Neutral Citation Number: [2021] EWHC 2105 (Fam)

Case No: FD21P90060

IN THE HIGH COURT OF JUSTICE (FAMILY DIVISION)

IN THE MATTER OF THE INHERENT JURISDICTION AND SECTION 8 OF THE CHILDREN ACT 1989

IN THE MATTER OF GW

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 9/07/2021

Before:

MRS JUSTICE THEIS

- -

Between:

Cambridge University Hospitals NHS Foundation Trust	**1st Applicant**
- and -	
Cambridgeshire & Peterborough NHS Foundation Trust	**2nd Applicant**
- and -	
GW (By Her Litigation Friend, The Official Solicitor	**1st Respondent**
- and -	
PW	**2nd Respondent**

- -

Ms Stephanie David (instructed by **Kennedys Law**) for the **Applicants**
Ms Debra Powell Q.C (instructed by The **Official Solicitor**) for the **1st Respondent**
Ms Sophia Roper (instructed by **Bindmans Solicitors**) for the **2nd Respondent**

Hearing dates: 3rd, 4th and 7th June 2021
Judgment: 9 July 2021

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Approved Judgment

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MRS JUSTICE THEIS

This judgment was delivered in private. The judge has given leave for this version of the judgment to be published. The judgment the anonymity of the children and members of their family 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.

Mrs Justice Theis DBE:

Introduction

1. The court is concerned with an application by the Cambridge University Hospitals NHS Foundation Trust ('CUHFT') and the Cambridge and Peterborough NHS Foundation Trust ('CPFT') (the Trusts) who seek orders relating to treatment for GW age 17 years, under the Inherent Jurisdiction. The other parties are GW, represented by the Official Solicitor, and PW, GW's mother.

2. CPFT run the unit where GW currently resides and receives treatment (the 'Unit'). GW has been there since February 2020. CUHFT manages Addenbrooke's Hospital, who have overseen GW's treatment.

3. The Trusts have brought this application as they are concerned about what they say is the significant and continuing risk that GW will refuse treatment for her severe multiple sclerosis ('MS') and her significant wounds as a result of her self-harming.

4. The context of this application is that GW suffers from a chronic depressive illness, as well as a severe neurological condition, MS. Understandably, as Ms Powell QC on behalf of the Official Solicitor observes, GW has struggled with these very difficult challenges.

5. The Trusts seek declarations from the court that the MS and Wound Management Treatment Plans, including physical restraint, are in GW's best interests for a period of six months, until her 18th Birthday, with a review hearing in 3 months' time. The Trusts submit having clear and consistent plans will assist GW by setting boundaries, addressing her impulse to refuse treatment in an unpredictable way and provide clarity and consistency to avoid the risk, as far as possible, of matters escalating and physical restraint being a last resort. This will avoid the serious consequences for GW's health if she does not receive the treatment, those consequences being either her death or severe permanent harm.

6. The application in so far as it includes physical restraint for MS is opposed by PW and the Official Solicitor, on behalf of GW. They submit it is not justified or proportionate on the evidence when undertaking the necessary balancing exercise, as having such authority is likely to be contrary to GW's best interests. In relation to the wound management treatment plan, the Official Solicitor supports that in principle; PW supports it in part but not in full, and, seeks further clarity regarding the situations it would operate in.

7. Prior to the hearing the Trusts refined their position to seek to use restraint in relation to the MS treatment once all other avenues have been exhausted. In relation to wound management the evidence developed during the hearing and the Trusts have now confined their position in relation to wound management in limited and circumscribed urgent situations. GW's treatment for her MS is Natalizumab ('Tysabri'), which is administered by way of infusions at hospital every 4 – 6 weeks.

8. Both GW and PW attended the hearing and through skilled cross examination on their behalf by Ms Powell QC and Ms Roper they respectively explored the rationale

underpinning the Trusts' position, this helped provide better clarity of what was actually being sought.

