Neutral Citation Number: [2008] EWHC 1403 (Fam)

Case No: 11531312

IN THE HIGH COURT OF JUSTICE
IN THE COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 25/06/2008

Before :

THE PRESIDENT

- -

Between :

A Primary Care Trust	**Applicant**
- and -	
P	
- and -	
AH	**1st Respondent**
- and -	
A Local Authority	**2nd Respondent**

- -

Fenella Morris (instructed by **Hempsons**) for the Applicant PCT
Joseph O'Brien (instructed by **Irwin Mitchell**) for the Official Solicitor as Litigation Friend of **P**
Angela Hodes (instructed by **Langleys**) for the **1st Respondent**
Hilton Harrop-Griffiths (instructed by The Local Council Legal Services) for the **2nd Respondent**

Hearing dates: 4th and 5th June 2008

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Approved Judgment

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

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THE PRESIDENT

This judgment is being handed down in private on 25 June. It consists of 10 pages and has been signed and dated by the judge. The judge hereby gives leave for it to be reported.

The judgment is being distributed on the strict understanding that in any report no person other than the advocates or the solicitors instructing them (and other persons identified by name in the judgment itself) may be identified by name or location and that in particular the anonymity of the children and the adult members of their family must be strictly preserved.

Sir Mark Potter:

1. On 5th June 2008 I made an interim order in respect of P and stated that I would hand down my reasons later. Those reasons are set out below.

2. These proceedings, brought under the Mental Capacity Act 2005 (MCA), concern P, an adult male of 22 who suffers from severe, complex and currently uncontrolled epilepsy. He resides with his adoptive mother, AH, who is his devoted carer. These proceedings were issued on 15 November 2007 by P's local primary care trust (the PCT) responsible for his treatment and, on 19 November 2007 P was the subject of an interim declaration of incapacity. The reason for the issue of proceedings was to secure adequate medical assessment and treatment for P because he and his mother were not complying with the treatment offered by the PCT through those commissioned to provide care for him.

3. As a result of his uncontrolled epilepsy, P is presently fitting frequently. How frequently is in dispute. It is virtually daily according to nursing staff who visit him at home, although according to AH it has recently been less frequent. Whichever is correct, it is clear on the medical evidence that he is at risk of cumulative brain damage and, in the worst scenario, sudden death. His fitting produces significant symptoms of fatigue. He can take little exercise and infrequently leaves the house. AH believes that the cause of his symptoms is the condition known as ME or chronic fatigue syndrome (CFS) and that it is P's prescribed treatment for his epilepsy which produces his symptoms of fatigue and makes his epilepsy worse. Both AH and PCT are anxious that an overall assessment of P's medical needs be effected as soon as possible but their conflicting views on the best way forward have produced a position of stalemate so far as the necessary steps are concerned and P's situation can only deteriorate in these dangerous circumstances unless the deadlock is broken as a matter of urgency.

4. It is not necessary for the purposes of this interim hearing to set out the background facts or the developmental and medical history of P. They appear well and fairly set out up to 27 February 2008 in the independent psychological report of that date from Dr Land, prepared on the joint instructions of the Official Solicitor representing P, the applicant PCT, AH (P's mother), and the local authority.

5. On the basis of that history, and Dr Land's consideration of reports by others concerned over the years with the care and medical treatment of P, and as a result of Dr Land's own interviews with P and AH, Dr Land concluded, on what appears to have been a correct application of the statutory principles set out in Section 1 of the MCA and associated codes of practice, that P lacks litigation capacity in relation to these proceedings. Dr Land also concluded that P lacked capacity to make decisions concerning his medication and treatment in respect of his serious condition of epilepsy, or to decide whether or not to attend a residential assessment of his physical and mental well being. Dr Land also considered that P lacks capacity to decide issues as to his contact with health and social care professionals and with AH, or in relation to wider issues as to the assessment of his health and social care needs and that he is unable to make and communicate decisions free from the influence of others, in particular AH, who has for so long devoted herself to his care.

