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Anorexia - Table of Cases

Victoria Butler-Cole KC, Mungo Wenban-Smith, Nicola Kohn

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Case	Facts	Reasoning
Re E (Medical Treatment Anorexia) [2012] EWHC 1639 (COP)	**Judge**: Peter Jackson J **Independent expert**: Dr Ty Glover **History:** Age 32. Sexual abuse in childhood. Controlled eating from 11; admitted to EDU aged 15. Four EDU admissions; 1 alcohol treatment "revolving door" of treatment **MHA?** Not detained at time of hearing **Options:** Palliative care or admission under MHA for further treatment including force feeding **P's views:**	*138 I would not overrule her wishes if further treatment was futile, but it is not. Although extremely burdensome to E, there is a possibility that it will succeed. Services and funding will now be provided that were not available before, and it would not be right to turn down the final chance of helping this very vulnerable young woman. I accept that the nature of the treatment is different to anything E has previously been offered […]* *139 I am also influenced by the fact that those who know E best are not in outright opposition to treatment taking place, however sceptical they justifiably feel.* *143 I record that the state, having instigated this plan of action for E in the way that it has, is now honour-bound to see it through by the provision of resources in the short, medium and long term. Had the authorities not made that commitment, I would not have reached the conclusion that I have.*

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	Did not want to eat or be fed. Recognised that this could lead to death. Had tried to make advance decisions refusing treatment. E describes life as "pure torment" [76] **Family's views:** Parents had supported palliative care **Order sought:** Local authority – further investigation required despite consensus of medical bodies that palliative care was appropriate **Order made:** Lacks capacity to decide about life-sustaining treatment In best interests to be treated and forcibly fed (likely under MHA detention)	
The NHS Trust v L [2012] EWHC 2741 (COP)	**Judge:** King J **Independent expert:** Dr Glover, Dr Danbury **History:**	Dr Danbury – no report in the literature of any patient with similar BMI surviving enforced feeding whilst sedated in intensive care *Ms L has been treated for the last six years in specialist eating disorder units which are nationally recognised as having expertise in the management of this condition. Despite this she has made no progress*

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	29 year old woman with anorexia and OCD. First inpatient admission age 14, and 90% of time since then spent in hospital (including under MHA). Weight 3 stone; BMI 7.7. end stage organ damage; hypoglycaemia, weeks to live. **MHA?** Recently discharged from detention as team concluded all treatment options exhausted. At time of hearing, on gastroenterology ward. **Options:** Palliative care or forced feeding. Would have to be sedated for force feeding by NG tube or PEG. Sedation would have close to 100% risk of death. If fed successfully, likely to die in any event due to organ damage. **P's views:** Wanted to move to a nursing home with an NG tube and no oral intake. Only accepting 580ml daily intake. No nursing home willing to accept her. Had bitten through the tube previously and found watching the food coming through the tube 'torture'. **Family's views:** Not in best interests for L to be forcibly fed	*The prospects of her recovery overall approach zero* *Ms L is now showing signs of irreversible multi organ failure and she is drawing towards the end of her life.* *Given that it is extremely unlikely that Ms L will recover from her anorexia it is not in her best interests to make attempts to reverse her weight loss which require coercion, restraint or sedation.* *Dr Glover in particular felt no pressure should be put on Mrs L to seek to persuade or coerce Ms L into agreeing to increase her nutrient intake; Ms L is very close to her mother who has throughout been her most powerful advocate, Ms L must continue to see her mother as being 'on her side' and there must be no risk of Ms L feeling that now, at the end, her mother is in any way 'against her' by trying to force her to do something which her illness prevents her from doing.*

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	Order sought: Not in best interests to be forcibly fed or treated for anorexia **Order made:** Lacks capacity to make decisions about nutrition and hydration and treatment for hypoglyceamia Has capacity to consent to antibiotics, analgesia and treatment for pressure sores In best interests to provide nutrition and hydration only if L agreed In best interests to administer dextrose to save L's life with minimal force if necessary In best interests to move to palliative care if L in terminal stage of her illness	
NHS Trust v Ms X [2014] EWCOP 35	**Judge:** Cobb J **Independent expert:** Dr Glover **History:** 'Young woman' with anorexia for 14 years and alcohol dependence syndrome. Advanced liver disease (but potential for recovery if abstinent). BMI 12.3-12.6; still	*The purpose of re-feeding an anorexic patient is to keep that patient alive whilst psychotherapy, talking therapies, can be facilitated in an endeavour to investigate and treat the underlying anorexia; this has been shown over many years not to work for Ms X. So it is that the medical professionals firmly believe that not only would in-patient treatment once again involve painful, invasive and wholly unwelcome procedures for Ms X, but it would be pointless in terms of achieving long-term treatment, and would be likely in their*

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	drinking alcohol to excess. Spent most of the last 2 years in hospital. 45 hospital admissions in total. Consistently refused to engage in talking therapy. **Options:** Palliative care. No offer of hospital admission. **MHA?** Not detained at time of hearing **P's views:** Supports orders sought by Trust – no treatment or forced feeding Felt MH services were making her worse Does not wish to die Valid advance decision to refuse treatment for liver disease **Family views:** Friend supported the Trust's position – did not want her to spend last period of her life detained and forcibly fed **Order sought:** Not in X's best interests to be detained under the MHA or forcibly fed **Order made:** Lacks capacity to make decisions about treatment for anorexia	*view to intensify her consumption of alcohol on discharge from hospital, thereby actually increasing her mortality, and accelerating her demise.* *…* *Both Dr. A and Dr. Glover were clear in drawing a distinction between Ms X's capacity to make decisions around her eating disorder (anorexia) and her use of alcohol. They both considered that Ms X was able to understand, retain, and crucially weigh up, the decision around drinking; they felt that her drinking was responsive to events – she appeared to be making choices about when to drink, when to drink more, and when to drink less.*

