39 Essex
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HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

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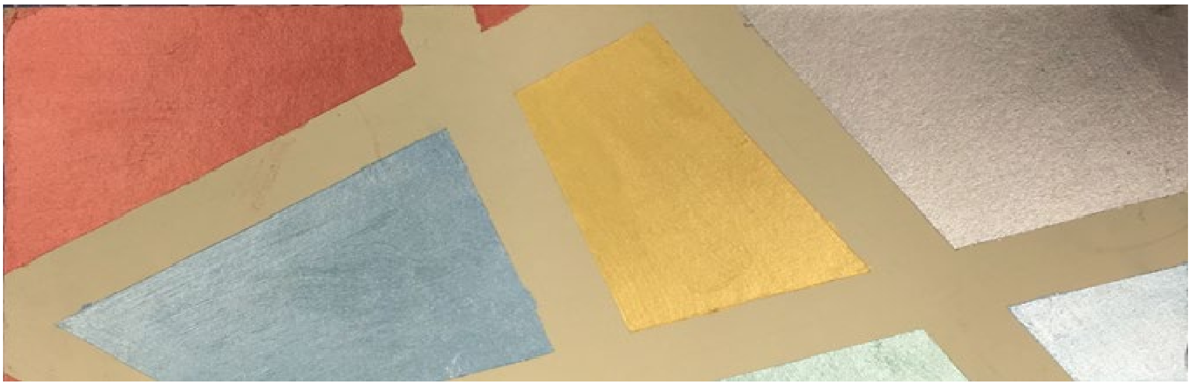

Welcome to the July 2025 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: what to do when an advance decision to refuse treatment may be in play, and the consequences of the gaps between services for those with disordered eating;

(2) In the Property and Affairs Report: capacity in the rear view mirror: how does the presumption work?;

(3) In the Practice and Procedure Report: disclosing position statements to observers; habitual residence, moving jurisdictions and 'lawful authority;' and the impact on P of being assessed;

(4) In the Mental Health Matters Report: progress of the Mental Health Bill and the tort consequences of a finding of Not Guilty by Reason of Insanity;

(5) In the Children's Capacity Report: a depressing snapshot from the national DoL court, human rights of children in the social care system and capacity and gender-affirming treatment;

(6) In the Wider Context Report: the Oliver McGowan statutory learning disability and autism training, and the pitfalls of facilitated communication

(7) In the Scotland Report: joint attorneys in dispute: appropriate remedies and; "If at first you don't succeed …": res judicata in tribunal proceedings.

The progress of the Terminally Ill Adults (End of Life) Bill can be followed on Alex's resources page here.

You can find our past issues, our case summaries, and more on our dedicated sub-site here, where you can also sign up to the Mental Capacity Report.

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The picture at the top, "*Colourful*," is by Geoffrey Files, a young autistic man. We are very grateful to him and his family for permission to use his artwork.

Contents

Cheshire West 2?

The hearing date for the Attorney General for Northern Ireland's reference concerning deprivation of liberty has been set: 20 and 21 October. Alex, Tor and Arianna all being somewhat constrained in what they say, being instructed in the case, they point readers to this article in Community Care which provides a convenient overview of the issues at stake.

"There are more things in heaven and earth that are dreamt of in the philosophy of NHS treatment"

The Hillingdon Hospitals NHS Foundation Trust v YD & Ors (Refusal of Withdrawal of Treatment) [2025] EWCOP 31 (T3) (Theis J)

Best interests – medical treatment

Summary

The flipside of the intense focus on the wishes, feelings, beliefs and values of the person required by s.4 MCA 2005, as clarified by the Supreme Court in *Aintree v James*, is that there may be situations in which, objectively, a person's medical situation might appear hopeless, but nonetheless continued treatment is in their best interests. Such a case is that of *The Hillingdon Hospitals NHS Foundation Trust v YD & Ors (Refusal of Withdrawal of Treatment)* [2025] EWCOP 31.[1] On the face of it, YD, who had been in a prolonged disorder of consciousness since October 2024 and had no prospect of emerging from the permanent vegetative state in which he now found himself, was a clear candidate for withdrawal of clinically assisted nutrition and hydration.

But the hospital caring for him, and the ICB commissioning his care, did not assert that continuing CANH was clinically inappropriate. Had they done so, then the Court of Protection could have probed their reasoning, but could not have required it to be continued. The question, therefore, was what was in YD's best interests.

One striking point about this case was that YD had not one, but two, partners, who had previously unknown to each other. Each of them, though, were:

> 73. […] *aware, without knowing names or numbers that YD was 'a central part of a community of people with shared beliefs that there was more to life than the material, and…that there are more things in heaven and earth that are*

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[1] In passing, we do wish more judges would do as was done here, and give a 'headline' in the title. Even if it does not need to be a spoiler, as here, it makes life so much easier when trying to keep track of the alphabet soup of case names.

> *dreamt of in the philosophy of NHS treatment. They had a shared belief that each person has psychic abilities but not every person can access them.' They each had an experience of YD that was not scientifically explicable and all explained that understanding the universe outside the material and 'exploring and developing his own transcendental powers, was [YD's] life's work'. NT emphasised the serious nature of YD's scholarship in this regard. [and that] YD 'believed that one's spiritual belief system is a personal matter and one of continuous development'. YD believed in 'self-improvement, giving thanks and doing good...that we have multi-dimensional existence outside linear time and he reported that he experienced that existence when asleep and unconscious. He believed we can communicate thoughts in an extrasensory way and his beliefs were manifest in waking life personal experiences. He believed in life after death'.*

The Vice-President of the Court of Protection, Theis J, in reaching her conclusion reasoned as follows:

> *79. When considering what is in YD's best interests it should be considered in its widest sense. Consideration must be given to all relevant circumstances, to the person's past and present wishes and feelings, to the beliefs and values that would be likely to influence their decision if they had capacity, and to the other facts that they would be likely to consider if they were able to do so (s4(6) MCA 2005). Account must be taken of the views of anyone engaged in caring for the person or interested in their welfare (s4(7) MCA 2005). In considering whether treatment is in the best interests of the person concerned, the decision-maker must not be motivated by a desire to bring about the person's death (s4(5) MCA 2005).*
>
> *80. The focus must be on whether it is in YD's best interests to continue to have the treatment, rather than whether it is in his best interests to withhold or withdraw it. The purpose of the best interests test is to consider matters from the patient's point of view, however that does not mean they are determinative.*
>
> *81. The medical evidence from Dr N and Dr Hanrahan unite in their conclusion that YD is in a PDOC. They both conclude he is in a VS in accordance with the assessments that have been undertaken following the RCP Guidelines. They were each firm in their evidence about the diagnosis and the prognosis. Each were pressed by Mr Hockton about the relatively small changes that had been noted by JG and MB since June, some of which is noted in the nursing records, including by the OT. They did not dispute what JG and MB saw, or what was recorded, but attached no evidential significance to it regarding diagnosis as it lacked the consistency over a period of time and the other features as set out in the RCP Guidelines to be of significance. In his written report Dr Hanrahan stated that when considering the burdens of continuing with CANH there does not appear to be great 'burdensomeness evident'. That accords with the medical evidence of YD's relatively stability, he has not suffered from infections. Whilst Dr Hanrahan stated that in broad terms by virtue of his current condition the trajectory is he would continue to deteriorate, however he did not detract from the view set out in his report due to the high quality of care, both medical and from the family, that he is receiving. The evidence about pain is equivocal. There is evidence of YD grimacing whilst his limbs are being stretched and both*

JG and MB describing being aware when it appears he is in discomfort.

82. I agree with the Official Solicitor that the court now has a rounded picture of the values and beliefs that would be likely to influence YD's decision if he had capacity. I reject any suggestion that JG, MB or NT sought to bring their values, beliefs, wishes and feelings over those of YD, or risked conflating them. They each gave compelling evidence with dignity and composure and maintained the clear blue line between what they felt and their evidence about YD's values, beliefs, wishes and feelings. This is despite their obvious deep affection for YD. They were each able to bring their own perspective of YD's beliefs and values. I reject the submission on behalf of the Trust that the evidence 'did not provide a direct answer to the question of what [YD] would have wanted to do in these specific, extreme circumstances'. In my judgment, that is considering YD's best interests through too narrow a lens. If there is no evidence of such a conversation the court needs to carefully look at the relevant evidence as a whole, evaluate it and see what, if any, conclusions can reliably be drawn.

83. What has been so striking about the evidence about YD from JG, MB and NT is that, certainly in relation to JG and MB, even though they had each known YD for 20 and 24 years respectively, they had not known each other prior to October 2024, and were unaware of each other's existence. Yet despite that separation over such an extended period of time they were each able to independently confirm many common features about YD's wishes and beliefs. In particular, regarding the depth of his interest in the spiritual world and his limitless curiosity about such matters that he held strong beliefs about. YD has long held beliefs about the healing power of the mind, body and soul and to understand and, if required, push established boundaries based on his learning and understanding. From their descriptions YD was compassionate, private person who was a fiercely independent thinker about a wide range of issues, in particular regarding the spiritual world and healing.

84. I agree with the Official Solicitor that the evidence establishes that whilst YD 'might not dispute Dr Hanrahan's opinion that recent physical changes are the manifestation of involuntary, rudimentary new connections to the brainstem, he would be likely to see that opinion as a limited and incomplete explanation of what had caused those changes'. His long standing interest in the healing power of the mind, spirit or soul would very likely be values that would inform his decision if he had capacity. The changes that have been observed he would regard as positive signs and that he had the potential to make further changes. These are likely to be relevant factors that would inform his decision if he had capacity, and would be likely to be a factor in him wishing and feeling that he wanted to continue to be provided with CANH. YD would also likely factor in, due to his long standing beliefs in such matters, that others believe they are in communication with him.

85. When looking at what evidence the court has about what decisions he has made in the past, the understanding of what VS is and the medical prognosis by Dr N and Dr Hanrahan it is unlikely to have caused YD to wish or feel that CANH should be withdrawn. When considering the evidence about the past YD is likely to value the devotion shown by JG and MB. Their evidence when asked about how YD would feel about the amount of nursing care he requires, bearing in mind the evidence about what a private person he was, was powerful,

> *as they each responded that YD would take it as part of the process of getting better or healing. They both described YD's high threshold for experiencing pain or discomfort in the past. This is consistent with his actions in the past (for example seeking the assistance of the NHS when he chose to) and his wider views of the holistic healing process. I agree with Mr Hockton, that from the evidence the court has about YD he would have approached the decision-making in this case in a very different way from Dr N and Dr Hanrahan.*
>
> *86. Having stood back and considered through a wide best interests lens whether it is in YD's best interests to continue to receive CANH I have reached the conclusion that it is.*
>
> *87. In my judgment the burdens do not outweigh the benefits. I have carefully considered each of the burdens it is said continuing with that treatment would involve for YD, both in the short and the long term, but I have to balance that with the benefits of such treatment continuing. Most importantly it would preserve his life. I depart from the evidence of Dr N and Dr Hanrahan as in the particular circumstances of this case I place greater weight on YD's past and present wishes, feelings, beliefs and values than they do. I accept the picture of YD painted by the evidence of JG, MB and NT. I do not regard the continuance of CANH in this case as futile where it sustains life. Having looked at the wider evidential picture I do not accept the narrow view taken by Dr Hanrahan as it did not pay sufficient regard to the evidence of YD's beliefs and values and wishes and feelings. Whilst it is recognised that any awareness on the part of YD, if present, is extremely limited and there may be little or no further improvement and a trajectory of general deterioration it is far from clear that in the circumstances YD is in he would regard his continued existence as a burden. There is a strong presumption in favour of preserving life which, in my judgment, having carefully evaluated the evidence in this unusual case, the Trust has not discharged.*

Returning to an issue which has troubled her for some time, Theis J also made some wider observations about the role of ICBs:

> *88. The focus of this judgment has been on YD. It is right that during the evidence the wider issue of the impact of cases such as this was raised. The Trust acknowledge there is scope for further work in relation to the timing of applications of this nature: on the one hand, there is a well-recognised need to bring cases of this kind promptly if treatment is not regarded as being in P's best interests, but on the other hand, there is the risk of unintended consequences if this leads to patients having prolonged admissions to acute neurorehabilitation beds versus a community placement. There has been no suggestion in this case that the Trust delayed in making this application.*
>
> *89. The issues raised are (i) whether the ICB should be a party to proceedings of this nature, or (ii) whether the ICB's engagement in matters (without party status; as occurred in this case) satisfies their need to be actively involved in withdrawal decision, and (iii) whether patients should, where possible, be placed in community beds, pending the outcome of an application.*
>
> *90. The Official Solicitor considers there is a lack of clarity in this case whether Dr N considered that YD should have been transferred to a nursing home some time ago and court proceedings initiated whilst he was there, or that he would not stand in the way of YD's CANH continuing so long as it did so at a*

> *nursing home not at the rehabilitation unit.*
>
> *91. It is clear that on a case by case basis these issues should be proactively and carefully considered at each stage, full disclosure must be made of any such concerns or considerations raised so that the Official Solicitor and the Court are fully appraised of the issues. The relevant ICBs should take a proactive interest in any such issues, taking such steps as are required to avoid delay and making sure all relevant parties are represented in any court proceedings and, if required, urgent directions sought from the court in any ongoing proceedings.*
>
> *92. None of these observations detract from the very clear message in cases such as NHS South East London Integrated Care Board v JP and others [2025] EWCOP 8 and NHS North Central London Integrated care Board v Royal Hospital for Neuro-Disability & XR [2024] EWCOP 66 about the need for effective decision making structures being in place for those who are in a PDOC, the need for careful and regular review and evaluation about what is in their best interests and, where required, an application being made to the Court of Protection for a decision as to what is in the patient's best interests.*

Comment

The full judgment requires reading for confirmation that real life is, as ever, stranger than fiction, and also as a case study in the navigation of complex relationships going beyond 'next of kin' to identify those who were expert in the person. It is also good to see that this was a case in which the case was brought with appropriate speed before the court for resolution of the question of whether continuing CANH was in YD's best interests.

This case is another in the number of small but increasing number of cases (including *Aintree v James* at first instance[2]) in which the Court of Protection has upheld a patient's understood wish for continued treatment in the face of medical concern as to whether it is in their best interests. This is immensely important – constructing the right decision for the person must include the potential for that decision to be to continue as well as for it to stop.

However, such an approach comes with consequences. The maintenance of patients in the position of YD is not cost-free. Just as in the case of admission and treatment in ICU, we tend to seek to avoid hard discussions about cost-benefit analysis of the sort that are now familiar in the context, say, of cancer drugs. For our part, would suggest that there is an increasing need for work to be done to establish a framework within discussions about such costs can be considered in a transparent fashion, and in a way which resolves the uncertainty justly. Otherwise, we run the risk of concerns about costs leading (no doubt inadvertently) to: (1) distortion of the clinical framing of the person's condition and of the treatment; or (2) distortion of best interests decision making (for instance, by asking whether the person would wish to be continue to be kept alive at the cost of "diverting" resources from others).

When does a Court of Protection order start to do more harm than good?

Patricia's Father & Ors v Patricia & Ors [2025] EWCOP 30 (T3) (Arbuthnot J)

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[2] Mr James had died by the time the case reached the Supreme Court so technically the decision of the Supreme Court does not count.

Best interests – medical treatment

Summary[3]

This case is challenging at a number of levels, over and above the human tragedy at the centre of it. Procedurally, it highlights the pitfalls of identifying the point at which a decision made by the Court of Protection needs to be revisited because it is harming, rather than helping. Substantively, it highlights the challenges for the Court of Protection of seeking to respect autonomy in the context of anorexia. Clinically, it highlights deep and insufficiently understood splits amongst clinicians about how to respond to anorexia, especially in the context of resource limitations which appear (all too often) to cut off first line responses. And ethically it highlights how anorexia has an almost unique ability to render relationships – both familial and clinical – all but untenable: brought home vividly by the fact that name of the case suggests that Patricia's father, mother and aunt are bringing a case against her.

As Arbuthnot J identified in the opening paragraph of her judgment:

> *1.This is an application brought by the parents and aunt of a woman who has previously been anonymised to "Patricia". Patricia is aged 25 and has lived with anorexia nervosa ("AN") since she was aged about 10. Patricia is very ill because she is not consuming sufficient calories. She is malnourished. When this case started in March 2025, her body mass index ("BMI") was thought to be around seven or eight and I was told she weighed about 19kg, which is what many five year olds weigh. She had not been able to walk unaided for two years and suffers bed sores. She has osteoporosis.*
>
> *2. Patricia also has been diagnosed in the recent past with autism and with pathological demand PDA avoidance ("PDA"). The combination of the PDA and AN means that although she has repeatedly said she wishes to live, she refuses to consume the calories that she requires to be able to walk without a Zimmer frame, let alone to have an enjoyable and productive life out of hospitals and Specialist Eating Disorder Units ("SEDUs").*

In 2023, Patricia's situation was considered by Moor J, who ordered:

> *6.* […] *in accordance with Patricia's strongly expressed views that it was in her best interests not to receive nasogastric tube feeding with restraint and not to receive any other medical treatment against her wishes and that Patricia should be given autonomy to make her own decisions about whether she put on weight or not.*

Patricia's parents and aunt were not parties in the 2023 proceedings, Arbuthnot J explained, and "they said they had not understood the import of the decisions made" (paragraph 6), nor does it appear that they had understood at any point until 2025 that they might have the ability to place her situation back before the Court of Protection. However, in March 2025, they made an urgent application to the Court of Protection, on the basis that they believed that Patricia was about to be discharged by the hospital where she was to a palliative care setting to die. An extensive series of hearings then took place.

> *4. The applicants initially relied on the evidence of Dr Ibrahim, a consultant psychiatrist, who recommended that the*

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[3] Tor and Katie having been involved in this, they have not contributed to this note.

