Neutral Citation Number: [2021] EWCOP 32

Case No: 13729452

COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 30/04/2021

Before :

MRS JUSTICE LIEVEN

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Between :

A MENTAL HEALTH TRUST — **Applicant**

and

ER
(by her litigation friend, the Official Solicitor) — **First Respondent**

and

AN NHS FOUNDATION TRUST — **Second Respondent**

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Miss Emma Sutton (instructed by **Hempsons**) for the **Applicant**
Miss Fiona Paterson (instructed by **Miles and Partners**) for the **First Respondent**
Miss Caroline Hallissey (instructed by **Bevan Brittan**) for the **Second Respondent**

Hearing dates: **30 April 2021**

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Approved Judgment

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MRS JUSTICE LIEVEN

The Judge hereby gives leave for this judgment to be reported in this anonymised form.

Mrs Justice Lieven DBE :

1. This case concerns a lady who is being known as ER, and what, if any, orders should be made under the Mental Capacity Act 2005 ('MCA') in respect of her. Miss Sutton represents the applicant Mental Health Trust, Miss Paterson represents ER, the first respondent by her litigation friend the Official Solicitor, and Miss Hallissey represents the second respondent Acute Trust.

2. There are two issues in the case. Firstly, whether ER has capacity in respect of both litigation and also decisions about treatment concerning her anorexia. Secondly, if she does not have capacity, what treatment is in her best interests?

Background

3. This is a particularly sad case, even by the standards of the Court of Protection. ER is 49 years old and has a diagnosis of anorexia nervosa. The documentation in terms of the history of her condition is sparse in respect of the onset of her eating disorders. However, it appears that her eating disorder issues first emerged when she was a teenager and have been with her in different forms ever since. There is reference in one of the reports to a report from Dr B, Consultant Psychiatrist, in 2009, which sets out some of the history.

4. ER was, when quite young, in a long-standing relationship and experienced a large number of miscarriages, which may or may not have had an impact on her mental health. There is reference in the reports to her being diagnosed with bulimia when she was a teenager and that appears to have continued throughout her adult life. She had a long-standing relationship, during which, she gave birth to a daughter who is now, I believe, 18 years old. There is reference to her having suffered from post-natal depression and alcohol was apparently also a feature. There is reference to her being admitted to The Priory for bulimia in 2005 but discharging herself very shortly thereafter.

5. Following the breakdown of that relationship, ER formed a new relationship and became pregnant. There is a record of her partner being violent. She had a child, who died in infancy in traumatic circumstances. She then served a custodial sentence for a number of years for a serious offence. It appears that the anorexia set in seriously whilst ER was in prison, and there is reference to her being frail at that time. She was referred to the adult eating disorder services by probation services when she was released from prison.

6. From March 2012 onwards, there are clearer records of her admissions to hospital. In March 2012, ER was admitted to a mental health unit as an informal patient, but self-discharged very quickly. Thereafter, over the following years, ER had a history of being admitted to hospitals, including two general hospitals, two psychiatric hospitals and two specialist eating disorder units. There appears to be a pattern of her putting on weight and then losing it when discharged back into the community. There is a pattern of her being unable to maintain anything close to a healthy weight in the community.

7. The most recent admission was to The Priory in February 2019 under section 3 of the Mental Health Act 1983, where she stayed for 3 months until being discharged in May 2019. The applicant Trust, who have been looking after ER since 2012, made enquiries

about a specialist bed in 2020 (another inpatient admission), but this was apparently not possible, partly in light of her physical conditions which by then had developed. In respect of those physical conditions, over the last 2 years, ER's health has deteriorated considerably. She now has very serious renal failure as well as osteoporosis, endocarditis and klebsiella. I will return to the failure of her renal functioning when I come to the evidence of Dr F.

8. Since ER's last admission to hospital in 2019, her weight is recorded to have fluctuated and, at one point, to have fallen as low as 29kg. More recently, she has managed to maintain a weekly weight that has varied between 35kg to 37kg. Those weights are significantly below those of a healthy patient and indeed are so low as to place her at very serious risk. In terms of her physical health, ER is by reason of her failed renal function currently receiving dialysis 3 times a week.

9. ER overdosed on 31 December 2020 (having stockpiled her prescribed medication) and was admitted to hospital. It is thought to have been an isolated event, and she is not currently prescribed medication for her mental health.

Position of the parties

10. Both the applicant, represented by Miss Sutton, and the Official Solicitor, represented by Miss Paterson, say that ER lacks capacity to make decisions about this litigation, and decisions concerning her anorexia. Both agree that ER has capacity to make decisions for treatment in respect of her physical problems. Both parties agree that ER should not be forced to accept treatment for her anorexia which she does not wish for, and that she should not be forced to go into a psychiatric hospital or a specialist eating disorder unit against her wishes.