9. A separate question arose during the hearing as to whether authorisation is required for any deprivation of GW's liberty arising out of the arrangements for her care and accommodation at the Unit. There is agreement between the parties that the court's authorisation is not required, because GW is not deprived of her liberty. GW is there as an informal patient, has been so since February 2020 and more recently has signed an agreed list of expectations, when she asked to return to the Unit following a period at home. It is accepted GW has capacity to consent to the arrangements for her care and support at the Unit.

10. The hearing took place on 3, 4 and 7 June 2021 and the court heard oral evidence from the following witnesses:

    1. Professor C (Consultant Neurologist)
    2. Dr H (Consultant in Emergency Medicine)
    3. Dr C (Consultant in Acute Medicine)
    4. Dr M (Consultant Child and Adolescent Psychiatrist)
    5. PW (GW's mother)
    6. Dr G (Consultant Psychiatrist)

11. GW set out her views in writing, both directly to the court in an email, and also via the notes of her meetings with her solicitor in January and June. I have considered with great care what GW has set out.

12. The court is grateful for the detailed and well-crafted written and oral submissions from all of the advocates in this case, each of whom have expertise and experience in the difficult issues that have arisen in this case.

Relevant Background

13. GW has been residing at the Unit since February 2020. Prior to that she lived with her mother. Her parents separated in about 2009. GW experienced difficulties in school from about 2011, the extent was such that her mother requested an emergency transfer of housing.

14. Sadly, there was a deterioration in GW's mental health and she started self-harming from about 2013. Due to the severity of this behaviour and the lack of progress GW was offered inpatient treatment at the Unit in August 2017, when she was admitted for about 8 weeks. Following her discharge there was a period of relative stability.

15. In late 2019 GW was diagnosed with MS. Soon after that a close relative was admitted to hospital and, tragically, died shortly afterwards. Unfortunately GW suffered a further / second deterioration in her mental health with her self-harming behaviour escalating in late 2019, early 2020. The community mental health team considered GW required inpatient admission and she was admitted to the Unit in early February 2020.

16. GW remains at the Unit with a plan for rehabilitation, although the precise timing and details remain uncertain.

17. GW has a number of diagnoses. First, she has a severe depressive episode without psychotic symptoms which is associated with feelings of worthlessness and anxiety symptoms. Second, intentional self-harm by sharp objects which has been present for a number of years. It is described as being of an extraordinarily severe nature. This is illustrated by the information that in 2020 GW required at least 21 documented emergency admissions to hospital relating to self-harming behaviour, which have included surgical management and specialist treatment. In addition, the records at the Unit refer to 48 incidents between December 2020 and March 2021 which are mainly wound related. Third, other non-compliance with medication, which includes a history of repetitive reluctance to consent to medical treatment, including antibiotic treatment, iron supplements. Fourth, as set out above, GW was diagnosed with relapsing and remitting MS which Professor C, who oversees the management of her MS treatment, describes as being one of the most severe cases of MS he has seen in a young person under 18 years.

18. GW is described as a highly intelligent and verbally eloquent young woman, with a dark sense of humour. However her low self-esteem and self-worth impact on her ability to accept help, to explain her refusals of treatment and can account for her rapid transitions between emotional states from being relaxed to severely anxious, irritated or depressed. In his report Dr G describes how her ability to reason can be *''overwhelmed by events'*, particularly in *'acutely challenging situations'* which include the requirement to give consent to invasive treatment. Whilst on one level GW recognises the need for support when that support is offered she finds herself unable to accept it and unable to explain her refusal.

19. This combination of cognitions has, at times, presented real challenges for those who support GW and the clinical teams who are treating her. At times GW's severe irritability and agitation are not in proportion to the triggering event, they can be started by relatively minimal interpersonal conflicts or when things do not proceed as she planned, or wanted. Such behaviour has meant there have been times when GW has either refused treatment or interrupted it, for example removing her cannula.

20. Prior to and after these proceedings being commenced in December 2020 there had been considerable engagement between the Trusts, GW and PW which PW recognised has brought about improvements in the treatment plans now being proposed. That collaborative process continued during the hearing.