> *court make an order that Patricia be fed under restraint by nasogastric ("NG") tube. His recommendation was that she be fed until her weight was fully restored, a weight of about 50 kilos, which she had never experienced.*
>
> *5. As the case continued, no SEDU was prepared to commit to that sort of weight restoration and in the event, as of July 2025, there is only one SEDU available (I will call it SEDU 3) which may be able to treat Patricia if the orders made by Moor J in 2023 are lifted and Patricia assessed positively by the SEDU.*

As Arbuthnot J noted:

> *9. I must observe that Patricia vociferously opposes the applications made by her parents and aunt. I have met her twice and she has sent a number of emails to my clerk in which she makes her views clear. She has said that she wants Moor J's orders to remain undisturbed. Any change would not be in her best interests and would lead to a worsening of her AN and a reduction in the calories she consumes. She wants to live but what she does not want to do, or is unable to do, is to eat to a level which is sufficient for her to stay alive.*

The issues before Arbuthnot J ultimately came down to two:

> *26. The first issue was whether in principle I could re-visit the 2023 order and secondly, if so, whether I should discharge the declarations made by Moor J in 2023. This would allow Patricia to receive whatever treatment the clinicians treating her consider she needs, whether that involves force feeding or not. The lifting of the order would bring her position into line with nearly every other anorexic patient in the country, as it would remove any perceived barrier to Patricia being detained and treated compulsorily under the Mental Health Act 1983 ("MHA").*
>
> *27. It is not disputed by the parties that there is reason to believe that Patricia does not have capacity to conduct the litigation herself and to make decisions as to her medical treatment for AN. It is not the position that someone with AN would never have capacity, it depends on their state of health, and whether they are unable to make the decision because of the AN, which is an impairment of, or a disturbance in the functioning of, the mind or brain. In 2023, at times, Patricia had capacity to conduct the proceedings and at other times when she had lost weight and her health had deteriorated generally, she no longer had it. I heard unchallenged evidence that the brain shrinks as the AN takes hold. Patricia is at a very low weight indeed with a BMI of about nine: I heard evidence that this is likely amongst the lowest in the country. Her cognition is greatly affected by this disease. I find she lacks capacity to conduct litigation or make decisions in relation to her treatment for AN.*

After a detailed review of the 2023 proceedings, the history thereafter, and the evidence before her, Arbuthnot J considered matters thus:

> *140. At the time of the first two decisions made in May 2023, Patricia was on an upwards trajectory and was increasing her calorific intake. During the first May hearing she had promised the judge she would increase her intake. By the second May hearing, her intake was higher than it had been. Moor J heard substantial evidence including from Professor Robinson, an independent expert and made the declarations and orders it did.*
>
> *141. By October 2023 however, this improving position had stalled. Another*

complication was that Patricia had gone into hospital with an infection. It may have been C. difficile which Dr PI said had led to Patricia losing more weight. In any event the Court confirmed the May 2023 order and made it wider. Patricia should not be force fed with restraint nor was she to receive any medical treatment against her wishes. Moor J decided Patricia should have the autonomy to decide what she should eat and how. I accept that the Judge in 2023 recognised that Patricia was almost certainly past the point of accepting treatment.

142. Just over 18 months later, now in July 2025, despite all the efforts made to work consensually with Patricia, she is much more ill than she was in 2023. There is no doubt now that the hands-off approach, leaving it to Patricia to decide whether to increase her BMI, has not worked. At the beginning of these proceedings in March 2025, her BMI was thought to be around 7.3. This was considerably lower than in 2023. The witnesses were all agreed that if nothing changed she would die, and probably very soon.

143. With the court order of 2023, there was no other treatment that could be offered to Patricia, and this was why the hospital was going to discharge her to a care home. During the course of these proceedings, and I have no doubt that it was because of them, Patricia had improved somewhat her calorie intake and her BMI had increased to about 9 or so. She is still at risk of death.

144. Whereas in October 2023, there was still some hope that Patricia might voluntarily start gaining weight, there was no hope at all in March 2025. Despite this, I noted Patricia's will to live remains strong. She speaks about what she would like to do in her life, including travelling. She does not want to die and she has been repeatedly saying she wishes to go into SEDU 1, the SEDU that does not use feeding under restraint.

145. At the early hearings in 2025, Dr Ibrahim had produced what he said was an alternative approach which included full weight restoration. This proposal was not before the Judge in October 2023 and in March 2025 appeared to be new evidence. As it turned out, by 20th May 2025, this option was not available for this court.

146. In looking at whether there has been a change in circumstances, or other new evidence, what struck me was how wrong it was that a potential life-saving option, open to every other anorexic in the country was not available to Patricia. 18 months on, the orders were preventing Patricia from going into a SEDU. The orders in 2023 had been shown to have failed. Without a change to the orders, there was no doubt that Patricia would die.

147. The respondents' final positions in 2025 were probably best described as neutral about whether there had been a change or not or whether that should even be the test. Ms Gollop KC for the hospital was the least neutral of the respondents.

148. The hospital position, ably put forward by Ms Gollop on 20th May 2025 was that Moor J's reasoning and decisions were not wrong. He had made no error of law nor had he failed to take into account any factor relevant to best interests so that the best interests decision was wrong. Nevertheless, the Court had now heard evidence from a number of clinicians and experts or quasi experts, and should now consider the application afresh.

149. The ICB argued at the hearing of 20th May 2025, that the Court should *engage with the application to discharge on its merits because the time to dismiss it would have been at the first hearing. It was far too late now to summarily dismiss the application as suggested in the decision of Poole J in An NHS Trust v AF & Anor [2020] EWCOP 55. Ms Scott for the ICB contended powerfully that it was for the Court to determine whether it was in Patricia's best interests for the orders to be discharged.*

150. Ms Scott argued that the Court should not make any declaration or order which might fetter the decision-making of the clinicians, such as declare that any particular treatment should be provided to Patricia. In her most powerful argument, Ms Scott contended that Patricia should be returned to the position that all anorexic patients are in, they have the opportunity to access all available treatments including forced treatment under the MHA, without any fetters imposed by the Court.

151. CPFT argued that although Moor J's decisions did not formally bind clinicians from detaining Patricia under the MHA, the order was intended by the Judge to ensure that she was not subject to further treatment she did not want including detention under the MHA. The only decision for the court was whether Moor J's order should be discharged.

152. Ms Roper KC for CPFT said there were two questions for the court, the first was whether it was open to the Court to re-open the previous decision of Moor J in 2023 and the second was, if so, should the previous orders be discharged. Ms Roper set out a detailed account of the evidence heard by Moor J. She considered the legal test and the case of AF. The decision made by Poole J was seven months after a decision had been made by Mostyn J. In the particular circumstances of AF, Poole J reopened the earlier decision made.