11. It might be thought in light of that level of agreement, that although sad, this case is legally relatively straightforward. However, at ER's request, I spoke to her for something in the region of 20 minutes the afternoon before the hearing. I noted her to be very articulate, clear in her views, and in my view, insightful as to her condition. I was concerned that given what I had heard directly, there was material that suggested that ER might well have capacity in respect of the two issues - ligation decisions and decisions regarding treatment for her anorexia. In those circumstances, I asked Dr Cahill, consultant psychiatrist, who provided a second opinion to the applicant, to give oral evidence, and I, and the applicant and the Official Solicitor, asked him a number of questions.

12. Both Miss Sutton and Miss Paterson agreed that ultimately under the statute, it was for me to be satisfied that ER did not have capacity, and this was not an issue that I could avoid or, to use a non-technical term "fudge". If I came to the conclusion that ER does have capacity, this court does not have jurisdiction. Therefore, although the parties were agreed, it was appropriate for Dr Cahill to give evidence, and for me to give a judgment on the issue.

The Evidence

13. I had written evidence from Dr F (consultant renal physician) and Dr P (consultant psychiatrist), and written and oral evidence from Dr Cahill. As far as Dr F's evidence is concerned, Dr F is a consultant renal physician employed by the second respondent.

He explains that ER suffers from end stage renal disease and requires dialysis 3 times a week. ER has been having dialysis since 2016. The dialysis is given at the local hospital and ER has attended regularly throughout. He also explains that ER has multiple physical comorbidities – mitral valve endocarditis and a chronic klebsiella infection, as well as longstanding anorexia. Dr F says in his first statement that ER has intermittently expressed a wish to be put on a transplant list, but her comorbidities preclude this. In practice, there is no prospect of ER being given a transplant.

14. Dr F was asked to give a view on ER's life expectancy in light of her renal condition and comorbidities. He explains that it is extremely difficult to do this with any level of certainty and has given an indication that ER is likely to have a life expectancy of between 6 and 12 months, but this can be by no means certain. It is a matter of record that ER has already lived considerably longer than was thought to be likely last year. Therefore, although I give some weight to life expectancy, I am very conscious of the degree of uncertainty in this regard.

15. In respect of ER's capacity to make decisions about her physical treatment, it is Dr F's opinion that ER does have capacity. He carried out a fresh capacity assessment on 15 April 2021 and he sets out in his statement why she can not only understand and retain the relevant information, but that she can weigh it up. I have no reason to doubt his conclusions in that regard.

16. I also have evidence from Dr P, consultant psychiatrist from the applicant Trust. Importantly, Dr P has been ER's treating psychiatrist since March 2012. Dr P records that she has assessed ER's capacity in respect of decisions about hospital admissions for her eating disorder, and she refers to the fact that she carried out a capacity assessment on 27 January 2021. Dr P concluded that ER did not have capacity to make decisions about hospital admission and treatment for anorexia. Dr P felt ER was unable to weigh up the information regarding the severity of her illness, and the impact it has had on her over the last years and in the immediate short term. She was also unable to understand the consequences of malnutrition and the risk that chronic low weight posed to her life. At that stage, Dr P considered that ER did have capacity to conduct proceedings, however she explained to me that she would ultimately defer to Dr Cahill in that regard, who has assessed ER more recently.

17. Dr P also sets out in some detail her consideration of what would be in ER's best interests and refers to a best interests meeting on 7 April 2021, which I have the minutes of. It was agreed by everyone at that meeting that another inpatient admission against ER's wishes would not be in her best interests, given ER's strong opposition, and the fact that it is unlikely to have any impact on her renal position (so her physical condition is unlikely to improve significantly), but that it may impact on her mental condition significantly.

18. Finally, in terms of evidence, I have a very detailed report from Dr Cahill, as well as some answers to two supplementary questions. Dr Cahill is a consultant psychiatrist at Chester and Wirral Partnership NHS Trust, and he is the clinical lead for eating disorder services over the North West of England. He is also a member of the North West regional MARSIPAN Group ("Management of Really Sick Patients with Anorexia"). I set out this expertise because it is relevant that his particular expertise is with patients with particularly severe anorexia.