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Betsi Cadwallader v Miss W [2016] EWCOP 13	**Judge:** Peter Jackson J **Independent expert:** Dr Glover **History** 28 year old woman; severe and enduring eating disorder for 20 years. Six admissions for inpatient treatment spread between five units (three of which were SEDUs), amounting to about 10 years in total; last admission 2.5 years. BMI 12.6. "if she continues to lose weight at this rate she will die". **Options:** Refeeding under sedation for up to 6 months to BMI of 17.5 (in theory only – no doctors willing to offer it), or discharge into the community with support (immediately or after a few weeks) **MHA?** Detained under s.3 at time of hearing **P's views** Did not want to die. Wanted to return to education. Most important to her was being able to make her own	*Dr X said that she had been involved in W's care for four years and intensively for the last 2½ years. She confirmed that she would immediately discharge W from compulsory detention because, while her condition warrants treatment, they have found no way of treating it. If W is to stay on the ward, there needs to be a treatment plan and a goal. It is not otherwise possible for an acute bed to be held open. The decision to discharge W into the community has received the utmost consideration. There may only be a glimmer of hope that the change in circumstances will lead to a change in thinking and behaviour. However, in Dr X's opinion, the alternatives are worse. She does not believe that life on the unit is a life for W, who anyway does not want to be there. It would be a continuation of what has been happening for the last 20 years, which hasn't worked. As to the prospect of a move to another unit, assuming one could be found, that would be cruel because the prospects of change are so remote.* *[Dr Glover] considers that coercion is no longer justified and that after such a long course of illness a cure is not to be hoped for. The early age of onset, the resistance to treatment, the distortion of personality, and the lack of insight are all negative prognostic factors. The best that could be achieved is a limited degree of recovery and the*

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	decisions. Wanted to try to manage on her own – but if it didn't work, would want to be readmitted to hospital. **Family's views** Anxious about discharge and prospect of no re-admission in future if it didn't work out. Supported W's suggestion of having a few more weeks in hospital before discharge. **Order sought:** In W's best interests to be discharged with community support **Order made:** In W's best interests to be discharged with community support	*maintenance of that state. He thinks that a move to an alternative unit while matters remain as they are would be very likely to be futile. If progress (by which he means no more than a significant period of limited deterioration) could be made, that possibility might be reconsidered, but it is not worth pursuing as matters stand. If W was now admitted elsewhere as a voluntary patient, the chances of her being able to start eating sufficiently would in his view be nil and the process would be unwise and unfair. Likewise, there would be no real benefit to W in postponing her discharge from the unit for a few weeks.* *After all that has happened, it now has to be accepted that it is beyond the power of doctors or family members, and certainly beyond the power of the court, to bring about an improvement in W's circumstances or an extension of her life. The possibility that the withdrawal of inpatient mental health services will bring about a change for the better may not be very great, but in my judgment it is the least worst option from W's point of view.* *W and her family are understandably anxious that she will not be readmitted to the unit if she deteriorates. As to that, I stress that in approving the order I am only endorsing the Board's plan in relation to the circumstances as they now exist and for so long as they continue. The court can only make decisions in relation to existing circumstances or circumstances that it can foresee with reasonable confidence. It is accordingly accepted by the Board that if a*

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		significant period of time passes, accompanied by signs that W's thinking and behaviour have been able to change, the normal ethical and legal obligation upon the health services to reassess the situation will exist. In brief, the Board is saying "not now"; it is not saying "not ever", and it is that outcome that the court is endorsing. *In the meantime, the Board will be under a duty to provide the community services that it has promised*
Cheshire and Wirral v Z [2016] EWCOP 56	**Judge**: Hayden J **Independent expert**: Dr Glover **History:** Age 46; anorexia first diagnosed age 15; "despite the fact that she has been admitted to hospital on innumerable occasions and received many different treatments, outpatient support and therapeutic input, it is impossible to identify any time in her history where Z has made anything which could be characterised as a sustainable recovery in terms of her weight gain"; never engaged in any meaningful way with treatment; BMI of 9.5; level of eating disorder fell at the most serious end of the spectrum of gravity **MHA?** Detained under s.3 at time of hearing **Options:**	[17] "…Z's position was already grave and, given her vulnerability to sudden death from a variety of causes, whether she survives for 2 months or 12 months, it seems to me is a calculation which does not in any way illuminate where her best interests lie in the meantime." [20] "By way of completeness I should say that Ms Roper, on behalf of the Official Solicitor, raised a point in closing submissions as to the jurisdictional reach of the Court of Protection in proceedings under the MCA 2005. She reminded me that s.28 MCA provides as follows: ***28 Mental Health Act matters*** *Nothing in this Act authorises anyone –*

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	i. Treatment under s.3 w NG tube under restraint - at least 3 members of staff permanently present to carry out the necessary restraint, ii. Treatment under s.3 under chemical sedation. Risk of death due to BMI of 9.5 iii. Discharged from treatment under MHA – treated only by consent. "I have come to the clear conclusion that I am choosing between 3 palliative care options" [para 11] [663] **P's views:** she would wish to stay at home with her parents where she believes she is likely to survive, that she will "do much better at home". **Family's views:** Her parents express a belief that Z will, if left broadly to her own devices, manage effectively to confront this terrible illness **Order sought:** A declaration that Z lacks capacity to make decisions about her care and treatment for her anorexia That Z should be discharged from treatment under MHA and treated only by consent **Order made:**	*to give a patient medical treatment for mental disorder,* *or* *to consent to a patient's being given medical treatment for mental disorder,if, at the time when it is proposed to treat the patient, his treatment is regulated by Part 4 of the Mental Health Act.* *(1A) Subsection (1) does not apply in relation to any form of treatment to which section 58A of that Act (electro-convulsive therapy, etc.) applies if the patient comes within subsection (7) of that section (informal patient under 18 who cannot give consent).* *(1B) Section 5 does not apply to an act to which section 64B of the Mental Health Act applies (treatment of community patients not recalled to hospital).* *"Medical treatment", "mental disorder" and "patient" have the same meaning as in that Act.* [21] This section effectively prohibits the making of a declaration concerning coercive treatment where it

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	Z should be discharged from the framework of the MHA and treated, if she is prepared to engage at all, only on a voluntary basis, subject to a structured plan which has at its heart the objective of providing support and encouragement to comply with a feeding programme and general therapeutic assistance.	falls within Part IV of the Mental Health Act 1983. In the way that this order has now been drafted I do not need to determine the point because in approving the third option, I recognise Dr Cahill will now discharge Z from detention under the Mental Health Act to her parents home. Accordingly, the declarations and orders I make are pursuant to the Mental Capacity Act 2005. That said, I consider that given this application is heard in the Court of Protection, sitting in the High Court, I would have had the scope to make the declarations under the Inherent Jurisdiction and so the debate seems to me to be arid."
London Borough of Southwark v NP & Ors [2019] EWCOP 48	**Judge**: Hayden J **Independent expert**: none – evidence only from treating clinician, Dr Cutinha **History:** Age 17; cerebral palsy, diplegia, atypical anorexia (no clear story of an initial desire to lose weight; unclear about the presence, strength, or severity of NP's eating disorder 'cognitions'; possible that NP's weight loss had been due to other emotional, social or 'relational factors', or a combination of them, rather than an eating disorder); BMI 10.9 when admitted to hospital, persuaded to submit to a re-feeding programme and	[33] I am satisfied, on the evidence, that NP lacks the capacity to determine the best options in relation to her treatment and where to live for the period of that treatment. The preponderant evidence points compellingly against the inclusion of M in any of NP's therapy at present. NP is still very underweight and there is significant evidence to suggest that M has been ambivalent in the encouragement of the regime designed to promote NP's return to a healthy weight. Similarly, given the progress that has been made so far, I do not consider that the time has yet come to increase NP's contact with her mother. This mother / daughter