153. The second case relied on by Ms Roper was Z v University Hospitals Plymouth NHS Trust (No. 2) [2021] EWCA Civ 22 where on an application for permission to appeal, King LJ said at paragraph 31 that "the court will, if appropriate, review an earlier best interests determination. As Francis J put it in Great Ormond Street Hospital v Yates (No. 2) [2017] 4 WLR 131 at paragraph 11, such a reconsideration will be undertaken "on the grounds of compelling new evidence" but not on "partially informed or ill-informed opinion"".

154. On behalf of Patricia by her litigation friend, the Official Solicitor, Mr Patel KC supported the ICB argument that the time had passed for the Court to dismiss the application using its case-management powers on the basis there has been no material change in circumstance.

155. The Official Solicitor argued that in any event, Patricia's condition had deteriorated since 2023; Patricia continued to express a strong wish to receive treatment for her AN and the approach in 2023 that of respecting Patricia's autonomy had not worked. Where there was a presumption to preserve life, the Court should make a substantive determination. Leaving the orders in place had put an "impossible burden on her". Moor J's order required her to agree to treatment which her anorexia could not allow her to. Without a discharge of Moor J's orders, Patricia could not access SEDUs. On balance the Official Solicitor considered that it was in Patricia's best interests to discharge the orders.

156. I did not accept the argument of the ICB and the Official Solicitor that the

> *time to revisit an earlier decision had to be at an early case management stage of proceedings. In many cases, it might be, but in the current proceedings it would have been too early. In March 2025, I had evidence only from Dr Ibrahim in his first statement. His conclusions and advice were based on a partial account given to him by the applicants and not on Patricia's medical records nor on conversations with her treating clinicians. Dr Ibrahim did not know therefore of the many attempts that had been made to treat Patricia over about 15 years in a variety of ways including by force feeding her before the orders in 2023.*
>
> *157. I see no reason why I could not dismiss the application now, several hearings on, despite having heard from a number of witnesses, although I found the decisions made in May and October 2023 were clearly the right decisions for Patricia at that time.*
>
> *158. In this case, at this stage, I am in a position to determine whether the application should be rejected. I should out of respect to my colleague and considering the importance of finality, give effect to the earlier decision made by Moor J unless there is either a change of circumstance, new evidence which may be persuasive, or, as is the case here and as Poole J in AF put it succinctly "if the decision or circumstances that the new court is being asked to consider are not clearly covered by the earlier judgment".*
>
> *<u>159. The most significant circumstance that is not covered by the earlier judgments in May and October 2023, is the burden on Patricia of the decisions made then</u>. What the court could not anticipate is how Patricia would react to the decision of the court. As the many witnesses explained it, her thinking is dominated by the AN. Her anorexic cognition has prevented her from understanding the link between living or even just being able to walk and the need to take on calories to give her the strength she needs. It is a complete block in her understanding caused either by AN or by her autism and PDA. She is a highly intelligent young woman yet she fails to accept the link between eating and living.*
>
> *<u>160. Leaving the orders in place had put an impossible burden on her. Moor J's order required her to agree to treatment which her anorexia would not allow her to. Without a discharge of Moor J's orders, Patricia cannot access a SEDU that might be willing to accept her, one that might save her life.</u>*
>
> *<u>161. I am conscious that a decision to revisit the orders made in 2023, will cause Patricia a very great deal of distress but it is right in principle and in Patricia's best interests that I look at her situation and circumstances again, when the autonomy given to her by Moor J has laid an impossible burden on her.</u>*
>
> *162. In my view there are circumstances in this case which amount to factors which were not clearly covered by the orders made by Moor J in 2023.* (emphases added)

This meant, therefore, that, that Arbuthnot J had the power to revisit Moor J's decision.

> *163. Having determined that I have the power to revisit Moor J's decision in 2023, the next issue is whether Patricia's best interests require a continuation of the order made in 2023 or whether the evidence supports a change of approach set out in a new order.*
>
> *164. The respondents invite me to take one of two approaches to the 2023 orders. The hospital and CPFT argue*

that the second issue needs to be decided at the same time as the first whilst the family, the Official Solicitor and the ICB argue that I should decide the principle of revisiting the orders only and adjourn the second to a time when there is a SEDU available to take Patricia. They are all concerned about the effect on Patricia of any decision I might take. There is only one SEDU, currently, SEDU 3, which might be prepared to consider Patricia for treatment if the 2023 orders were removed.

165. On balance I have decided to make both decisions at once. This is because my decision to revisit the orders made in 2023, will be very distressing to Patricia. If I adjourn the second issue, Patricia, who is extremely intelligent, will realise what is going on. She will work out the way the wind is blowing and that suspicion without any certainty will add to her distress. Added to that, Patricia has been waiting for four months now to find out the outcome of this application, the delay has caused her great upset too. I also consider that there is a chance if I deal with both issues at once, that other SEDUs may become available were I to lift the orders.

166. In 2025, it is undoubtedly the case that Patricia is much nearer to death than she was in 2023 and yet she does not want to die. It was her cognition caused by the AN in addition to her autism and PDA which have led to her refusal to take on the calories she needs to live. She said she wanted to be able to walk again and travel yet what was preventing her from doing this was her refusal to increase her BMI.

167. The professional witnesses I heard from were agreed that Patricia's opposition to compulsory treatment, was driven by her anorexia. I agreed with Mr Lewis when he said, echoing Dr Ibrahim's observation, that by "respecting [Patricia's] autonomy, the court [in 2023] had permitted her anorexia to call the shots".

168. The significant issue which I have had to grapple with is the effect on Patricia of any change in approach. I must consider Patricia's past and present wishes and feelings and the beliefs and values that would be likely to influence her decision if she had capacity. Patricia has had AN since the age of 10. She has never had values or beliefs which were not enmeshed with her AN. All she minds about is how to avoid putting on weight although she values her life and likes to imagine the life of travel she could have.

169. Patricia cannot have made it clearer that she does not want the orders to be lifted. She believes a lifting of them would lead to her being force fed. She says she is traumatised by the thought that this may occur again. She says she suffers from PTSD caused by past force feeding. She says it is torture. This is her longstanding view and she points out with some force that in the past force feeding did not work.