19. Dr Cahill's report sets out, in considerable detail, the recent history of ER's admissions and assessments. It is clear from his report that he has considered the papers very carefully. Dr Cahill met ER for about an hour and a half on 30 March 2021. He sets out in his report quite a detailed account of what ER said to him during that meeting. It is noteworthy that he records that she was depressed during that meeting, that she said she had had enough, and felt that dialysis and medical treatment seemed a waste of time. He also records that she said she was very lonely, and that she thought that being around other people might make her feel better about life and improve her mood.

20. In his summary section, Dr Cahill refers to the fact that there is a pattern of ER gaining weight to 38 – 39kg, but then quickly losing it again when she leaves hospital. He sets out in his report detailed conclusions in his opinion section. To summarise, it is Dr Cahill's view that ER lacks capacity to make decisions about treatment for her anorexia and, in particular, about inpatient treatment. He explains in paragraphs 5.20 - 5.22 why he considers she lacks capacity in this regard:

> *"5.20 From assessing [ER], the medical documentation and from [Dr P's] account, my opinion is that she lacks capacity to make this decision. Although it is entirely true that she regains weight during hospitalisation, and then loses it soon after, it is her ability to weigh up the information necessary to arrive at this decision that I question. This is for several reasons. In my opinion, she is not aware of her own disability. There is ample evidence that she lacks the insight into the seriousness of her condition when, at desperately low levels of BMI around 10, believing that a BMI of around 12.8 is safe. It is concerning that when at an incredible low weight, there is evidence of body image distortion, believing she is 'chunky.' Despite the ongoing severe risks of her low weight, she engages in behaviours to appear higher in weight, in order to 'trick' staff, rather than engaging in a plan to manage and minimise risk. There is evidence that she believes she can regain weight in the community, back to a weight of above 38kg, when there is no evidence to support this, and a clear lack of insight into the overwhelming nature of her anorexic thoughts and behaviours. Although there is an understanding of the physical health consequences of her renal disease, there appears to be a lack of insight with regards to the physical health effects of poor nutrition and low weight. There is consistent evidence that [ER] believes she is eating enough to regain weight, despite evidence to the contrary.*
>
> *5.21 In addition to this, we must question why she is declining inpatient treatment, when there are points in her history when she has accepted this, as a voluntary patient, but also just after discharge, when she is in a much better place psychologically. Although there are challenges to the admissions, in terms of the dialysis etc, there is evidence that inpatient treatment does lead to weight restoration, even though this is negated on discharge. [ER] has never required nasogastric feeding, or more importantly, feeding under restraint. Although she struggles to comply with all the treatment on the unit, there must be a degree of compliance with the program, otherwise the result would not be weight restoration. Therefore, we are not considering a 'traumatic' admission as such. If anything, [ER] is being looked after, with a reduction in isolation and*

loneliness. However, at the heart of the condition is a fear of weight gain, a drive for thinness, and a body image distortion. [ER] is likely to be fearful of this, whether she perceives this as relinquishing of control, a threat to her safety, security, and identity, or simply that she cannot tolerate the inevitable weight gain. I put to [ER] that in my experience, similar cases have been managed by 'top-up' shorter admissions, possibly 2-3 times a year, to minimise the likelihood of ongoing weight loss and to help manage overall risks. [ER] told me that she did not find the eating disorder units helpful, but gave reasons around it feeling military, regimented, controlled, and that the other patients were immature. Yet, through all the admissions, [ER] managed to restore weight, and was discharged at a more stable physical position than at admission. Although she talked about being watched in the bathroom as 'disgusting' which I do acknowledge, there was no evidence from [ER] that the admissions have been traumatic for her. She even recognised herself that she regained weight and came out 'stronger.' Therefore, it is very likely that her anorexic cognitions are driving her decisions regarding admission, and therefore, due to this impairment of the mind, in my opinion she struggles to weigh up the information.

5.22 Despite periods of hopelessness, and helplessness; short episodes of declining dialysis, and a recent impulsive overdose, there is recent evidence that [ER] has not voiced a desire to die. However, without intensive inpatient treatment for her eating disorder, there is an absolute risk that her physical health will deteriorate further causing likely death. In my opinion, her lack of insight into this puts her capacity to question. She also minimised her vomiting and laxative misuse during my assessment. There is significant evidence in the medical documentation that this is a running theme and is likely contributing to her significant poor health. Not acknowledging the risks of these behaviours reflects her poor insight and is likely affecting her ability to weigh information."