21. PW places some reliance on the evidence relating to the history of wound management when restraint has been used and the consequences that have flowed from that.

22. On 31 May 2020 GW was taken to A&E due to her reduced haemoglobin levels. According to GW she was the subject of restraint by the ambulance staff, no other records record this although the ambulance records were not available. When GW got to hospital the hospital did not consider GW required an urgent intervention and she returned to the Unit. GW refused an iron transfusion on 2 June, when she returned on 3, 7 and 8 June for blood and iron transfusions the Trust records set out that restraint was used for the treatment to take place, based on an assessment that GW lacked capacity. On 8 June GW was detained under section 2 Mental Health Act 1983, and

remained detained until 29 June 2020. PW gave consent for the treatment on 3 June, as a result of which there was a two month breakdown in GW and PW's relationship when GW excluded PW from knowing about her care. GW considers these events are likely to have had some bearing on PW's refusal of her Tysabri treatment (for her MS) in July.

23. More recently there has been a similar situation. On 22 May 2021 GW reopened her leg wounds. A blood transfusion was arranged for the following day, GW said she would prefer to go the next day and that preference was accepted. Later that day GW self-harmed again, and the records note she did not want to go to hospital without her observations having been taken. GW was taken to hospital by ambulance with the use of restraint. GW consented to the blood transfusion that was completed at 4.15 am 24 May. The records note GW's distress at being restrained the previous day. That night she caused damage to her room at the Unit and assaulted a member of staff, whilst the details about the incident are disputed by GW there is no issue that an incident took place which resulted in GW injuring a member of staff. Dr M records that *'the main trigger was paramedics and staff taking her forcibly to [hospital] to have blood transfusion'.*

24. The consequence of these events is that an urgent decision was made for GW to be discharged home, which took place on 25 May. On 26 and 27 May there are notes in the records that GW wished to return to the Unit (following an incident of self-harm on 26 May which required PW to take GW to A&E). Following further discussions, a short list of expectations was sent on 27 May, which GW agreed to and she returned to the Unit on 28 May following her Tysabri infusion at the hospital.

25. This hearing took place on 3, 4 and 7 June 2021. After the hearing on 7 June the closing submissions from the Trust provide a summary of events that have taken place since.

26. As Dr M outlined in his oral evidence, discharge planning has been actively considered during GW's time at the Unit. Once discharged the primary responsibility for GW's care and support will fall upon the Clinical Commissioning Group (CCG) and the local authority. The CCG has assessed GW as eligible for continuing healthcare funding and CPFT's role in respect of discharge planning is limited to support for GW's mental health in the community. The management of GW's physical health needs would be the responsibility of the CCG and GW's general practitioner.

27. At the time the proceedings commenced in December 2020 it was not considered GW's actual discharge would take place for a number of months due, in part, to the Covid-19 restrictions and the delays in identifying suitable accommodation for PW. For a number of months the Trusts have sought to engage the relevant NHS Foundation Trust (North West Anglia NHS Foundation Trust – 'NWAFT') that would be responsible for GW's care on discharge. According to Ms David that to date has not resulted in any meaningful engagement from the NWAFT. As a consequence of these delays consideration was being given to where GW would move to on her 18th birthday, as the Unit is a resource limited to under 18 year olds.

28. An MDT meeting took place on 9 June to include work on a multi-agency risk assessment framework in advance of any decision for GW to be discharged into the community. This is a dynamic document that will remain under review as the discharge planning process takes place.

29. According to Ms David's closing submissions, there was an incident on 9 June when GW caused damage to her room, possibly caused by an issue regarding GW's request to move rooms. There were discussions with PW and a further Care Plan Review (CPA) took place on 14 June, with the next CPA meeting scheduled to take place on 12 July 2021.