6. Following the issue of proceedings, on 19 November, the court granted the interim declaration to which I have referred, based upon reports by Dr Scott, P's general practitioner, Dr Taylor and Dr Easby, a consultant in the psychiatry of learning disabilities employed by the PCT. All have been concerned for some time with the treatment of P which, during a period of increased of seizures required emergency admission to York hospital between 7 July and 12 July 2007. It was revealed that AH had been cutting down the medication P received for his epilepsy over a period of months, during which time P's control faltered and he eventually stopped his own

medication a day or two before admission to hospital. AH's reasons for removing the anti-convulsant therapy was that she felt that it was not controlling the epilepsy but making him worse. It was her lay opinion that her son suffered from multiple allergies, multiple chemical drug and electrical sensitivities, B12 deficiency and, of most relevance and importance at this stage, severe ME/CFS.

7. The position was and is that, over the years, AH who is P's adoptive mother, has become increasingly absorbed and concerned with his treatment and increasingly sceptical about the role of conventional medicine in providing effective treatment for his epilepsy. As a result of these events, and of the concern of the consultant neurologist who saw P on admission in July 2007; because also of the fixed views of AH and her reluctance to accept any medical advice in respect of P with which she did not herself agree; because of AH's rejection of an offer of assessment of P under the care of Dr Easby, and because of accumulated concerns among medical and health care workers over the years, an Adult Protection Meeting was held. At their meeting, it was concluded that P ought to be admitted as an in-patient to Oak Rise, a local unit of the PCT for assessment of his general health needs, in particular in relation to his epilepsy and his emotional and social needs away from the influence of AH. As a result an application was made to the Court of Protection, in the light of expected opposition by AH and P to P's admission as an in-patient.

8. In the event, the PCT put forward two possible options to provide TH with the further assessment and treatment which he requires. The first was a community based option using a range of York and Leeds-based services, whilst the second was an in-patient assessment based at the chronic fatigue unit at the Queen's Hospital, Romford under the clinical direction of Dr Chaudhury. The residential assessment at Dr Chaudhuri's unit focussed on obtaining a diagnosis for TH's fatigue symptoms and gaining a better understanding of his seizure disorder.

9. The community based assessment sought to deliver the same aims as well as assessing optimum drug treatment for TH's seizures, assessing whether mood dysfunction was contributing to his current health status, and recommending appropriate treatment. This included a regular assessment of whether P's capacity could be regained and initiating controlled social and recreational activities to that end. It was recognised that, if the Romford option was taken up, its principal function would be diagnostic and it would have to be supplemented by on-going community assessment and treatment of the type discussed, on return of P to York.

10. Dr Land concluded that, if AH and TH were prepared positively to accept the community assessment option at Oak Rise, to which they appeared resistant, that option offered the most comprehensive assessment and allowed the opportunity for positive gains to be built on long term.

11. However, if (as appeared to be the case) AH and TH were strongly opposed to the local option, then the opportunity of a residential assessment by Dr Chaudhuri in Romford would be invaluable as providing baseline expertise in respect of TH's chronic fatigue symptoms. This alternative undoubtedly appealed to AH and therefore presented the best opportunity for a co-operative stance over time in what was a difficult situation characterised by mistrust on the part of AH as to the expertise and motivation of those who would be concerned in the local option.

12. On 25 April 2007, Munby J made an order declaring by way of interim order that P lacked the capacity to make decisions about how his health and social care needs were to be assessed and treated or met; that it was in P's best interests for his medication for his epilepsy to be administered as determined from time to time by Professor Crawford, or whichever clinician approved by the PCT was responsible for

P's epilepsy care and treatment at the material time, and that it was in P's best interests to his health and social care needs to be assessed in accordance with the assessment plan which set out the two options.

13. In effect, however, Munby J approved and promoted the Romford option on the basis of the report of Dr Land, a report of Mr Fowler (a social worker and independent expert instructed under the original direction of the court report in parallel with Dr Land) and the statement of AH in which she made clear her preference for the Romford option. The preamble to the order contained a number of recitals relating to an agreement to share the costs of the Romford option between the PCT and the local authority; the agreement of AH to make herself and P ready to be transported to Romford in accordance with arrangements to be notified, the agreement of AH that she would write to Dr Chaudhuri setting out her views and queries in relation to his assessment of P at Romford, and inviting Dr Chaudhury to contact AH if he considered it appropriate for and/or during the assessment. Directions were given for supplementary reports by Dr Land and Mr Fowler by 5 June 2008 and a review hearing before Moylan J in Newcastle on 27 June 2008, with the date for final hearing in October 2008.