170. She has said that even the knowledge that there is a chance that the court may reconsider the orders made in 2023, has prevented her from sleeping, has led to her having nose bleeds, and hitting her head against a wall. She has become increasingly pressing in her emails to the parties and the court, trying to negotiate an alternative approach. She suggests that she should go to SEDU 1 where she knows she cannot be force fed. That unit, however, for good reason, has not offered her a place.

171. I am not being asked to consider what specific treatment she will receive in any SEDU and I agree that that question should be left to the clinicians *treating her. My view is that Patricia should have access to the treatment or lack of treatment that any other anorexic patient does. The court should not impose an order which would prevent her from having the treatment which may save her life when she wants to live. I hope that once she gets to a SEDU she will work to increase her BMI within a collaborative treatment plan which will take into account her autism. This will allow her to achieve the aims she has spoken about.*

172. All sorts of treatments have been attempted before and there is not much optimism that Patricia can be saved. Any SEDU which can care for her, needs the flexibility which will be given by the removal of the orders.

173. As part of the decision I am to take into account the views of her family, who bring this application and anyone engaged in caring for Patricia. The family want her to live and also want her to have the life of any 25 year old. Their views are reflected in this application. They want the order to be lifted.

174. The views of the clinicians who know her best is that a plan for force feeding was unlikely to succeed. Patricia would fight any restraint and this could harm her. Dr PI, whose views I respect, and who knows Patricia very well, considers that force feeding is not in Patricia's best interests. The witnesses who have worked with her point to the many years of failure when Patricia has put on a little bit of weight in a specialised hospital setting before losing it in very short order when she leaves.

175. I have reminded myself that the January 2025 treatment plan was contributed to by Patricia and it was formulated with her PDA and autism in mind. She had special carers allocated to her and support from SEDU 1which led to them having to close three beds to accommodate their work with her. This lasted for eight days.

176. Although every treatment has been tried with Patricia, rather counterintuitively, I was told by the clinicians and the expert that patients with anorexia can be restored to health even when they are very resistant to increasing their BMI and weight and even when past attempts have failed.

177. The balance of harm versus benefit is nearly equal. On the one hand, if I lift the orders, Patricia may "down tools" and she may become even more ill than she is already. I am conscious that before 2023, there had been numerous attempts to treat Patricia including by NG feeding under restraint. None of it worked and the witnesses were clear that Patricia found restraint incredibly distressing.

178. I accepted the evidence that AN is part of who she is and Patricia will find it traumatising to lose control over her treatment, if she entered a SEDU and a treatment decision was made to NG feed her under restraint. I also accepted the evidence that AN is so much part of who Patricia is that she will not want to get rid of it and could never get to a weight where she is not hospitalised from time to time. At the same time, I bear in mind too that in 2022 she agreed to NG feeding when she had no alternative to that and said it was not as bad as she had anticipated. She now denies ever saying that.

179. The best that the court could hope for is that she gains weight a little, increases her BMI, so she does not spend her life in hospital or a SEDU, although the evidence from the past was that if she were treated and increased her weight, it might well

> *reduce again when she leaves the facility.*
>
> *180. On the positive side, I bear in mind that if I lift the orders, there is a chance a SEDU will take her, whether it is SEDU 3 or another, and although the past history of such admissions is not positive, she could turn a corner and put on weight. The clinicians were clear that this does happen, when a patient later thanks the clinician for forcing them to gain weight.*
>
> *181. I have had to balance the factors set out above and consider Patricia's Article 3 right not to be treated inhumanely when she believes strongly that force feeding will breach her rights. I remind myself I am not being asked to make an order that she be force fed, but to lift the orders which would then allow SEDUs to decide what is the appropriate treatment for this young woman who wishes to live.*
>
> *182. Having considered the balance of the imminent risk of death versus the harm which will be caused psychologically and emotionally by the lifting of the orders, the balance is in favour of trying to save her life. The removal of the orders will allow the clinicians to work out what is best for Patricia, without the restrictions that currently prevent this.*
>
> *183. I lift the 2023 orders. This is in Patricia's best interests.*

Comment

The recent decision of McKendrick J in *Leeds and York Partnership NHS Foundation Trust v FF & Anor* [2025] EWCOP 26 (T3) (covered in the Practice and Procedure section of this Report) which is not referred to in the judgment of Arbuthnot J, was notable for the way in which the orders were carefully framed so as not to be seen to bind decision-making by clinicians in the future in the event of a material change in circumstances. By contrast, the orders made in 2023 by Moor J, no doubt entirely inadvertently, became – as Arbuthnot J noted with evident concern – barriers to appropriate decision-making because they were perceived as being binding for all time. As the Court of Appeal confirmed in the *Re A* case (see paragraph 90) he Court of Protection is not a supervisory court, and exists to make decisions at a specific point in time; but the flip side of this is that those who have brought cases to court to obtain decisions must keep under review whether those decisions remain in the person's best interests.

The focus on 'autonomy' in the judgment of Moor J, and the repeated references to the concept in the evidence before Arbuthnot J is also striking. It is worth remembering that the word does not appear in the MCA 2005 itself; it is also worth remembering that it is a concept that frequently hinders more than it helps. As Swift J felt the need to point out in the *Royal Bank of Scotland* case, for instance, it is just as much a failure to respect autonomy not to interrogate evidence that the person may lack capacity to make a decision as it is to barge ahead and make decisions for them without establishing that they do, in fact, lack capacity to make the decision. It might be thought that (as with the term 'dignity') it would be sensible to strive to avoid making use of the term in decision-making in this context, at least without a very clear-eyed understanding of what exactly is being intended.

The observations of Arbuthnot J about the 'impossible burden' having been placed on Patricia by the judgment of Moor J are powerful. Hayden J has also in a number of cases (see, for instance, the *NR* case) sought to give decision-making authority back to a person who has been found to lack capacity to make the relevant decision. The drive to do so is clear, and in many ways entirely laudable: seeking to ensure that the person's wishes, feelings, beliefs and values are determinative, notwithstanding their (legal) incapacity, and also, in the anorexia context, seeking to ensure that further harm is not caused to them by imposing treatment against their will. However, it might be thought that where the person's wishes, feelings, beliefs and values are so profoundly ambivalent, it is actually an abdication of judicial responsibility to take such a course of action. It is not for nothing that those closely involved with the Convention on the Rights of Persons with Disabilities, who wish all decisions to be based upon the person's will and preferences, consider anorexia cases so difficult – or that, for all their efforts, they are not able to provide a clear way through such dilemmas. That the buck may have to stop with a judge may, ultimately, be necessary in such cases, which (1) places a responsibility on the judge which should not be underestimated; and (2) increases the responsibility on the parties and experts to provide the best possible evidence upon which the judge can reach their decision – including evidence that frankly acknowledges uncertainty.