30. Ms David's closing submissions summarise the outcome of the meeting on 14 June 2021 as follows:

    i) *Given that waiting for a bungalow could take years, the current plan is to discharge GW home. Adaptations to PW's property were offered, but were declined because they might prevent a move to a bungalow.*

    ii) *The agreed next step is increased home leave, which will be trialled over the next few weeks (starting with 20-22 June 2021, two nights the following week, three nights a week for the two weeks after that) and reviewed on 12 July 2021.*

    iii) *GW's General Practitioner will manage wound monitoring and redressing, as well as blood tests, in the community. Blood tests will be undertaken at least once a week. The practice nurse would do the dressings.*

    iv) *For planned transfusion, the General Practitioner can refer to the PCH medical unit by phoning the Acute Physician in Charge.*

    v) *PCH will manage her urgent wound treatment.*

31. Although these proceedings were commenced in the Court of Protection, they were reallocated, with the agreement of all parties, to the High Court by Roberts J on 16 April 2021. As set out below, it is agreed that the framework within which this application is being considered is what order is in GW's best interests.

Evidence

Professor C

32. Professor C is the Consultant Neurologist who oversees GW's MS treatment. He provided three witness statements setting out his involvement in GW's care since 2019. He agreed that there had been a change in GW's compliance with the Tysabri treatment since September 2020. When asked about the account of events around 19/20 May 2021 he said he received a different account of events than that suggested by PW, although he agreed the notes do not give any context as outlined by Ms Roper. Professor C made clear his team would be very reluctant to use any restraint provided for in any treatment plan. He accepted he had not discussed the issue of restraint with GW, although he had been present at an MDT meeting when GW explained it was not necessary.

33. Ms Roper took Professor C to the evidence about the impact on GW when restraint had been used in June 2020 and May 2021. He noted these events did not involve MS treatment, and did not consider himself qualified to respond about the impact on GW's mental health of this being included in the MS treatment plan. In his view including restraint *'represented our best attempt to strike the balance'*.

34. In answer to questions from Ms Powell he agreed that since September 2020 persuasion and reassurance had worked. He accepted what GW had told her solicitor in January 2021 that she understood the treatment was important and the consequences for her if she refused. He accepted that there had been compliance since September 2020, his concern was that can't be taken in isolation from GW's mental health, which he accepted was not his area of expertise. He acknowledged the risks of having a provision for restraint on the therapeutic relationship his team have with GW, but his concerns are underpinned by the consequences for GW if she does not have the Tysabri treatment in the timeframes.

Dr H

35. Dr H is a Consultant in Emergency Medicine at CUHFT. In her two written statements she sets out what has taken place when GW has attended the emergency department (ED). Ms Roper took her through the various scenarios in which the Trust sought authorisation to restrain GW, this helped inform the revised position of the Trust in the plan produced after the conclusion of the evidence. She confirmed in the ED department they had not seen active bleeding, as by the time GW gets to them steps have already been taken. She made the point that medical support is available at the Unit, although not immediately on hand if she was living at home. She was not aware of any history of concerns about GW not complying with a wash out, steps have already been taken to stop the bleeding.

36. Dr H stressed in response to questions from Ms Powell the need to have the clinical picture, as she said the situation can be more nuanced. Dr H expressed the view that a treatment plan has got to be able to work clinically.

Dr C

37. Dr C is a Consultant in Acute Medicine at the CUHFT. His evidence was focussed on GW's haemoglobin levels. He considered an Hb level at 50 would raise serious concerns regarding heart rate, pulse and level of consciousness and in his view that level would raise significant risk of cardiovascular compromise/collapse. As a result of the evidence he gave about the long term consequences of chronic anaemia (such as long term strain on the heart and kidneys with risks of heart failure and kidney disease), an appointment has been offered with a specialist Consultant for GW and PW to attend to understand the long term effects of chronic anaemia and repeated transfusions. In answer to questions from Ms Roper about occasions when either one or two units of blood are needed, he said getting Hb levels up to 70 was only a temporary solution to a longer term problem.

Dr M

38. Dr M is a Consultant Child and Adolescent Psychiatrist and Clinical Director at the Unit. He has filed four statements setting out his involvement with GW's care. In his oral evidence he provided some detail about how GW's care would be supported if there was a discharge home. In relation to the events that took place on 25 May when a member of staff was injured, he described the difficulties in managing that situation in circumstances where GW is an informal patient. His opinion is that GW has the capacity to decide whether to stay at the Unit, and that was confirmed in the list of expectations she was asked to agree to when she requested to return to the Unit on 28 May.