14. Unfortunately arrangements for the Romford option broke down. By letter of 14 May, the PCT informed P it had secured a bed for him at Queen's Hospital, Romford on 20 May. However, on discovery by AH that Dr Chaudhury would be on leave until 27 May, AH withdrew her consent to P attending at Romford on 20 May. At a hearing fixed at short notice before Hogg J on 19 May 2008, she made an order that it was lawful and in P's best interests that P attend Queen's Hospital on 20 May. However when Dr Taylor called on 20 May to coincide with the planned arrival of the ambulance and to provide AH with cash in lieu of a travel pass to enable her to visit TH in hospital at Romford, AH said that P would not be travelling because he did not want to and AH locked herself and P in the house. She insisted it was not she who was refusing to go but P. P informed Dr Taylor in stilted terms that he did not wish to travel to Romford that day and wished to see Dr Chaudhuri only.

15. The matter returned before Hogg J on 23 May, when it was declared that it was in P's best interests to attend an out-patient clinic appointment with Professor Crawford at York District Hospital on 27 May and that if, in Professor Crawford's opinion, P's clinical condition was such that he required immediate admission to York, that he be so admitted for purposes of assessment and treatment for his epileptic condition as directed by Professor Crawford. However if that position did not pertain, a care plan should be produced in respect of P's proposed in-patient assessment at Romford providing, if possible, for P's admission there on or before 6 June 2008 and setting out under whose care P would be admitted; the steps which would be taken to assess and/or treat P, including assessment of any chronic fatigue syndrome, assessment monitoring and control of P's epilepsy, and assessment and management of the thyroid condition recently developed by P. The care plan was also to state how anxiety on P's part caused by separation from his mother might be minimised or alleviated, the level of involvement of the lead clinician in assessment or treatment of P, who else would be involved, the anticipated length of admission and any arrangements for visiting.

16. The case was to be listed for a further hearing before a High Court Judge on 4 June (Moylan J if possible) with a time estimate of one day. Provision was made for Professor Crawford to file a statement dealing with P's epileptic condition and Dr Land to file a statement providing his updated views with specific reference to the care plan and P's epileptic condition and treatment. These provisions were all essentially agreed provisions, AH indicating that she would co-operate with them and

giving no reason to suppose that she would not. Unfortunately, however, she cancelled or failed to attend appointments arranged with Professor Crawford for 22 May 2008 and an appointment rescheduled for 3 June, on the basis that, since Dr Chaudhuri, in whom she presently placed her trust, would be carrying out work the following week, there was no point in Professor Crawford doing so beforehand.

17. When the matter came before me on 4 June 2008 it had unfortunately not been possible to comply with the detail of Hogg J's order so far as the proposed care plan was concerned, in that Dr Chaudhuri had by a letter of 29 May explained to some extent his plans with regard to P's assessment at Romford but had not set out all the details required to comply with the care plan provided for by that order. In particular he did not specify the arrangements for visiting which were of particular concern to AH, in respect of which she stated through her solicitor by e-mail dated 2 June that she would have difficulty approving a plan which did not allow her to be in Romford with P for the duration of the assessment.

18. When the hearing started, it had still not been clarified so far as the availability, (and in particular the date of such availability) of a bed at Romford was concerned, or as to the degree of contact which AH would be permitted. Further, the position of the PCT and the local authority had hardened to a position where they both sought to press for an order for an immediate admission of P to hospital as an in-patient at Oak Rise in Yorkshire on the basis of an updated assessment plan proposal which appears at page 307-311 of the main bundle. The matter was put on the basis (a) of the updated views of Professor Crawford and Dr Scott as to the urgency of the need for an immediate in-patient assessment and any necessary adjustment of P's treatment within an acceptable timescale and (c) the unlikelihood, whatever AH's declarations of enthusiasm for assessment by Dr Chaudhuri, that she would allow the treatment to proceed without interference objection or removal of P, if she did not approve of all aspects of his treatment.