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	assessed as ready for discharge within a few days; condition periodically reaches life-threatening concern; concerns about the home environment and deficient care provided by mother at home **MHA?** Not detained under s.3 at time of hearing **Options:** NP to remain at the residential unit and to continue to receive treatment, on an out-patient basis; or return to live with her mother Whether or not to permit NP's mother to be included in NP's treatment sessions **P's views:** Wishes to be able to rejoin her brothers **Family's views:** Mother wished P to return to live with her **Order sought:** NP lacks capacity to decide where she lives and to consent to treatment for her 'atypical anorexia'.	dynamic requires to be more fully explored by the relevant professionals. It has already been identified as potentially associated, in some way, with the cause of the underlying disorder. It is undoubtedly a fact that NP does not thrive in her mother's household. To promote the relationship in the way suggested strikes me as having the real potential to send entirely the wrong messages to NP and to jeopardise the progress she has made, which ought properly to be identified as tentative. Investigation of the mother and daughter relationship requires careful and properly considered planning. Any alteration to the core arrangements presently in place is, in my judgement, pre-emptive. Ms Paterson has suggested that the case should return to the Court in November. I agree.

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	It is in NP's best interests to remain at the residential unit and to continue to receive treatment, on an out-patient basis **Order made:** NP lacks capacity to decide where she lives and to consent to treatment for her 'atypical anorexia'. It is in NP's best interests to remain at the residential unit and to continue to receive treatment, on an out-patient basis. It is not in NP's best interests for her mother to be included in any of NP's therapy at present or for contact with her mother to increase	
Northamptonshire Healthcare NHS Foundation Trust v AB [2020] EWCOP 40	**Judge**: Roberts J **Independent expert**: None **History:** Age 28 with anorexia since 13; diagnosis of severe and enduring eating disorder; currently only25.8kg; chronically low potassium, oedema, anaemia; she could die at any time from cardiac arrest as a result of the ravages caused to her body by the illness and/or any attempts to deliver the only form of life-sustaining	[26] "…Dr B's evidence speaks to the existence of "an overvalued idea" or fixation which arises as a direct result of AB's illness and which overwhelms her thought processes so as to prevent, or disable, her from conducting the sort of weighing and balancing exercise required by s. 3(1)(c). This seems to me to go beyond the application of her individual subjective 'values or outlook' which she is perfectly entitled to bring to that decision making process." …

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	treatment which is now available to her in the form of tube feeding using physical restraint or chemical sedation. **MHA?** Not detained at time of hearing **Options:** Only one treatment option available is to undergo forced NG feeding – treating doctors consider not in her best interests **P's views:** Wishes to stop all further treatment: "I believe in fact that to ask anything else of me would make me worse: both physically and mentally. It would be like being punished twice: once by having the illness, and once in an attempt to 'treat' it (whatever that means)." **Family's views:** Each of her parents agree that AB should not receive any further treatment **Order sought:** Declaration that it is not in AB's best interests to receive further active treatment **Order made:**	[28] "Finally, I must, as I do, direct myself that each case has to be determined on the basis of its own specific facts. AB and her interests lie at the very heart of this case and her individual circumstances must throughout remain my focus both in relation to the issues of capacity and, insofar as it is necessary for the court to express its view, best interests. The fact that similar cases which have come before the courts have been decided on the basis of different outcomes does not, and must not, influence me one way or the other. Just because they may have involved a similar 'risk matrix' in terms of the underlying facts does not, and cannot, lead me into conclusions based on a comparative analysis with case law: see Cheshire & Wirral Partnership NHS Foundation Trust v Z [2016] EWCOP 56 per Hayden J at para 18." … [64] "… It seems to me that, given the chronic nature of AB's illness and its current clinical presentation, her decisions in connection with food, calorific intake and consequent weight gain are so infected and influenced by her fixated need to avoid weight gain at all costs that true logical reasoning in relation to these specific matters is beyond her capacity or ability. Whether one calls this an "overvalued idea" or the fundamental manifestation of an illness which renders a sufferer powerless to resist a compulsion which, in this case, has proved incompatible with a normal life

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	By agreement, AB has litigation capacity By agreement, not in AB's best interests to receive further medical treatment beyond that in which she voluntarily participates through regular health checks and visits to the hospital and her GP in addition to palliative care when that proves necessary. Declaration that AB lacks capacity to make decisions in relation to her treatment	expectancy seems to me to matter not. It is the effect on AB which this illness has had which lies at the heart of the decision I have to make in relation to capacity. She plainly has the ability to use and weigh information about many aspects of the life she currently experiences. She has very sound and straightforward reasons for not wishing to experience the trauma and pain of further admissions to hospital for the purposes of tube feeding with all that it will entail. Those reasons are based solidly on her lived experience of previous episodes and the anticipation of being forced to undergo similar trauma on a future occasion. It seems to me that is different from her ability to respond rationally to the advice which she is being, and has been, given about the overriding imperative to gain weight if her death through starvation or some related cause is to be avoided. Her judgement in relation to this is critically impaired by an intense and irrational fear of weight gain. She may objectively appreciate that she will only avoid death in the weeks or months ahead if she finds the ability to overcome this illogical fear but she appears powerless to reach any other decision which will preserve her life. In my judgment, the fact that she does not want to die and sees many reasons to continue living are, in themselves, the clearest manifestation of the extent to which her judgment is