39. Dr M was pressed about the impact on GW of having provision for restraint in the treatment plans. His opinion was that whilst every effort would be made to avoid it, having it there provided a level of certainty or acted as a safety net.

40. When asked by Ms Roper about the impact on their therapeutic relationship with GW of the decision to discharge her home on 25 May, Dr M said it is sometimes helpful for people to know there are limits. Whilst he acknowledged the risks in having provisions for restraint in the treatment plans, he considered the structure and limits it would provide would be of assistance when weighed in the balance with the clinical risks, namely the consequences to her health. When asked about the events in June 2020 when the ambulance was called, he said the references to restraint came from GW, rather than the Unit records. In relation to the position regarding MS treatment after GW refused the Tysabri treatment in July 2020, he agreed it *'probably was the case'* that they had not appreciated then how important it was for GW to have the treatment within the 8 week timescales.

41. In answer to questions from Ms Powell, Dr M confirmed GW had been engaging more since her return in May 2021. Regarding restraint he agreed GW strongly objected to it being included in the treatment plans. Ms Powell took Dr M through GW's compliance with the MS treatment over the last 9 months, Dr M agreed with that but stated he had to take into account the fluctuation in GW's mental health. He agreed GW had matured which does help the risk reduce as it adds *'a layer of cognitive control',* and GW's attitude to her MS treatment was different from her other wound related treatment. He said it is the balance between control and responsibility that needs to be struck and it shifts over time. Whilst he acknowledged GW's compliance had improved, other changes (such as returning home) may impact on that. He agreed there was a low risk that GW may refuse the MS treatment, as she wants to have it. Whilst he accepted there was a window of opportunity to make an urgent application he was concerned how that would take the focus away, could impact on GW's mental health and the ability of the MS team to re-arrange appointments, although he accepted Professor C's team had been very good to date.

PW

42. PW has filed two statements. She described how the MS relapse had impacted on GW last year and gave details about her understanding of the sequence of events on 19 and 20 May 2021. She was able to produce the text message with Ms Roper's submissions that confirmed her oral evidence about GW's request to re-arrange the Tysabri appointment on 19 May. PW described the limitations in her current home for GW to get about in the home. Regarding any provision for restraint in the treatment plan, she said she is not opposed to it for life saving treatment and had not known GW refuse treatment in such circumstances. In relation to the MS treatment plan she does not support provision for restraint as it would have a negative impact on GW and she would lose control. She is more confident about compliance because of GW's experience in September and her better understanding of the consequences; GW has learned a *'very difficult lesson´* in relation to the need for this treatment. Her evidence in relation to the wound management treatment plan has been overtaken in part by the revisions to the plan made after the hearing. Ms David took PW through some of the medical records where GW had refused wound treatment, some PW was not aware of. She agreed there may be times when GW needs urgent treatment for her wound management but PW didn't accept in those circumstances GW would not accept it.

Dr G

43. Dr G is a Consultant Psychiatrist instructed by the Official Solicitor. He provided two reports and met with GW on 25 January 2021 in person at the Unit. His conclusion is that GW is suffering from an adjustment disorder with depressive symptoms, and an adjustment disorder with mixed disturbance of emotions and conduct. GW's depressive symptoms are uncontested and the disturbance of emotion and conduct self-evident. In his oral evidence, having had the opportunity to listen to most of the oral evidence, Dr G considered he did not sufficiently highlight the qualitative difference between GW's engagement with her MS treatment, as compared to that caused by her self-harming in his reports. He agreed with Dr M's evidence that GW had the ability to consent to being at the Unit. Dr G considered that GW had matured regarding her MS treatment and been through life altering experiences such that he felt *'minded to listen to GW and PW's voice'*. He considered, although finely balanced, that it was not in GW's best interests to include restraint in her MS treatment plan. He did not consider it would give an incentive to co-operate if it was included, due to the cost to GW's independence which would, in his view, be a greater risk for GW to be exposed to. Although he recognised he was not up to date with the clinical position, he did not consider the declaration sought would lend a hand and is more likely to give a sense of alienation, which could make things worse. He recognised the argument regarding clarity, but considers in the event of GW refusing her MS treatment the whole situation would be fraught, but in his view the balance of harm still tips in favour of not making the declaration.

