whilst Ms Gollop QC accepts that such circularity will be both justified and unavoidable in some cases, she submits it is not appropriate in AB's case because it assumes that which it sets out to prove and/or fails to take into account AB's reasons

for declining tube feeding. She does not seek to assert that the Trust is making an unjustifiable assumption about capacity based solely on the fact that she suffers from anorexia in contravention of s 2(3)(b) of the 2005 Act. *"What is suggested is that by focussing on just one of AB's reasons for not consenting to be force fed (desire to avoid repetition of past experience which was physically and mentally injurious for her and which striped* [sic] *her of dignity), and interpreting it as illness impaired reasoning, the applicant is making an unjustified assumption that the illness must be impairing that reasoning and, presumably her reasoning generally."*

58. On behalf of AB it is submitted that she has carefully weighed and considered why she does not want to be forcibly tube fed. She recognises that the consequences for her are likely to be trauma and pain. Because of her experience of that treatment option (so vividly described in her own words in her statement as I have recorded extracts above), she is using that experience of past trauma and its likely effects upon her as part of the balancing process which is envisaged by s 3(4) of the 2005 Act (i.e. the reasonably foreseeable consequences of deciding one way or the other or failing to make the decision). She is also clear that there is no real prospect of the tube feeding resulting in a successful outcome for her in terms of her ability to sustain weight gain in the medium to longer term. She recognises that she is now so ill that an attempt to tube feed could result in cardiac arrest and death. This is in direct contradistinction to the applicant Trust's approach which says that her use of previous traumatic experience of this treatment is in fact her illness compelling her to avoid weight gain so her reasoning is incapacitous. Ms Gollop QC makes a distinction between AB's wish not to endure further trauma and her avoidance of the option of tube feeding in order to avoid ingesting calories and putting on weight. She accepts on behalf of AB that her motives may well be plural but one of them is to avoid the threat, fear and risk of another episode of forcible feeding. She submits that *"to characterise that motive as illness impaired reasoning is to negate the reality of what AB has been through and its true effect on her"* (para 70 of her skeleton argument).

59. In terms of AB's reasons for resisting the only treatment option which is now available to her, Ms Gollop QC submits that each has a solid foundation and has been reached as a result of capacitous analysis undertaken by AB. They are :-

    (i) the effect of her past experience and the violence it has done to her sense of self and her personal dignity;

    (ii) the risks and futility of further tube feeding;

    (iii) the desire to be at home;

    (iv) the desire to focus on quality, not quantity, of life.

60. Finally, Ms Gollop QC submits that all of these reasons are reasonable. *"If, and the argument is moot, one of her reasons is impaired by her anorexia nervosa and consequent compulsion not to put on weight, then the effect of her mental disorder on her ability to use and weigh the relevant information – so far as is demonstrated by all of her reasons – is tangential at best"* (para 80 of her skeleton argument).

Analysis and conclusion

61. I would want AB to know that I have considered all that has been said on her behalf very carefully. I have read, and re-read, all that she has said to me through the two very personal statements which she has prepared. No one who heard (or reads in this judgment) her account of her experience of tube feeding could fail to be both moved and appalled by its graphic detail. I recognise fully the effects upon her of that experience. I understand completely why, even in the context of a life-critical decision, she does not wish to endure further treatment. I accept that she is aware of the options which are currently available to her and the likelihood that tube feeding is very unlikely now to produce any sustainable benefits. I acknowledge that she understands the risks of any attempt to restart tube feeding. In this context she has shown remarkable dignity in her contemplation of a very significantly shortened life expectancy. Despite all she has endured in the past fifteen years (which is the majority of her life), there is still much which makes her life worthwhile. She has the love of a devoted family and it is abundantly clear to me from all the material I have read that the unstinting love and support they have provided over the years has been a very precious resource to this young woman in coping with all she has had to endure.

62. The issue at the heart of this case is the ability of this particular illness in its current presentation in AB's case to so infect to such a significant extent the very nature of her decision making processes which are engaged in relation to food, calories and weight gain that any decisions flowing from those processes cannot be considered as legally capacitous decisions. This is not to introduce any generalisations or circularity of argument into the decision which is now before the court. I am concerned only with AB, the powerful evidence which she has presented to the court, and the professional views of those charged with the responsibility of caring for her. I have weighed fully in the balance the fact that she is intelligent, articulate and demonstrates clear insight into some of the aspects of her illness. She is also a delightful young woman despite all that she has gone through. That she has managed to retain personal and emotional resilience to the extent she has is humbling to any reader of the chronology of interventions she has endured in the attempts of professionals to reverse the progress of her illness.