19. The real difficulty in this case has been, and continues to be, that, such is the closeness of the relationship between P and AH, his mother and carer, that (1) there is real and unresolved doubt as to how far P's expressed views as to where, by whom, and in what manner he wishes or is prepared to accept treatment, are his own, and how far they are no more than simple adoption and repetition of his mother's views in a situation where he would otherwise be malleable and co-operative with the attempts of the experts to understand the true aetiology and interrelationship of his various symptoms and to relieve P from what is now largely a wheelchair bound existence. (2) In order to perform an overall assessment, reach an holistic diagnosis, and set in train an appropriate course of treatment in respect of P's condition, it is necessary for him to be assessed as an in-patient over a substantial period, during which he is seen, observed and treated as an individual patient rather than on the basis of his symptoms and condition as reported or recounted in the presence and under the influence of his mother. This is particularly so because, despite her genuine and praiseworthy concerns, AH holds views which, so far as medical orthodoxy is concerned, are in many respects eccentric, misguided and, in the view of the experts, positively harmful rather than helpful in relation to the diagnosis and treatment of P. (3)There is no doubt that, if P is removed from his mother and his home against her and/or his will for in-patient observation and treatment, it will prove a highly distressing experience to both P and AH, and will raise for consideration resolution of human rights issues of the kind canvassed by Munby J in *City of Sunderland v PS* [2007] EWHC 623 (Fam) and *Salford City Council v GJ and Others*[2008] EWHC 1097 (Fam), 16 May 2008. (4) The task of assessment and the carrying out of the various tests which will necessarily be involved in reaching the holistic diagnosis to which I have referred, and which in principle at least, AH (as well as the doctors) is

anxious to have performed, will be rendered the more difficult if P is a reluctant and fearful, rather than willing and co-operative, patient. Thus, against the background of what they see as a real need for urgent admission and treatment of P's epilepsy in order to avoid harmful and, at worst, fatal consequences, Dr Land, as well as Dr Scott and Professor Crawford, have rightly been concerned to achieve a course of treatment which enjoys the acceptance and co-operation of AH and hence of P, rather than seeking a court order which may involve a physical removal of P from his house to Oak Rise for the purposes of his in-patient assessment and an order restraining AH from interference from such removal.

20. I have considered the statements of Dr Land, Dr Scott and Professor Crawford and their oral evidence given to the court over the telephone yesterday. I have also considered the objections of AH advanced in her unsigned statement dated 2 June 2008 and her further unsigned statement dated 4 June 2008 handed to me by her counsel. I have also considered the letter from Dr Chaudhuri of 29 May 2008 in which he responds to Dr Scott's request for a care plan pursuant to the order of Hogg J, and Dr Land's comments upon that response in his letter of 3 June 2008. I have also considered the submissions of counsel.

21. I am satisfied that it is appropriate at this interim stage to accept and continue to rely upon Dr Land's findings as to P's incapacity.

22. Despite the absence of some of the detail required under the order of Hogg J, I consider that on the basis of the requisite balance sheet approach (see *R S (Sterilisation: Patient's Best Interests)* [2000] EWLR 1288 and *City of Westminster v IC and Others* [2007] EWHC 3096 (Fam) and MCA Code of Practice at para. 5. 62), I have enough material to form a clear conclusion as to where P's best interests lie for the purposes of today's further interim hearing and that it is necessary for me to make an order which provides for the nature and circumstances of P's admission for urgent assessment of his condition. In doing so, I have carefully balanced the conflicting welfare considerations which have emerged in the material before me and, in particular, the necessity, as I judge it, to act upon the medical evidence as to the continuing serious risk to the health of P if his epileptic condition, its treatments and medication, are not immediately reviewed. The alternative courses to be considered are either an order for immediate admission to Oak Rise, or an order for somewhat delayed admission to Romford for assessment under the clinical direction of Dr Chaudhury, if a bed is available.