21. To summarise, his view is in part because there is evidence of body image distortion, a failure to understand the severe risks of her low weight and her continuation to engage in behaviours which appear to be designed to trick staff as opposed to engaging in a plan to manage and minimise risk. Dr Cahill refers to ER declining inpatient treatment where there were points in the past that she accepted it, and when her psychological position seemed to be better. Dr Cahill refers to the fact that although she knows that she gains weight whilst in hospital and comes out stronger, her cognitions in that regard are driven by her condition and impairment of mind, and that she struggles to weigh up information about her weight. He also records in his report that she has no desire to die and does wish to take steps to avoid that. He also concludes at paragraph 5.45 that she does not have capacity to litigate. He does this largely on the basis of the decision of Munby J as he then was in <u>Sheffield City Council v E</u> [2004] EWHC 2808 (Fam), that, given that ER lacks capacity in respect of the subject matter, it follows that she lacks capacity to litigate given how the two are closely related. In respect of best interests, Dr Cahill does consider that there may be benefit to a short-term admission for ER to gain weight and boost her mood.

22. I should also refer to the evidence of Ms Turner, ER's solicitor, who is very experienced in this field, and who, having had discussions with ER, considers that ER lacks litigation capacity. As far as ER's wishes and feeling are concerned, Ms Turner has produced a detailed document setting out ER's wishes and feelings. It is clear on reading this document that, unlike some such cases, ER has set out her own views in her own words. To summarise that statement, ER takes a pretty realistic view of her condition, and certainly her physical condition. She explains she does not like eating disorder units and sets out, in my view, perfectly rational reasons for this. In particular, that she is much older than other patients and finds their behaviours unhelpful for her condition. She also finds the approach of being encouraged to eat large meals very unhelpful to her.

23. ER acknowledges the support she has received from carers, however she does make clear, as she did to me, that she would like more support in the community to help her to eat more, and she feels that more support would be useful. ER also explains that she often feels very nauseous, particularly after dialysis, and that is what often stops her eating more calories. ER explains that she does feel lonely in her current accommodation with carers coming in. She would be interested in moving to a residential placement or supported living, as long as her privacy could be maintained. ER makes it very clear that she doesn't want to be treated in a psychiatric unit or treated against her wishes, but says she doesn't want to die, and wants medical help.

24. There is an additional note from Ms Turner following a phone call on 21 April 2021. Two passages in this note were particularly focussed on by Miss Paterson. In paragraph 5, ER is recorded as saying that she gets very nauseous, particularly with gastric reflux, which is making her very uncomfortable and is a significant reason for not eating more. However, ER says that she has little confidence in her GP and had not felt that she could speak to her GP about this. The point Miss Paterson makes is that although ER is making complaints, she has not raised those complaints with or about her GP until very recently. Miss Paterson suggests that this might be ER showing a pattern of "putting up excuses for not eating" (my terminology). The other passage Miss Paterson turns attention to is paragraph 10, which does suggest that ER is unrealistic about the weight she needs to attain, and her "changing the goalposts" in terms of pushing the target weight down to justify her position that there that does not need to be further intervention.

The Law

25. At this stage I must thank Miss Sutton for producing a very helpful note on the law, which was agreed by Miss Paterson, and which I can refer to without there being any contest. Under section 1(2) MCA, a person must be assumed to have capacity unless it is established that they lack capacity. The burden of proof lies on the person asserting a lack of capacity and it is always decision specific. Capacity must be assessed at the time the decision needs to be made. Pursuant to section 2(1) MCA, a person lacks capacity in relation to a matter if at the material time they are unable to make a decision for themselves in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.

26. Pursuant to section 3(1) MCA, a person is unable to make a decision for himself if he is unable (a) to understand the information relevant to 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. An inability to undertake any one of these four 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.

27. As is clear from what is set out above, the real issue in this case is whether ER can meet section 3(1)(c) – i.e. whether she can she use and weigh information. In the case of *PCT v P, AH and The Local Authority* [2009] EW Misc 10 (EWCOP) at paragraph 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"*.

28. 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 as he then was observed at paragraph 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 …".*

29. There are a series of reported cases dealing with the issue of anorexia nervosa and capacity:

(1) *Re E (Medical Treatment Anorexia)* [2012] EWHC 1639 (COP), before Mr Justice Peter Jackson;

(2) *The NHS Trust v L* [2012] EWHC 2741 (COP) before Mrs Justice King;

(3) *An NHS Foundation Trust v Ms X* [2014] EWCOP 35 before Mr Justice Cobb;

(4) *Betsi Cadwaladr University Local Health Board v Miss W* [2016] EWCOP 13 before Mr Justice Peter Jackson;

(5) *Cheshire & Wirral Partnership NHS Foundation Trust v Z* [2016] EWCOP 56 before Mr Justice Hayden;

(6) *Northamptonshire Healthcare NHS Foundation Trust v AB* [2020] EWCOP 40 before Mrs Justice Roberts.