In light of the observations in the paragraph above, some might be wondering whether cases such as Patricia's should really come to the Court of Protection, to speak the language of 'best interests,' and be guided by a requirement to make a decision framed by reference to the person's known wishes, feelings, beliefs and values. They might think that life is (metaphorically) easier under the MHA 1983, with its 'harder-edged' approach to decision-making – there is, in other words, no need to become tangled up in the essentially existential dilemma that faced Moor J. Rather, it is a simple(r) question of identifying what treatment is appropriate, and simply going ahead and providing it, irrespective of whether it is what the person says that they want. There is an element of truth to this, and this case might make some take stock of whether they want to have recourse to the Court of Protection, or whether they want to approach patients with anorexia through the prism of the MHA 1983 which makes no (formal) pretence to putting the clinician in the shoes of the patient. However, case-law is already bending the 'appropriate treatment' test firmly towards the best interests test within the MCA 2005 – and, when the MHA Bill comes into force – statute will follow suit.[4] And, as the decision in the *Leeds and York Partnership NHS Foundation Trust v FF & Anor* [2025] EWCOP 26 (T3) shows, it is likely that clinicians who consider (for whatever reason) they have reached the 'end of the line' as regards compulsory feeding may still want to obtain the confirmation of the court (in this case the King's Bench Division) that non-treatment under the MHA 1983 is lawful even if it may lead to the patient's death. We are therefore likely to still to see cases before the court, and, for our part, we consider that this is only appropriate given the gravity of the issues at stake. Again, however, this brings with it the requirement that the court is given the best possible evidence about the options, is empowered to interrogate those options, and builds in sufficient contingency planning for the future (and a reminder that the judgment that is then given only relates to that case, rather than to the treatment of eating disorders more generally).

Three last observations:

1. These dilemmas are made much worse by the fact that services are so stretched. It is not coincidental that the frequency and severity of cases coming to the Court of Protection has increased so significantly over

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[4] Albeit without using the language of best interests, because the MHA 1983 will still be applicable to those who have capacity to make decisions about medical treatment for mental disorder.

the past few years – or that the choices being placed before the court have become so stark;

2. As Arbuthnot J's observations about the evidence of Dr Ibrahim in her judgment make clear – and perhaps in part a side-effect of (1) above – emotions are running very high in this context, not just amongst family members, but amongst professionals. I hope that the case will allow stock to be taken: (1) as to why there are such differences in approach between clinicians; (2) what common ground there is; and (3) what both lawyers representing parties and the courts need to be told of as regards the potential differences in approaches. A starting point might be the relevant part of this webinar, in which Dr Lucy Stephenson gives a primer on anorexia and why (colloquially) it pushes so many buttons, especially when it seems to have become in some way untreatable.

3. As the webinar noted at (2) above discusses, it is hardly surprising that anorexia is featuring so heavily in the debates around the Terminally Ill Adults (End of Life) Bill, as it is a condition which cannot be neatly compartmentalised off from the conditions which are intended to be within the scope of the Bill.

Short note: cancer investigations and mental ill health

Those living with serious mental health conditions also regularly fail to be supported to access the physical health care that they need. In *St George's University Hospitals NHS Foundation Trust v MN* [2025] EWCOP 28 (T3), the Trust brought an application – albeit some 10 months after the first suspicion arose – to ensure that a person with a serious mental health condition underwent the necessary investigations of potential anal cancer. He lacked the relevant decision-making capacity, and was (inconsistently) expressing reluctance to undergo the investigations. Peel J considered that the delay in making the application could not "remotely be justified," and suggested that the Trust needed to review why it took so long to embark on legal proceedings (paragraph 10).

Peel J was clear that the application should be granted, for the following reasons (at paragraph 21):

> *i) MN's objections to the exploratory investigations are not based on an informed, rational understanding of what is proposed, the benefits and the burdens. His resistance is, instead, infected by delusional beliefs outlined above. This is not a case where there is evidence of his views before loss of capacity. In this case, his personal beliefs and appraisal of what the clinicians are proposing are rooted in long standing paranoia.*
>
> *ii) There is nothing to suggest that he actively wants his life to end, or, putting it another way, that he would not want the opportunity for the quality of his life to be enhanced, and for the duration of his life to be prolonged. Indeed, he expressed the clear view to the OS's agent that he does not want to die. Further, his views about undertaking further medical investigation seem to have fluctuated, in that he did not vigorously oppose it when talking to his IMCA or the OS's agent whereas he is aggressively dismissive to the clinicians.*
>
> *iii) The evidence is that at mention of the word "cancer" he becomes agitated, so it would clearly be sensible not to use that word to or in front of him when informing him about the intended hospital admission.*
>
> *iv) The investigations are required to confirm the diagnosis, the stage of the*