44. His view was different regarding the wound management treatment plan as the risk would be immediate. He considers the wound management treatment plan made clear what the parameters are and, on balance, he would include the areas (active bleeding and washing out wounds) that GW has not refused before, due to the risks to GW, but acknowledged it was finely balanced.

MS treatment plan

45. MS is an inflammatory condition that is characterised by lesions in the brain and spinal cord. A feature of MS is that people with this condition experience relapses and each time that happens new areas of the brain are impacted, which can lead to increased disability and cognitive impairment. Without treatment the trajectory for GW involves both short and longer term consequences for her cognitive functioning, mobility, independence and life expectancy.

46. Following discussions with GW, her mother and Professor C and his team GW chose the Tysabri treatment. The current plan is for this treatment to be continued for six months, in light of the MRI scan in April 2021, with a formal review in January 2022. If GW continues on Tysabri after January, it would be reviewed again at the 2-year mark in April 2022 given the PML risk.

47. Tysabri is administered intravenously via a cannula, and therefore needs to be given in hospital. The infusion takes an hour, followed by an hour of observation. It must be given regularly (every 4 – 6 weeks). If the infusions are missed, and the intervals are greater than 8 weeks there is a serious risk of relapse.

48. This has been experienced by GW as she missed her Tysabri infusion in July 2020. As a consequence of that, she was admitted to hospital in September with an acute relapse presenting as falls due to weaknesses in both legs. GW was treated with intravenous steroids and had her overdue Tysabri infusion. A brain MRI scan revealed multiple new lesions.

49. The framework for the MS treatment plan is focussed around the Tysabri infusions and the support for GW in having that treatment. The treatment plan records the risks of missing an infusion as *'the risk of future attacks of her MS will increase and are likely to cause her further permanent neurological damage'.* The plan sets out the anxiolytic treatment that will be offered to GW if she appears anxious. The structure in the plan is if GW refuses to attend the hospital on her first arranged date or, if having attended, refuses the infusion or any part of it, a further appointment will be re-arranged within the timeframe (maximum of 8 weeks between infusions). The plan then sets out the detailed support that will be offered to facilitate GW attending the rearranged appointment. The plan provides '*Physical restraint will be considered only at the rearranged visit and then only in three scenarios'* and outlines those situations and what would be done. In the event that GW refuses to attend for her rearranged visit, the plan sets out that the hospital will arrange for transport and where no other support works for authorisation to use physical restraint to transfer GW to hospital.

50. In their closing submissions, the Trusts describe the final version of the proposed MS treatment plan submitted after the conclusion of the oral evidence seeking authorisation for the option of restraint (including on transfer to hospital) as '*an absolute last resort'* on the rearranged visit should GW refuse her infusions. They also submit as an alternative that the Official Solicitor is notified should restraint actually be used, so the Official Solicitor can decide whether there is a need for a further hearing.

51. The Trusts base their application on the history of GW's compliance with this treatment and the risks if the treatment is not given. The Trusts rely, in particular, on GW's refusal to attend for the transfusion in July 2020 and the communications with GW that followed, including an email to GW from the MS nurse on the date of a rearranged appointment stressing the importance of GW attending the appointment *'as it will be 8 weeks since the last treatment and you will have a high risk of rebound relapse if you don't have the treatment'.* Although GW attended the hospital for the rearranged visit she refused the infusion, despite a number of members of the MS clinical team and her Consultant Psychiatrist discussing matters with GW for a number of hours to try and persuade her to take the infusion. This failure to have the infusion in July resulted in her being admitted to hospital on 13 September and, after refusing the transfusion on 16 September, she accepted it the following day.