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		impaired in relation to this narrow field of decision making. [66] "…the wishes and views of the professionals, the family and AB herself are entirely aligned. No one is suggesting that this is a case where forcible tube feeding or tube feeding under sedation is in AB's best interests. To embark on that course now is likely to be futile and may well precipitate her death in any event. There is a clear plan moving forwards in terms of the palliative care which will be made available when it is required. The fact that all parties appear to agree that a declaration that tube feeding under any circumstances would not be in AB's best interests does not relieve the court from balancing all the relevant factors and reaching an independent conclusion as to where her best interests lie. I have done so and endorse such a declaration as being in AB's best interests."
A Midlands NHS Trust v RD (by her litigation friend, the Official Solicitor) et Ors [2021] EWCOP 35	**Judge**: Moor J **Independent expert**: Dr Cahill **History:** Age: 37 year old woman; anorexia since 13; 15 admissions to hospital since 2000, inc. four under MHA; expert recommendation that two further interventions	[29] "There is one further matter that I should mention and that relates to the question of the interaction between the Mental Capacity Act and the Mental Health Act. I am quite satisfied that I should apply Paragraph [21] of the judgment of Mostyn J in *Nottinghamshire Healthcare NHS Trust v RC* [2014] EWCOP 1317 where he said:

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	should be attempted before application made for no further compulsory treatment: discharge on a Community Treatment Order with four visits per day – no successful; and admission to a specialist rehabilitation unit - not possible because RD did not meet requirements of BMI above 13, willingness to engage; and physically stable. Last admission under MHA to a specialist ward for five months with some physical restraint required for NG tube feeding regime, but no significant improvement in her BMI and now vomiting up her feed so discharged home on basis that further forced treatment was unlikely to be of benefit, would not preserve her life, was likely to cause significant distress and result in an undignified death. **MHA?** Not detained at time of hearing **Options:** (i) Further compulsory admissions and treatment in hospital under the MHA; (ii) not to take any further steps towards forcing nutrition against RD's wishes **P's views:**	*"In my judgment where the approved clinician makes a decision not to impose treatment under section 63, and where the consequences of that decision may prove to be life-threatening, then the NHS trust in question would be well advised, as it has here, to apply to the High Court for declaratory relief. The hearing will necessarily involve a 'full merits review' of the initial decision. It would be truly bizarre if such a full merits review were held where a positive decision was made under section 63, but not where there was a negative one, especially where one considers that the negative decision may have far more momentous consequences (i.e. death) than the positive one."* [30] In fact, there was going to be a full merits review in this case in any event, pursuant to the Mental Capacity Act, but I take the point that questions involving the Mental Health Act engage public law matters. In particular, the safety of the public is one factor that doctors have to take into account. I do therefore take the view that I should make the declarations that I am invited to make, pursuant both to the Mental Capacity Act and the inherent jurisdiction of the High Court for the avoidance of any doubt." … [34] I am quite clear that the cycle of compulsory admissions to hospital has been distressing to her. They have achieved very little in the sense that, whilst

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	She did not want treatment forced on her against her wishes and told the judge that, if she was in the community, she would comply with the treatment plan and drink her juices. **Family's views:** Parents support the NHS Trust's application **Order sought:** RD lacks capacity to litigate the proceedings and to make decisions about her nutritional intake and about her care and treatment in general. It is lawful and in RD's best interests not to take any steps towards forcing nutrition against her wishes, notwithstanding that, by so doing, it might, in the short-term, prevent her death and to provide palliative care when appropriate **Order made:** By agreement: RD lacks capacity to litigate the proceedings and to make decisions about her nutritional intake and about her care and treatment in general. It is lawful and in RD's best interests not to take any steps towards forcing nutrition against her wishes, notwithstanding that, by so doing, it might, in the short-	historically they did improve her BMI to a certain extent, it was achieved under compulsion and probably after causing her distress, discomfort and psychological trauma. Moreover, as soon as she returned into the community, she immediately lost that weight again and did so in an extremely short timescale. She cannot be kept in hospital under compulsion for an indefinite period and, if she is going to lose any weight that she did gain as soon as she is back in the community, it is difficult to see what it is achieving. [35] In the autumn of last year, the position became even more stark, because the treatment did not even work in the hospital. It may well be that this was caused by her vomiting. She denies that and therefore I do not intend to make a Finding of Fact. The simple fact of the matter was that, notwithstanding this extremely invasive, compulsory treatment which she hated, she did not put on any significant weight. [36] … I am quite satisfied that requiring her to go through any such further compulsory detention would achieve nothing and would merely cause her further trauma, upset and psychological and emotional damage, whilst doing nothing significant to ameliorate her terrible anorexia nervosa. I am quite satisfied that I should make the declarations that this

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	term, prevent her death and to provide palliative care when appropriate	Trust asks me to make to authorise no such further compulsory admissions.
A Mental Health Trust v ER [2021] EWCOP 32 b	**Judge**: Lieven J **Independent expert**: Dr Cahill **History:** Age: 49 years old; eating disorder since teens inc. bulimia; alcoholism; history of admissions to hospitals, including two general hospitals, two psychiatric hospitals and two specialist eating disorder units. further evidence from Dr Cahill sought by judge after speaking to P; weight in range 35-37 kg at time of proceedings, having previously fallen to 29kg; pattern of losing weight quickly when leaves hospital; In terminal renal failure; limited life expectancy **MHA?** Not detained at time of hearing **Options:** Further compulsory treatment; voluntary support in the community **P's views:**	**Capacity:** [31] "I find this a very difficult case because of the question of capacity. There are particularly tragic circumstances that have led to ER to be where she is. In respect of best interests, everyone agrees to what conclusions I should reach. Therefore, it might be thought that, to some degree, the issue of capacity is "academic". It is also right to acknowledge that it might strongly be in ER's interests to be thought not to have capacity as it allows the Court of Protection to have continued oversight of the case, which itself can provide more focus on the services that she needs. However, capacity and autonomy are such important principles, that lack of capacity cannot be assumed for the sake of expediency. I cannot fail to engage with the issue in detail, and as stated above, it is of course the case that if ER has capacity, the Court of Protection has no jurisdiction. [32] "I should start by stating that I fully accept Dr Cahill's expertise and Dr P's much greater experience of ER. Considering the factors set out by Baker J in *PH*, I am in the position where both ER's treating psychiatrist for the last 8 years thinks that ER does not

