The judge has given leave for this version of the judgment to be published on condition that (irrespective of what is contained in the judgment) in any published version of the judgment the anonymity of RL and members of his family and the treating team must be strictly preserved. All persons, including representatives of the media, must ensure that this condition is strictly complied with. Failure to do so will be a contempt of court

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COURT OF PROTECTION
(Sitting at the Royal Courts of Justice)
[2023] EWCOP 22

No. 14051838

Royal Courts of Justice
Strand
London WC2A 2LL

Friday, 17 February 2023

Before:

SIR JONATHAN COHEN
(Sitting as a Judge of the High Court)

(In Public)

B E T W E E N :

(1) NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST
(2) NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST

Applicants

- and -

(1) RL
(by his litigation friend the Official Solicitor)
(2) VL
(3) XY NHS TRUST

Respondents

ANONYMISATION AND REPORTING RESTRICTIONS APPLY

MR I BROWNHILL appeared on behalf of the Applicants.

MISS D POWELL KC appeared on behalf of the First and Second Respondents.

MR J RYLATT appeared on behalf of the Third Respondent.

J U D G M E N T

SIR JONATHAN COHEN:

1 This case concerns RL, a man in his thirties, who is serving a sentence of life imprisonment for murder. He moved prisons in 2020 and early the following year concerns started to be raised in respect of his mental health. The symptoms included appearing to respond to unseen stimuli and food refusal, but he did not engage with mental health services provided by the prison and was discharged from their service.

2 By the end of 2021, he had stopped verbally communicating and was only using non-verbal gestures. He started speaking again in March 2022 but then was assessed soon afterwards as having become selectively mute. By September 2022, he was refusing food, was not engaging with mental health services and appeared to have lost weight.

3 In mid-January 2023, he was admitted to hospital for assessment and treatment but that lasted only for a short period. He then had various out-patient appointments and a further short in-patient admission until 6 February, eleven days ago, when he was returned to hospital due to his very low body weight.

4 All the evidence suggests that he is severely malnourished. He refused nasogastric feeding and he has refused antipsychotic medication which is deemed by the treating doctors to be essential to restore his mental health.

5 The view of one treating doctor is that although he will not die, as it was put, within the hour if he does not receive adequate treatment, the longer it is before he is treated, the more dangerous the situation becomes both in the immediate and in the long term. It is very important to consider the potential for refeeding syndrome because, without an appropriate feeding regime, the more he is at risk of refeeding and it will be very hard to control due to his extreme weight loss.

6 Refeeding is itself a life-threatening situation as it can cause cardiac dysfunction extremely quickly; and, continued the doctor, “My view is that if we do not give sustained feed to RL now, we will precipitate a life-threatening scenario which could occur at any time.” It is the view of the treating team that it would be deeply undesirable to delay and that the risk grows exponentially the longer he is not fed or does not receive the appropriate medication.

7 It is against that background that the case comes before me today when the Trusts ask for the court’s authorisation for the administration of a nasogastric feeding tube for the treatment for malnutrition and also for his mental health condition and, in addition, as became apparent during the hearing, the treatment of his thyroid condition. The Official Solicitor, having considered the matter carefully, acting on behalf of RL accepts the urgency of the situation and has not sought an adjournment, as is often the case, in order to obtain further information or third-party expert opinion.

8 The first question that I have to ask myself is whether or not RL has the ability to make a decision for himself. I have to start from the presumption that he is able to make his own decision. The statutory tests that are put before me are not that he does not understand the information relevant to the decision or is unable to retain that information, although that may be the case, but specifically that he cannot weigh the information as part of the process of making his decision as to whether or not to accept treatment and feeding and cannot communicate his decision by reason of his mental illness.

9 The treating team and, in particular, Dr D, consultant psychiatrist, are all of the same view albeit that it is Dr who was the witness before me and whose evidence I have to consider.