30. Although all of those cases are of course of considerable importance, I do also note that the issue was focussed entirely, or very largely, on P's anorexia. The complicating factor here is that ER has a renal condition, which is terminal and is likely to lead to the

end of her life in a relatively short period. Although that may have been caused originally by the consequences of her eating disorder, it now stands as a free-standing condition.

Conclusion

31. I find this a very difficult case because of the question of capacity. There are particularly tragic circumstances that have led to ER to be where she is. In respect of best interests, everyone agrees to what conclusions I should reach. Therefore, it might be thought that, to some degree, the issue of capacity is “academic”. It is also right to acknowledge that it might strongly be in ER’s interests to be thought not to have capacity as it allows the Court of Protection to have continued oversight of the case, which itself can provide more focus on the services that she needs. However, capacity and autonomy are such important principles, that lack of capacity cannot be assumed for the sake of expediency. I cannot fail to engage with the issue in detail, and as stated above, it is of course the case that if ER has capacity, the Court of Protection has no jurisdiction.

32. Turning to my conclusions, I should start by stating that I fully accept Dr Cahill’s expertise and Dr P’s much greater experience of ER. Considering the factors set out by Baker J in *PH*, I am in the position where both ER’s treating psychiatrist for the last 8 years thinks that ER does not have capacity to make decisions about her treatment for her anorexia, but also Dr Cahill, who is an expert in this particular area, also considers that ER does not have capacity. However, my hesitancy in accepting their views stems from two things. Firstly, when ER spoke to me, I thought she was articulate and clear in her views, but, most importantly, insightful into her condition, both in terms of her eating disorder, and her renal failure. Secondly, that ER’s position is not that of a more “normal” anorexic patient. Her renal failure is terminal, and she has a limited life expectancy, so the decisions she makes about not wanting an inpatient admission have to be seen in that context. Treatment would not prolong her life, therefore the views she expressed seemed potentially rational.

33. However, with considerable reluctance, I have decided to accept Dr Cahill and Dr P’s evidence and I accept that ER lacks capacity to make decisions about her anorexia treatment and, it follows, litigation capacity. I start from the statutory presumption in section 1(2) MCA that ER has capacity to make decisions regarding her anorexia treatment. However, Dr P has long experience of ER and her disordered thinking. I would be very slow to depart from the view of a treating consultant psychiatrist, absent any concerns about the closeness of the relationship, which I do not have here. Secondly, Dr Cahill has long and considerable experience of treating patients with anorexia nervosa and I wholly accept that is experience I do not have. Dr Cahill is convinced that ER’s thinking is distorted by issues regarding her body image and that she is incapable of weighing up the information. Thirdly, I do accept that there is evidence of unrealistic thinking, especially around her weight levels. Fourthly, I accept that there is evidence that ER does not act rationally in respect of some of the decisions she makes around her eating problems. I do accept that the evidence that ER has failed to address concerns about nausea with her GP, suggests that she is seeking to avoid the issue and is perhaps being less than open with professionals.

34. Therefore, I am satisfied that the test in section 3(1(c) MCA is not met here. Although ER can understand and retain the relevant information, she cannot use and weigh it up. The issue of litigation capacity is a difficult one but given the very close relationship

between anorexia treatment and litigation capacity, I accept Ms Turner and Dr Cahill's evidence that ER lacks litigation capacity. As stated above, Dr P deferred to Dr Cahill in this regard.

Best Interests

35. Given these conclusions, it is appropriate to turn to ER's best interests and this is more straightforward. The parties agree, and I accept, that it is not in ER's best interests for her to be forced to accept treatment for her anorexia which she does not wish to accept. In particular, she should not be forced to go into any inpatient hospital and treated against her wishes. In my view, it is plain that this is in her best interests given her renal failure and extreme dislike of eating disorder units and psychiatric hospitals. I also note that this conclusion accords with ER's wishes and feelings.

36. However, it is in ER's best interests to be given more support in the community. I do not criticise the support she has received to date, and her criticism of the support might be unfair. However, the evidence is fairly clear that if she could be moved to a supported living placement where she can have dialysis and more support and company, this could much improve her mood and potentially improve her physical health over the next few months. In those circumstances, I will approve the care plan in the short-term, but I will list another hearing and direct that the Local Authority and the CCG are joined as parties to these proceedings, and are directed to put forward amended proposals in terms of extra support and possibly a move to a supported placement. This is on the basis that they are the relevant public bodies with responsibility for commissioning any future placements for ER. I will consider the terms of any further case management proposed.