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	She expressed an extreme dislike of eating disorder units and psychiatric hospitals **Family's views:** Not known **Order sought:** ER lacks capacity to make conduct the proceedings and to make decisions about her treatment. It is not in ER's best interests for her to be forced to accept treatment for her anorexia at any inpatient hospital and treated against her wishes. **Order made:** ER lacks capacity to make conduct the proceedings and to make decisions about her treatment. It is not in ER's best interests for her to be forced to accept treatment for her anorexia at any inpatient hospital and treated against her wishes. It is in her best interests to be given more support in the community, listing the matter for a further hearing with the local authority and CCG joined as parties to put forward amended proposals for additional support and possibility of a supported placement.	have capacity to make decisions about her treatment for her anorexia, but also Dr Cahill, who is an expert in this particular area, also considers that ER does not have capacity. However, my hesitancy in accepting their views stems from two things. Firstly, when ER spoke to me, I thought she was articulate and clear in her views, but, most importantly, insightful into her condition, both in terms of her eating disorder, and her renal failure. Secondly, that ER's position is not that of a more "normal" anorexic patient. Her renal failure is terminal, and she has a limited life expectancy, so the decisions she makes about not wanting an inpatient admission have to be seen in that context. Treatment would not prolong her life, therefore the views she expressed seemed potentially rational. [33] However, with considerable reluctance, I have decided to accept Dr Cahill and Dr P's evidence and I accept that ER lacks capacity to make decisions about her anorexia treatment and, it follows, litigation capacity. I start from the statutory presumption in section 1(2) MCA that ER has capacity to make decisions regarding her anorexia treatment. However, Dr P has long experience of ER and her disordered thinking. I would be very slow to depart from the view of a treating consultant psychiatrist, absent any concerns about the closeness of the relationship, which I do not have here. Secondly, Dr Cahill has long

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		and considerable experience of treating patients with anorexia nervosa and I wholly accept that is experience I do not have. Dr Cahill is convinced that ER's thinking is distorted by issues regarding her body image and that she is incapable of weighing up the information. Thirdly, I do accept that there is evidence of unrealistic thinking, especially around her weight levels. Fourthly, I accept that there is evidence that ER does not act rationally in respect of some of the decisions she makes around her eating problems. I do accept that the evidence that ER has failed to address concerns about nausea with her GP, suggests that she is seeking to avoid the issue and is perhaps being less than open with professionals. **Best Interests** [35]…The parties agree, and I accept, that it is not in ER's best interests for her to be forced to accept treatment for her anorexia which she does not wish to accept. In particular, she should not be forced to go into any inpatient hospital and treated against her wishes. In my view, it is plain that this is in her best interests given her renal failure and extreme dislike of eating disorder units and psychiatric hospitals. I also note that this conclusion accords with ER's wishes and feelings.

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		[36] However, it is in ER's best interests to be given more support in the community. I do not criticise the support she has received to date, and her criticism of the support might be unfair. However, the evidence is fairly clear that if she could be moved to a supported living placement where she can have dialysis and more support and company, this could much improve her mood and potentially improve her physical health over the next few months. In those circumstances, I will approve the care plan in the short-term, but I will list another hearing and direct that the Local Authority and the CCG are joined as parties to these proceedings, and are directed to put forward amended proposals in terms of extra support and possibly a move to a supported placement…"
Pennine Care NHS Foundation Trust v Mrs T [2022] EWHC 515 (Fam)	**Judge:** Morgan J **Independent expert**: none – evidence from treating clinicians. **History:** 17 year old girl, "Amy", suffering from anorexia in the context of obsessive compulsive disorder. Detained under s.3 MHA 1983; Amy developed an ability to expel the majority of nutrition she was being fed under restraint such that her weight continued to decline rapidly and clinicians considered her to be at risk of death. The applicant trust proposed, with the support of	22. In this case there is not the heated and passionate disagreement between the parties which sometimes accompanies this sort of decision. It has seemed to me to be all the more important to look with greater care to see what would or even might be proposed to me as an alternative course if there were such disagreement. Similarly whereas here I do not have Amy's explicitly expressed view, because despite attempts to give her a voice it has proved impossible for her to allow herself to use it, it is important to take particular care that when I hear from those who love her most that; of course she would want to live, that is something more

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	her parents, to transfer Amy to a general hospital for treatment and re-feeding over 3-7 days of sedation under general anaesthetic. **MHA?** Detained under s.3 **P's views:** refused all medication, examinations, treatment, intervention or assessment. Selectively mute; refused to engage with Guardian. **Family's views:** Supported the application **Order sought & made:** Authorisation for transfer to an intensive care unit for a period of sedation under general anaesthetic for a duration of 3-7 days. **NB** P being a child at the time of the application, this application was heard in the Family Division of the High Court and orders made under the Inherent Jurisdiction	than simply a reflection of the fact that to believe otherwise would be for them unthinkable. 23. Such communications as there are from Amy have glimmers of her own occasional daring to contemplate a future in them: – her own previously expressed ambition for a particular future career; her pride and more importantly her encouragement of her siblings towards their ambitions showing explicitly an interest in their future… Those expressions of hope for her own future are not, I am satisfied, consistent with someone who does not want to live. In the context of the decision which I have to make, they are inconsistent with an outcome which does not permit the deployment of the treatment I am asked to sanction…. Within the medical records, I was directed during the hearing to other instances in which there are albeit infrequently direct written communications from Amy which are consistent with a wish to live and not consistent with a wish to die. 24. Set against that of course is that seemingly contrary to what may be gleaned from what she from time to time communicates, appears on one view of it to be a steadfast and robust determination to reject all attempts to provide nutrition. This might well be understood as putting into effect a clear intention by an intelligent young woman to end her life by starvation. I accept however, the evidence of Drs Cooper and Dr Dalme that this is not an intention by Amy but is a

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		manifestation of the symptom of her illness. Dr Cooper most helpfully illustrated what he meant when he was asked by Mr Sachdeva whether he had previously encountered a patient who had developed the skill to expel nutrition in the way Amy has. Dr Cooper was at pains to distance himself from the use of the word 'skill' because, he told me it implied for him a misunderstanding of Amy's actions as something intentional and for a purpose. It was he told me, and I accept, important to understand it properly as a manifestation of the mental disorder in the grip of which she found herself and which she could not at this stage overcome."
Lancashire and South Cumbria NHS Foundation Trust v Q [2022] EWCOP 6	**Judge:** Hayden J **Independent expert**: Dr Glover **History:** 50 year old woman with bulimia, depression, PTSD and Emotionally Unstable Personality Disorder. Lives independently, photographs sunsets. Low potassium: hypokalaemia; Abusive adoptive father; career in army; spent time working in Romanian orphanages. Was previously married with three children; at least eight admissions to mental health units; 2 admissions to eating disorder wards; protracted periods of stability; metabolic state particularly unstable in last two years.	**Capacity to litigate:** [21] The observations of Mostyn J *in An NHS Trust v P [2021] WL 01 700358 [2021]* had been afforded greater weight than I am sure he would have intended. In particular, a good deal of reliance had been placed on the following observation: *"I would go further and say that it is virtually impossible to conceive of circumstances where someone lacks capacity to make a decision about medical treatment, but yet has capacity to make decisions about the manifold steps or stances needed to be addressed in litigation about that very same subject matter. It seems to me completely illogical to say that someone is incapable of making a decision about medical treatment, but is capable of making a decision about*