23. I have no doubt that on the material before me the premium involved in securing a place at Romford is obvious and desirable. However, the position needs to be resolved swiftly and it is not in P's best interests that it should remain unresolved and uncertain beyond Friday 13 June 2008. On balance, it seems to me, the best interests of P lie in the admission to Romford provided that, as has now been indicated, a bed will become available on or before Friday 13 June. That is only preferable, however on the basis that it is clear that, if P is to be admitted, AH will co-operate and not impede any course of treatment proposed by Dr Chaudhuri or resist any restriction which Dr Chaudhuri may see fit to impose upon AH's participation or contact with P in the course of that treatment. The whole basis upon which the experts are agreed that such a course, albeit involving a short delay, is nonetheless a desirable alternative to immediate admission at Oak Rise is that it will involve consensuality rather than any degree of unwillingness, let alone coercion. Failing such consensuality, then it will be necessary to provide for P's immediate admission to Oak Rise, and for provision to be made as to the need for reasonable and proportionate measures for securing the removal of P from his home for the purposes of the in-patient assessment on the assumption that he and/or AH may not willingly comply.

24. Upon that basis, and upon AH having indicated through her counsel and confirmed to the court orally over the telephone, her willingness to give and abide by various undertakings in respect of P's admission to, and treatment at, Romford under the clinical direction of Dr Chaudhuri, I have approved a form of order prepared in draft by Miss Morris for the PCT on the basis of such undertakings. It provides that if, for any reason, P's admission to Romford on or before Friday 13 June is unable to proceed, P should immediately be admitted to Oak Rise without the need for return to this Court to obtain sanction for that course.

25. Because of P's physical condition and generally compliant temperament, it is unlikely that he will be physically resistant to being transported from his home to Oak Rise or to his assessment and treatment once there. However, in case that should not be so, I have been prepared to approve a provision that it will be lawful for there to be use of a reasonable and proportionate degree of force in that respect, subject to provision for review of P's position by this Court within a period of 28 days. I have provided that, in any event, the matter should return before me on 3 July 2008 upon the assumption that, as is intended, P is in fact admitted to Romford because by that date he will be on the verge of discharge after his assessment and treatment there. If, however, that proves not to be the case and it has been necessary instead to effect his admission as an in-patient to Oak Rise, the return to Court upon 3 July will enable his position and progress there to be reviewed.

26. In making provision for the use of reasonable and proportionate force to remove P to Oak Rise and for his treatment there as an in-patient I have been operating in the area of what has come to be known as the 'Bournewood Gap', which emerged from the decision of the European Court of Human Rights in *HL v UK* [2004] 1 FLR 1019. Nonetheless counsel came to court and argued the matter before me unarmed with any authority in this respect, save for a reference in the case summary and position statement of Miss Morris for the PCT to the decision of Munby J in *City of Sunderland v PS and Others* [2007] EWHC 623 (Fam) [2007] 2 FLR 1083. As I pointed out, that was a decision in relation to the inherent jurisdiction of the Court in which Munby J convincingly set out the power of the court in such as case to make an order authorising the minimum degree of force or restraint necessary for detention of an incapacitated adult just as in relation to a child and the minimum requirements necessary in such circumstances to satisfy the requirements of articles 5 and 8 of the ECHR.

27. His observations in that case have since been developed in his recent decision *In the matter of GJ NJ and BJ (Incapacitated Adults)* [2008] EWHC 1097 (Fam) concerning the provisions appropriate to be made for review at reasonable intervals of any order authorising detention, and thus deprivation of liberty, of an incapacitated adult for the purpose of his medical treatment. However, those decisions beg, rather than answer, the question whether the powers of the Court of Protection in proceedings brought pursuant to the provisions of the MCA, and not under the inherent jurisdiction of the Court, are identical in scope in the light of the terms of Section 6 of the MCA which expressly provides that the definition of restraint in the act for the purposes of Section 5 (which authorises such acts if necessary in order to prevent harm to P) does not extend to acts which deprive P of his liberty within the meaning of Article 5(1) of the European Convention on Human Rights.