> *tumour, and whether it has spread. Further, they are necessary to enable an assessment of treatment options to take place and, if treatment is not viable, how palliative care can be implemented.*
>
> *v) If the investigations are not carried out, potentially life saving treatment options cannot be considered. If cancer is present, MN would likely experience an increase in pain and discomfort, including itching, pain, bleeding and blockage in the anal canal. It would spread to other areas leading to death.*
>
> *vi) The testing should provide a definitive diagnosis of whether he has cancer, and enable the team to prepare a treatment plan, which would include pain mitigation. He is currently experiencing physical discomfort and it is desirable to reduce or eliminate the pain if possible.*
>
> *vii) I regard MN's situation as urgent given the lengthy delay since anal cancer was first suspected. In my view, the investigative work should be done as soon as possible, although the evidence is that it will require 2 weeks to make all the necessary arrangements which are challenging and multi faceted to coordinate.*
>
> *viii) General anaesthetic would minimise movement and distress and enable all the tests to be completed in one day. I am satisfied that carrying out the investigations without a general anaesthetic is not a clinically recommended option in this case, and although there are risks involved, they are no greater for MN than any other patient. I was told that the general anaesthetic would last 1 ½ - 3 hours and it is advantageous to carry out all the investigations under the one anaesthetic.*
>
> *ix) If the diagnosis is confirmed, likely future treatment options are chemotherapy and radiotherapy, potentially followed by surgery which would be major and accompanied by a permanent colostomy bag. Authorisation to take these steps is, properly, not sought by the Trust at this stage which must await the outcome of the testing procedures, and then reconsider capacity and best interests. At this stage, what is sought is investigative only and, in my judgment, a proportionate and appropriate step to take.*
>
> *x) I approve the Deprivation of Liberty sought, if and insofar as it is required to enable transportation and the planned investigative medical procedures. It is likely that restraint (physical and/or chemical) will be required. It is, in my judgment, a proportionate and necessary interference with MN's rights to facilitate the testing to be carried out.*

The application was adjourned to a further hearing to consider any potential treatment options required in consequence of the investigations.

SCIE sounds the alarm on MCA reform

The Social Care Institute for Excellence is not normally an alarmist body, which makes its recent (26 August 2025) statement on MCA reform all the more striking. We reproduce the material sections below:

> *Failure to act on long-delayed reforms to the Mental Capacity Act is contributing to* ***preventable deaths****,* ***unlawful detentions*** *and* ***growing human rights concerns****.*
> *The Mental Capacity Act (MCA) is the legal foundation for decisions made on behalf of people who cannot decide for themselves, because of dementia, learning disability, brain injury or serious*

> *illness. It governs some of the most sensitive decisions in life: medical treatment, financial control or the need for care.*

Crucially, the MCA also governs when and how someone can be lawfully deprived of their liberty, such as when they are confined to a hospital or care home for their own safety. These safeguards, known as Deprivation of Liberty Safeguards (DoLS), are embedded in the MCA. If DoLS aren't working, the MCA isn't working.

The Government's attempt to fix this, through the Mental Capacity (Amendment) Act 2019 and the introduction of Liberty Protection Safeguards (LPS), has stalled. Implementation was paused in 2020. Five years on, reform is frozen, yet demand is rising and consequences are escalating.

> *The Social Care Institute for Excellence's (SCIE)* ***new analysis of Care Quality Commission*** *(CQC) assessments of local authorities, as of August 2025, reveals that:*

- ***67% of local authorities*** *inspected were found to require improvements to their DoLS arrangements.*
- *The most frequent issue raised in CQC inspections was* ***failure to process deprivation of liberty requests lawfully or on time****.*
- *Local authorities themselves cited* ***staffing shortages and rising demand*** *as key drivers of the backlog.*

> *This is occurring against a backdrop of soaring requests, with over 332,000 DoLS applications made in 2023/24, a stark contrast to the original Government estimate of just 21,000 per year. In practice, only 19% of these are completed within the 21-day legal requirement, with significant numbers waiting between 12 and 18 months for completion.*
>
> *The Mental Health Bill 2025 aims to stop adults with autism or a learning disability from being inappropriately detained under mental health law unless they also have a co-occurring mental illness. But many of these individuals will instead be placed under the DoLS system, a system already at breaking point. Without functioning MCA safeguards, these adults risk being transferred from one form of detention to another, without any legal protection or meaningful right of appeal.*
>
> *Similarly, the proposed Terminally Ill Adults (End of Life) Bill relies on an individual being able to demonstrate clear and settled capacity in deciding to end their life. However, the MCA provides no adequate framework for assessing capacity in such decisions.*

As the Chief Executive, Kathryn Marsden OBE, notes:

> *The concern is that while other parts of the legal and policy framework are being modernised, such as the Mental Health Bill and potential assisted dying legislation, they are being built on a foundation that is crumbling.*
>
> *The Mental Capacity Act is the bedrock of these reforms. If that foundation is not functioning, then nothing built on it will be stable.*
>
> *Reform cannot wait for the long legislative cycles of Government. While the full implementation of LPS may still be some way off, urgent action is needed to stabilise and improve the current system.*
>
> *With rising demand, mounting delays and legal ambiguity, continuing inaction will only deepen injustice and increase costs, both human and financial.*

SCIE is therefore calling for:

- *renewed Government commitment to the Mental Capacity (Amendment) Act, with a roadmap for review and implementation*

- *publication of updated Codes of Practice, which have not been revised since 2007, despite major legal developments*

- *investment in workforce training, supervision and post-qualification development so professionals can confidently and lawfully apply the MCA*

- *revisiting the core principles of the LPS model, enabling a more flexible, portable and person-centred approach to deprivation of liberty*
- *strengthening of CQC inspections, so that failures in applying the MCA itself (not just DoLS backlog) are monitored and addressed.*

We are particularly glad to see that SCIE is asking for things to be thought across across the piece – and we would add to the piece also the changes that the Law Commission are proposing in relation to Wills which include (buried in the report) proposals for reforms to enable better support for decision-making, and a recasting of the MCA to place greater weight on the person's wishes and feelings. Whilst the DoLS saga shows that simply having law in place is not a guarantee that rights protected by that law will actually be protected, having the right law in place is a crucial foundation.

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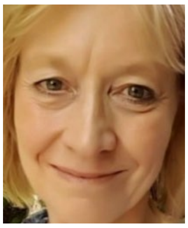

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Conferences

Members of the Court of Protection team regularly present at seminars and webinars arranged both by Chambers and by others.

Alex also does a regular series of 'shedinars,' including capacity fundamentals and 'in conversation with' those who can bring light to bear upon capacity in practice. They can be found on his website.

Advertising conferences and training events

If you would like your conference or training event to be included in this section in a subsequent issue, please contact one of the editors. Save for those conferences or training events that are run by non-profit bodies, we would invite a donation of £200 to be made to the dementia charity My Life Films in return for postings for English and Welsh events. For Scottish events, we are inviting donations to Alzheimer Scotland Action on Dementia.

Our next edition will be out in September. Please email us with any judgments or other news items which you think should be included. If you do not wish to receive this Report in the future please contact: marketing@39essex.com.

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