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	In Oct 2020, Q made a written Advance Decision to Refuse Treatment (ADRT) for her low electrolytes arising from chronic bulimia regardless of her physical condition, save so as to be kept as physically comfortable as possible at home until she dies Q was subsequently detained under s.3 MHA for eight months before being discharged under a Community Treatment Order requiring regular blood monitoring and management of hypokalaemia through oral feeding and parenteral potassium at hospital as required **MHA?** Not detained at time of hearing, but subject to community treatment order **Options:** Case proceeded to resolve specific issue as to Q's capacity to conduct the proceedings, to take decisions for the treatment for hypokalaemia and to make an ADRT for low electrolytes regardless of her physical condition **P's views:** Q gave evidence from witness box at her request expressing the view that she had capacity in each domain **Family's views:** Not known	*what to submit to a judge who is making that very determination*" [para 33]." [22] I have little doubt that an individual who lacks capacity to decide about medical treatment will frequently lack the capacity to litigate in a case where that is the sole or predominant subject matter. I have equally no doubt, however, that the proposition is not ubiquitous, in the sense that the two tests should be regarded as synonymous. Though I would not put it as high as Mostyn J, I note that he does not discount it absolutely, but regards it as "virtually impossible" for the two decisions to be different. … [24]…the test for [capacity to conduct proceedings] 'remains that in Masterman-Lister v Brutton & Co [2002] EWCA Civ 1889; [2003] 1 WLR 1511, endorsed in Dunhill v Burgin [2014] UKSC 18; [2014] 1 WLR 933. The essence of those judgments is to confirm, unambiguously, that capacity to litigate is addressed by asking whether a party to proceedings is capable of instructing a legal advisor "with sufficient clarity to enable P to understand the problem and to advise her appropriately" and can "understand and make decisions based upon, or otherwise give effect to, such advice as she may receive". It follows that the issue of litigation will always fall to be determined in the context of the particular proceedings: Sheffield City

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	Order sought: At conclusion of evidence, applicant invited court to determine that Q had capacity in each domain, contrary to the evidence of Dr Glover **Order made:** Declarations that Q has capacity to conduct the proceedings; to make decisions as to her medical treatment for hypokaelimia; and that the ADRT was valid	Council v E [2005] Fam 236. None of this requires P to instruct his advisers in a particular way. Like any other litigant, in any sphere of law, he may instruct his lawyers in a way which might, objectively assessed, be regarded as contrary to the weight of the evidence'. … [26] Although Dr Glover had considered that Q was "unable to appropriately instruct her legal team" because she would "almost certainly argue for a course of action that will lead to a significant risk to her life", he yielded on this point, to the view of Q's legal advisers. The guiding principle here, as always, is the importance of distinguishing an "unwise decision" from one upon which P lacks capacity. I consider that Dr Glover has taken the Mostyn J approach (i.e., that capacity to litigate and to take decisions relating to treatment are synonymous), either because he has taken that judgment to set out the test, or because it accords with his own views. In any event, I agree with Ms Hirst that Dr Glover has applied the incorrect test for litigation capacity. Ms Hirst goes further: *"With respect to Dr Glover, that assessment is flawed: it does not apply the correct test for litigation capacity, and wrongly conflates the issue of capacity with that of best interests / 'unwise' decision-making. [Q] may through these proceedings be pursuing a course of action which Dr*

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		Glover views as deeply unwise, but that does not mean that [Q] lacks capacity to conduct these proceedings." **Capacity to make decisions about treatment** [44] In his evidence, Dr Glover repeatedly referred to "*Q's inability to recognise the value of life*". I formed the impression that Dr Glover afforded the value and/or sanctity of life very significant weight in his analysis of Q's capacity. In his report he made the following observation: "*Q attributes little value to her own life and sees little of value in her future. It must follow that her ability to weigh life and death medical decisions in the balance, is impaired.*" I have considered this passage carefully. However, I do not think the second proposition follows, axiomatically, from the first. The value an individual attributes to life may correlate with their experience of it or their perception of its quality. An individual with motor neurone disease, for example, may attribute little value to his or her life and see little of value in the future. To my mind, that does not automatically establish an inability to weigh life and death in the balance. On the contrary, it may represent a finely calibrated utilitarian calculation. …

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		[53] "…Dr Glover's real and muscular commitment to saving Q's life, is powerful and impressive. But it is difficult to resist the conclusion that his instinctive professional desire to save Q's life has, to some degree, obfuscated his focus on the central question of capacity. Jackson J described this as: "to allow the tail of welfare to wag the dog of capacity." (Heart of England NHS Foundation Trust v JB (supra)). That is an ever-present danger for all the professionals involved in these cases including, if I may say so, the Judge." … [55]… The MCA erects a presumption of capacity; I have to ask myself whether that presumption has been rebutted. I have come to the clear conclusion that it has not. [56] It is also important to state that whilst Q loathes her own frailty, as she sees it, in being unable to combat her own eating disorder, I, like Dr Gauge, did not consider that crushed her self-esteem in other areas of her life. As I have already commented, her confidence in the witness box was striking and she responded thoughtfully and reflectively to Counsel's questions. She gave evidence because she wanted to and, by that stage, I had already concluded that she had litigation capacity. Her evidence was not structured in a way as to require her to assert her

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		capacity on the central issue nor was she challenged on this by this experienced team of advocates. She was, however, sensitively, and properly questioned about her self-esteem. She turned to Counsel and said, "I think all women have self-esteem issues of some kind". It was an answer delivered with both confidence and humour. Additionally, Q lives independently and alone within the limits of her physical condition, she looks outwards towards the world and to other people. This too signals something of her self-confidence and self-worth, particularly if one has regard to the traumas of her past. [57] Q does not want to die, but she does not want to live under a medical and mental health regime which she finds oppressive and corrosive of her autonomy. As she puts it, she is simply "sick of it". On paper, that regime may not appear rigorous but for Q, it undoubtedly is. I regard her view, if she will forgive me for saying so, to be an unwise one. Whilst I hope that recovering her autonomy may be empowering for her, I consider, on the evidence, not least her own, that it is most likely to hasten her death. I am sure that those who have had regular dealings with her, and her friends will consider that a considerable loss. She is an engaging personality with much to offer. However, whilst her decision may be objectively