28. In that regard I was assured by Miss Morris and had confirmed to me by the experienced counsel present, including Mr O'Brien for the Official Solicitor, that they accepted that I had jurisdiction to make an order of the type proposed by reason of the breadth of the wording of Section 15(1)(c) of the MCA which confers on the Court

the general power to make declarations as to "the lawfulness or otherwise of any act done, or yet to be done, in relation to" a person who lacks capacity to make a decision as to his best interests in relation to medical treatment. Reliance is also placed upon Section 48 of the MCA which provides in general terms that the Court may, pending the determination of an application to it in relation to P, make an order or give directions in respect of any matter if there is any reason to believe that P lacks the capacity in relation to that matter, which is one to which the Court's powers under the Act extend and it is in P's best interest to make the order or give the directions without delay. Furthermore, Section 17 provides in relation to the personal welfare of P that the powers of the Court under Section 16 to make an order making a decision or decisions on P's behalf in respect of matters concerning his personal welfare extend to "giving or refusing consent to the carrying out or continuation of a treatment by a person providing health care for P": see Section 17 (1) (d). Counsel also drew my attention to paragraph 6.51 of the Code of Practice, which is of course not part of the statute but which provides that, "in some cases the Court of Protection might grant an order that permits the deprivation of a person's liberty, if it is satisfied that this is in the person's best interests".

29. I was informed that other Judges of the Family Division, and in particular Charles J, have taken the view that the wording of the provisions to which I have referred, which are in wholly general terms, are plainly intended and should be construed as entitling the Court of Protection to make orders under the MCA of the kind previously made by the Judges of the Family Division under the exercise of the Court's inherent jurisdiction prior to the commencement of the Act (c.f. *Re S (Adult Patient Claims) Inherent Jurisdiction: Family Life)* [2002] EWHC 2278 (Fam) [2003] 1 FLR 292 and *City of Sunderland v PS* already cited). Thus, where the facts so justify, and the immediate welfare interests of an incapacitated adult so dictate the Court may, by a prior declaration in appropriate terms, render lawful an act of restraint under S.6(1)-(4) of the Act which might otherwise amount to a deprivation of liberty under S.6(5), thus bridging the "Bournewood Gap".

30. Upon that assurance and the agreement of Miss Morris that she would supply the authorities upon which she relied for the purposes of incorporation in these reasons, I was prepared to make a declaration in appropriate terms.

31. I have since received from Miss Morris a copy of the judgment of Charles J in *Surrey Council v MB and others*, 9 October 2007 [2007] EWHC 3085 (Fam) in which he did indeed express himself satisfied to that effect. That case was itself commenced under the inherent jurisdiction of the Court, but it was transferred by Charles J into the Court of Protection for consideration upon the basis that henceforth the proceedings were to be conducted pursuant to the provisions of the MCA. Charles J was concerned in those proceedings, as I am in these, with a situation where, despite making findings of incapacity in relation to the status of P in those proceedings, the medical witnesses were not prepared to proceed under the terms of the Mental Health Act, albeit they supported the making of a declaration to the effect that P could be compelled to go to, and stay in, the medical unit in which his treatment was proposed to be carried out. Thus, whereas Charles J had previously made a declaration under the inherent jurisdiction, when the matter returned before him he dealt with it and made a declaration on the basis of his jurisdiction as a Judge of the Court of Protection under the MCA. Having heard extensive submissions, Charles J held (at para. 46 of the judgment) that the statutory provision granting the Court discretion under Section 15 (1) (c) to make declarations as to the lawfulness or otherwise of any act done or yet to be done in relation to P, is a free standing provision which co-exists with the provisions of the Mental Health Act, and he went on to hold that he considered the language wide enough to include the making of a

declaration permitting compulsory removal and detention for the purposes of medical treatment, if found to be in the best interests of P, and that such an order would not be in breach of Article 5 of the ECHR, provided that the conditions enumerated by Munby J in *City of Sunderland v PS* were met. Those conditions are that P is incapable of making a decision whether or not to go to the place of treatment ("the unit") and/or to stay within it; that a requirement to go to and remain in the unit would be in his best interests; that the Court has declared in advance that it is in the best interests of P to be taken there and to be compelled to remain there by using reasonable and proportionate measures; and that there is a mechanism for timely and ongoing review of P's capacity and best interests with regard to his remaining in the relevant unit.

32. I agree with the reasoning of Charles J and those are the principles upon which I have proceeded in coming to my conclusions upon this interim application and approving the form of order to which I have referred.