She has seen him on many occasions; twice in December 2021 and four in, I think, April 2022 when he was in prison. Since January 2023 she has seen him four times. Her evidence is that since January 2023, save for one very limited communication, he has not communicated with her at all. She thought he was severely mentally ill, suffering from a severe psychotic disorder complicated by hyperthyroidism. The symptoms of psychotic behaviour that she has read about and observed are his bizarre behaviour, his inhibited behaviour and responding to unseen stimuli. He became worried about safety of food.

10 Dr D considered that RL was suffering from depression, and described him as virtually stuporous and mute. When she last saw him, he did not even flicker his eyes when she put papers in front of him and was not willing to communicate his wishes in any way at all. She described him as presenting as "quite shutdown." Her view was that he does not understand information presented to him. The picture is not completely consistent because, on 26 January, he is recorded as having said, when in accident and emergency, that he was trying to kill himself. But that seems to be the only occasion that he has said that, and she accepted that there was a possibility that his mental state might be fluctuating.

11 He is described by his mother as being a completely changed person from the son that she knew and that he has very much deteriorated over the course of recent times. He is not engaging with the family either, contrary to the way that he used to. When the Official Solicitor's representative went to see him, he literally was not able to do so because RL would not come out from under the bedclothes; he remained completely invisible and would not engage in any way whatsoever.

12 The evidence which I accept is that, on the balance of probabilities, he is indeed unable to weigh up the information as part of the process of making a decision or to communicate his decision in the words of the statute "whether by talking, using sign language or any other means." He simply has made it impossible for anyone to know what his wishes are because he will not express them himself. He does not give any indication of understanding the link between receiving food and treatment and life and death.

13 It seems to me, therefore, clear that he does suffer from those two incapacities and that is caused by his psychosis. I agree with counsel that the fact that the precise nature of the psychotic illness cannot be diagnosed at the moment does not invalidate the diagnosis.

14 There is one other important matter that I should add into the equation. Apparently this morning the treating team inserted a nasogastric tube. That was a new development because last week and, indeed, up until today, RL was not prepared to accept it. I think it is fairer to describe what happened this morning as an absence of any resistance by RL rather than a sudden piece of insight into his condition. He did not in any way try to interrupt the process; he was awake and conscious, but he said and did nothing.

15 It therefore follows that I find that there is a lack of capacity and make the appropriate declaration under s. 15. I agree that it is more appropriation to use s. 15 than s. 48 MCA as I have the evidence which enables me to make a declaration under s. 15 and, of course, if capacity were to returns, RL will fall out of the statutory framework.

16 In consequence I am required to make a best interests decision. There is, as counsel has rightly pointed out, a strong presumption in the preservation of life and that is at the forefront of my mind. I would obviously give great weight to what RL's own views would be, but it is very difficult to assess what they are. There is no evidence of a clear and settled wish to end life; what he said in A&E on 26 January does not establish that. His attitude towards taking food and drink has been inconsistent, albeit the amount of food that he has

taken has not been anywhere near sufficient to lead to any form of recovery. He would not communicate with the Official Solicitor to indicate what his views are.

17 I look to see what others might say about his views. His mother was very clear in her discussions with the Official Solicitor's representative that her son's current presentation is out of character. She believes – and she knows him better than anyone else in this case – that he would want treatment if he was well.

18 It therefore seems to me that there is a very strong balance in favour of the administration of treatment and I consent on RL's behalf to the administration of the Carbimazole, Olanzapine and Lorazepam and thyroid medication and Pabrinex. These can be administered by the NGT and, if for any reason the NGT becomes displaced, I authorise the treating team to be able to use restraint to re-instate it. I hope that does not become necessary but, if it does, it is plainly in RL's interests that he should receive medication and nutrition and hydration.

19 The matter will come back before the court in a week's time, that is next Friday, and before me if I am available. The reason for a speedy return is that within five to seven days there should be at least some indication as to whether or not the feeding issue is beginning to be resolved, even though the time for knowing whether the medication for his psychosis is assisting will be much longer. Since the court order includes the power to use restraint in order to address the issues of nutrition and hydration, it is appropriate that the matter should come back sooner rather than later.

20 I will, therefore, make that order and the consequent orders that we have discussed so that the evidence that the court needs is before it next Friday.