63. Ms Gollop QC reminds me that the opinion of Dr B that AB lacks capacity is based upon the profound effects of her illness which gives rise to a compulsive desire not to put on weight. To achieve that seemingly irresistible end, she has starved her body of the nutrition which it needs. Ms Gollop points to the fact that nowhere in her evidence does AB herself cite this as a reason for resisting this final treatment option. She submits that there are no references in any of the medical records which refer to discussions with her therapists or counsellors about a compulsive desire not to put on weight as the basis of her resistance to forcible tube feeding. This may have informed her submission to me that any compulsion not to put on weight experienced as a direct result of her illness and the impact of any potential mental disorder which may impact on her ability to use and weigh the relevant information – so far as is demonstrated by all of her reasons – is 'tangential at best'.

64. In this case, and on the basis of the evidence which I have heard and read, I cannot agree with that submission. It seems to me that, given the chronic nature of AB's illness and its current clinical presentation, her decisions in connection with food, calorific intake and consequent weight gain are so infected and influenced by her fixated need to avoid weight gain at all costs that true logical reasoning in relation to

these specific matters is beyond her capacity or ability. Whether one calls this an "overvalued idea" or the fundamental manifestation of an illness which renders a sufferer powerless to resist a compulsion which, in this case, has proved incompatible with a normal life expectancy seems to me to matter not. It is the effect on AB which this illness has had which lies at the heart of the decision I have to make in relation to capacity. She plainly has the ability to use and weigh information about many aspects of the life she currently experiences. She has very sound and straightforward reasons for not wishing to experience the trauma and pain of further admissions to hospital for the purposes of tube feeding with all that it will entail. Those reasons are based solidly on her lived experience of previous episodes and the anticipation of being forced to undergo similar trauma on a future occasion. It seems to me that is different from her ability to respond rationally to the advice which she is being, and has been, given about the overriding imperative to gain weight if her death through starvation or some related cause is to be avoided. Her judgement in relation to this is critically impaired by an intense and irrational fear of weight gain. She may objectively appreciate that she will only avoid death in the weeks or months ahead if she finds the ability to overcome this illogical fear but she appears powerless to reach any other decision which will preserve her life. In my judgment, the fact that she does not want to die and sees many reasons to continue living are, in themselves, the clearest manifestation of the extent to which her judgment is impaired in relation to this narrow field of decision making.

65. Whilst it has been described as a finely balanced decision by Ms Gollop QC, I have reached a clear conclusion that AB lacks capacity to decide whether or not she should be tube fed. In my judgment, the applicant Trust has established on the balance of probabilities that the statutory presumption in this case has been displaced. It seems to me that it is unnecessary to go beyond that in terms of the wider aspects of potential treatment for her anorexia. No other treatments are available or contemplated.

Best interests

66. My finding in relation to AB's incapacity will not have the result of requiring her to undergo further tube feeding. As I promised her at the conclusion of last Friday's hearing, that was a course which I was unwilling to contemplate in this case despite the potentially life-threatening consequences of her weight reducing further still. In this context the wishes and views of the professionals, the family and AB herself are entirely aligned. No one is suggesting that this is a case where forcible tube feeding or tube feeding under sedation is in AB's best interests. To embark on that course now is likely to be futile and may well precipitate her death in any event. There is a clear plan moving forwards in terms of the palliative care which will be made available when it is required. The fact that all parties appear to agree that a declaration that tube feeding under any circumstances would not be in AB's best interests does not relieve the court from balancing all the relevant factors and reaching an independent conclusion as to where her best interests lie. I have done so and endorse such a declaration as being in AB's best interests.

67. It will be very important to draft with care the declaration which will flow from this judgment. In particular, I would want to make it clear that AB's inability independently to make an Advance Decision about the prohibition on future tube feeding (for example in the event of an emergency admission) should not expose her to the possibility of this intervention by a different hospital or Health Trust. I read

with care the declaratory relief granted by Mrs Justice Eleanor King (as she then was) in *The NHS Trust v L & Others* (cited above) in paragraph 71 of her judgment. I have not attempted to embark on that course in this judgment since I did not hear submissions on these points. Whilst I will invite counsel to submit a draft of the declaratory relief (if any) which is considered to be appropriate over and above the principal declaration in relation to capacity, it should, where possible, enable AB to make autonomous decisions in relation to the care she is to receive as her illness progresses in accordance with the capacity she is acknowledged to have now in relation to other aspects of her medical treatment. Whilst I accept that capacity is always subject matter specific and can fluctuate, AB deserves to make her own decisions about the life which she will continue to experience from the love and warmth of her home with her family. She is quite right to remind me that she has at last found a path for herself. She wishes to continue along that path living the life she loves for as long as she can and that is what this court would wish for her.

Order accordingly