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		unwise, it is hers and not mine. I must respect her autonomy. **Capacity to make the ADRT** [58] …Ms Power submits, and I agree, that the issue of capacity at the time of the ADRT would stand or fall with the issue of current capacity.
A MENTAL HEALTH NHS TRUST v BG [2022] EWCOP 26	**Judge**: Sir Jonathan Cohen **Independent expert**: Dr Glover **History:** Age 19; diagnoses of anorexia, mixed personality disorder, depression, chronic fatigue and fibromyalgia. From very early age exceptionally sensitive and struggled with regulating her emotions and dealing with the ordinary events of everyday life that others take in their stride; in contact with mental health services from age 8; two courses of CBT aged 10 and 13; depression from 14 with suicidal and self-harming behaviour shortly thereafter; diagnosed with anorexia in 2018 and under continuous care of psychiatric services from then inc. 6 months of eating-disorder focused therapy sessions; inpatient in hospital almost continuously for three years, save for four months at home; 9 sessions of electro-convulsive therapy produced no improvement.	[48] This case is quite unlike any that I have come across and although similar in some respects, it is also markedly different to A Local Authority v E [2012] EWHC 1639 (COP). The distinction lies above all in the fact of the agreement between experts that there is nothing more that can be done to help BG. [49] The law contains the strong presumption that all steps will be taken to preserve human life unless the circumstances are exceptional. However, the principle is not absolute and may yield to other considerations: Airedale NHS Trust v Bland [1993] AC 789: "*There will be a limited number of cases where treatment is futile, overly burdensome to the patient or where there is no prospect of recovery*" [50] To be asked to make an order which will be likely to lead to the death of a sentient, highly intelligent and thoughtful individual who, if otherwise able and minded, might accept treatment which could assist

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	By early 2022, BG had received over 1,000 NG feeds under restraint of four staff members, causing immense distress; BMI maintained at 15. Mental health trust considered it had exhausted all treatment options that might alleviate her various disorders. **MHA?** Detained under s.3 at time of hearing **Options:** (i) continuation of an active treatment plan, including current medication and NG nutrition, against P's wishes; (ii) for active treatment to be discontinued – the consensus of all parties and Dr Glover **P's views:** She wished to have the absolute autonomy to be allowed to decide for herself what medical treatment she will accept or decline and the knowledge that her voice and her rights will be respected. She was exhausted from being in so much intolerable pain for so long, and she would like to be sure that any palliative care plan guarantees pain relief such that she is not obliged to suffer further than absolutely unavoidable	her is as grave a decision as can be made. It has of course weighed heavily for a long period with BG, her parents and Dr Z, and now me. Simply because all the evidence points one way does not extinguish the burden. But, in the tragic and deeply distressing circumstances of this case, I am in no doubt that it is in BG's best interests that I made the various declarations.

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	Family's views: Supported the application for no further treatment against P's wishes **Order sought:** 1. BG lacked capacity to conduct these proceedings and/or to make decisions about her care and treatment including nutrition and hydration; 2. It was lawful and in BG's best interests for no further treatment to be provided to her against her wishes and for her to be discharged home from hospital notwithstanding her admission pursuant to section 3 MHA; 3. It was lawful and in BG's best interests for her to receive palliative care and not to be provided with any invasive or life-saving interventions against her wishes. **Order made:** By agreement: BG lacked capacity to conduct these proceedings and/or to make decisions about her care and treatment including nutrition and hydration; It was lawful and in BG's best interests for no further treatment to be provided to her against her wishes and for her to be discharged home from hospital	

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	notwithstanding her admission pursuant to section 3 MHA; to receive palliative care and not to be provided with any invasive or life-saving interventions against her wishes.	
North East London NHS Foundation Trust v Beatrice (Rev1) [2023] EWCOP 17 (09 May 2023)	**Judge**: Mostyn J **Independent expert**: Dr Glover **History:** Age 50; highly intelligent woman with various degrees and a social media presence; suffered from anorexia since 14 years old; BMI of 11.5 at time of hearing; **MHA?** Unknown **Options:** Unclear from judgment **P's views:** P gave evidence: She no longer has the strength or mental resources to carry on the struggle, and is now ready to capitulate. She wished to be taken to a hospice to die. **Family's views:**	**Capacity to decide on care and treatment** [27] In answer to Ms Sutton KC, Beatrice stated: "Q: In relation to what you have heard from Dr A and Dr Glover, and their joint opinion that you are unable to make decisions in relation to your nutritional intake, do you understand how they have come to that conclusion?" A: No, I don't, I am of the opinion that I might have capacity." It was interesting that Beatrice did not assess herself as certainly having capacity to make decisions in relation to nutritional intake but only the possibility that she might have it. I have to say that the subliminal message I received from Beatrice was that she did not think she had capacity to make decisions in relation to nutritional intake. [28] In my judgment, the evidence shows there is no doubt at all that Beatrice cannot weigh the

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	Father: P has to be encouraged not to say ok go off to palliative care and starve yourself to death. That should not be allowed to happen. There is hope and light at the end of the tunnel. There is a lot of love and goodness in her. **Order sought:** Declarations that P lacked capacity to conduct the proceedings and to decide on care and treatment options in respect of her nutrition and hydration An application for final orders would be considered at a further hearing; **Order made:** Declaration that Beatrice lacked capacity to conduct proceedings and make decisions about nutrition and hydration	information relevant to a decision about the options for her care and treatment. The weighing process requires her to recognise that into the scales go the stark fact that if she does not eat and hydrate normally, and very soon, she will die. I agree with Mr Sachdeva KC that for the purposes of the test there is nothing else to weigh. There are, pace Hedley J, no various, inter-relating, parts of the argument. There is nothing to put on the side of the scales objectively in favour of starvation. [29] Yet Beatrice cannot and does not undertake this weighing exercise because of the anorexia nervosa. The experts explained to me graphically and eloquently that the condition impairs Beatrice's mind by taking it over and creating delusions that she is overweight, with a fat, ugly body rather than being skeletal and at death's door **Capacity to conduct the proceedings** [36] As for the second declaration I remain convinced, as a matter of logic (I forebear from saying common sense), that if Beatrice is robbed by the condition of the key element in the decision making process of weighing the relevant information, then she will be equivalently disabled from formulating and making submissions to a judge as to how he or she should

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		undertake that very weighing exercise: see An NHS Trust v P (by her litigation friend, the Official Solicitor) [2021] EWCOP 27 at [33]. [37] The test for litigation capacity surely has to be premised on Beatrice acting in person for, if that were not so, there would have to be an invidious debate as to the quality of the legal team hypothetically engaged by her. I am not getting into that in this case as I am completely convinced that Beatrice, even if represented, would not be able to formulate valid instructions to her lawyers by virtue of the impact of the condition to which I have referred above. [38] In Lancashire and South Cumbria NHS Foundation Trust v Q [2022] EWCOP 6 at [24] Hayden V-P posited that when determining whether P lacked capacity to conduct litigation the court could take into account when analysing a hypothetical instruction by P of hypothetical lawyers that P would not be "required" to instruct her advisers in a particular way, and that "like any other litigant, in any sphere of law, [she] may instruct [her] lawyers in a way which might, objectively assessed, be regarded as contrary to the weight of the evidence". [39] I confess to finding the intellectual process which I should undertake under this formulation to be

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		extremely difficult. I think it is being suggested that even though I have found that the anorexia has robbed Beatrice of the ability to weigh the relevant information she nonetheless may have the capacity to litigate that very issue because she has the facility to give completely unrealistic and objectively untenable instructions to her hypothetical lawyers. I do not accept that this is a valid or useful exercise for the purposes of the decision I have to make. I think the exercise is difficult enough without having to go down what I regard as an intellectual cul-de-sac.
In the Matter Of Patricia [2023] EWCOP 42 (15 May 2023)	**Judge**: Moor J **Independent expert**: Prof Paul Robinson **History:** Age 23; ten years of treatment in a number of different settings and at a different times over a prolonged period including 6 episodes of forced feeding. Best interests meeting in November 2022 unanimous that she should be discharged from mental health services because continued treatment was counterproductive. By time of hearing, perilously close to death. Agreed by all parties that P has capacity to litigate these proceedings; Previous decision on 9 May 2023 that P should not be treated by NG feeding under compulsion on basis that	Evidence on 9 May from Professor Robinson was that "He said there was no advantage to her remaining under the care of eating disorder clinics against her wishes and that plan C, which was the restraint plan, was "so harsh that it would be extremely unpleasant for her, for her family and for clinical staff and was unlikely to work". But that “"if she was my patient, I would not allow her to die from anorexia. I would do whatever is necessary to bring her to the point where she can either enter treatment or be sent home, and that would include forced feeding and forced intravenous phosphate if that was necessary."

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	Moor J did not consider ordering such treatment "would do any good to her in the long term" and "would cause her very significant distress. I wanted to avoid that distress." (Z NHS Foundation Trust v Patricia [2023] EWCOP 41). At the time of the 15 May hearing, P had managed to increase her calorie intake from 700-800 to 1,200-1,300 calories per day. **MHA?** Not detained at time of hearing **Options:** (i) Treatment under compulsion, whether restraint or sedation; (ii) No treatment by compulsion **P's views:** Passionately opposed to treatment by NG feeding under compulsion P considers she has capacity to make decisions about her treatment **Family's views:** At hearing on 9 May: "[Her father] told me – and I do not think Patricia was present when he told me this – that Patricia is very weak. He told me the thought of her being held down to be	Hearing on 15 May: [19] As far as Professor Robinson is concerned, I have already indicated that I was particularly taken by his evidence last week about Patricia having a partner, namely anorexia, which controls the other part of her mind and stops her carrying out her wishes. That is, in my view, clear evidence of incapacity. [20] Dr B is an important witness because, unlike Dr H, she has known Patricia for five years. She has had very close contact with her and she is clear in her view that, at present, the anorexic thinking takes over such that Patricia cannot decide for herself. I accept that evidence. [21] I find that I do have jurisdiction on the basis that Patricia, at present, lacks capacity to take decisions as to her medical treatment. I accept the submission that Ms Butler-Cole KC made to me that judges should not automatically come to the conclusion that those with anorexia nervosa lack capacity. I am clear that, if Patricia was to get herself to a position where she was well enough to go back to an SEDU unit or to go home, by taking over 2,000 calories a day, I might well take a different conclusion. My mind is entirely open.

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	force-fed was terrifying, but he then added that the thought of her dying was even more terrifying. He said the huge anxiety for Patricia of this litigation and the threat of force-feeding was having a hugely detrimental impact on her. She gets very stressed and it was horrible to see how upset she was, although he wanted me to do what was for Patricia's overall good." **Order sought:** A declaration that P lacks capacity to decide on her medical treatment for her anorexia **Order made:** A declaration that P has capacity to conduct proceedings A declaration that P lacks capacity to decide on her medical treatment for her anorexia It is not in P's best interests to force-feed her against her wishes	[22] Despite the fact that I take the view that I, in the Court of Protection, have jurisdiction to deal with this case, I repeat, and I repeat loud and clear for Patricia to hear, that I am still of the view that she should have her autonomy on the basis that it is not in her interests to force-feed her against her wishes, as it would be futile and cause her nothing but distress and turmoil. I accept her evidence when she tells the court that, if she put on weight as a result of compulsory nasogastric feeding, she would just lose it again as soon as the nasogastric feeding stopped. Last week, I did say to her that, if her liver function deteriorated, I would really hope that she would be able to accept nasogastric feeding not by compulsion, but by agreement, as she did last year, with dramatic improvements in her health. I am quite sure that, if she was to do that, it would be relatively easy for Ms Butler-Cole to convince me that she had regained capacity and I would dismiss these proceedings. That is not the position today. I have, therefore, decided that I do retain jurisdiction, but I am still of the view as to her best interests as articulated in my judgment on 9 May 2023. [Judgment on 9 May states: "The question then is whether I should authorise force-feeding on the basis that, if I do not, her liver function is likely to deteriorate even further. This is

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		the issue that has caused me the greatest concern, because I recognise and accept that if I do not do so, she may not last until next Monday and she may die. That is something that I do not want to occur. That is why I have found this case so difficult and troubling but I have come to the conclusion that it would not be right for me to direct force-feeding this afternoon. I remind myself that Dr B told me that, if I was to do it, it would only be one last attempt. I am very concerned that all I would be doing would be causing Patricia enormous distress, possibly physical harm and damage to achieve very little, perhaps a short-term improvement and then a long-term deterioration again. If this is going to work, Patricia has got to do it. Nobody else can do it other than Patricia. She has got to get her intake up. She has got to learn to deal with it herself without a judge in London telling her what to do. In the long-term, that is her only chance.”