52. Since then GW has accepted the infusions, although the records refer to her possibly not having the full infusion on 30 October and refusing the cannula flush for an hour in early December. There was also an issue as to whether she refused an infusion on 19 May 2021. The evidence describes her having to attend hospital late the night before the 19 May appointment and reference to her having a temperature/feeling unwell. The records confirm the following day 20 May GW is recorded as having a temperature. It is accepted she attended the rearranged appointment on 28 May and had the infusion.

53. In his written and oral evidence Professor C describes in some detail how the MS team work, and the support and encouragement they have given to GW following her diagnosis and in supporting her treatment.

54. Dealing with the evidence about the infusions since September he accepted that although there is a note in the recording of the Unit records from the person who attended with GW for her infusion on 30 October that she pulled her cannula out part way through the infusion, the hospital records confirm GW received the full dose. He said he would expect to have been told if she hadn't or there were any problems on that date, and he wasn't notified of any difficulties.

55. In relation to the May 2021 infusion, GW was booked in to have it on 19 May 2021. Professor C accepted that his position about the need for restraint to be an option was based, in part, on what he understood to be a refusal by GW to have an infusion on that day. In oral evidence he acknowledged that if this had not been a straightforward refusal then that put a different picture on it.

56. PW explained in her evidence that GW had sent her a text in the early hours of 19 May to ask for the infusion to be moved to another day, as she had attended the hospital late the previous evening for a blood transfusion. In the closing submissions on behalf of PW, a copy of the text message was attached that she referred to in her evidence and it confirms GW's request.

57. In his oral evidence Professor C confirmed he was encouraged by GW's recent compliance but he remained concerned in the light of the longer history about whether the current compliance can be maintained.

Wound management treatment plan

58. The purpose of the wound treatment management plan is to provide a clear workable arrangement as to when GW can be sent urgently to hospital from the Unit, what steps can be taken in respect of offering GW treatment for her wounds (including blood transfusions), ensuring that her difficulties are understood and encouraging GW's compliance. The plan provides for the circumstances in which restraint is sought to be authorised, and how it should be administered.

59. The evidence sets out that urgent wound management can include possible treatment such as blood tests, vascular investigations, drainage of wound abscess, oral or IV antibiotics and blood or iron transfusions. In terms of planned treatment at hospital this would be for blood transfusions if GW's haemoglobin falls below certain levels but she is not actively bleeding, or blood or iron transfusions due to GW's anaemia. The day to day wound management mostly takes place at the Unit. It involves daily assessment of any open or healing wounds, daily monitoring of clinical parameters, photographs of wounds for specialist review and administration of medicines to support treatment.

60. As set out in the witness statements and oral evidence, if GW initially refuses any treatment the clinicians provide support in seeking to persuade and negotiate with GW to have the treatment, including giving her time to reflect and become less anxious. Only if this doesn't work is consideration then given to use of oral anxiolytics. As a last resort rapid tranquilisation is considered, which would be consultant led.

61. The oral evidence has helped clarify the circumstances in which the option of restraint is sought and the Trusts now seek authorisation for the use of restraint in the following circumstances set out in their revised plan, the relevant parts are set out below:[1]

*3.This plan sets the **threshold** for:*

- ***a.*** *GW requiring urgent treatment for her wounds in hospital as an emergency **without calling** call the Acute Physician in charge ("APIC") on the day or the Emergency Department Physician in Charge ("EPIC") overnight in order to discuss the transfer (see para 6);*
- ***b.*** *When the use of physical restraint is authorised (i) to administer that treatment to GW and (ii) to transport her to hospital.*

PRINCIPLES INFORMING THIS TREATMENT PLAN

4. The plan aims to maximise GW's participation as far as possible and obtaining her wishes and feelings, recognising this needs to be balanced against clinical urgency.

5. The least restrictive means are to be used wherever possible, persuasion and negotiation need to be used first to ensure compliance with treatment. Only if this is unsuccessful can consideration be given to rapid tranquilisation and as a very last resort, physical restraint, as long as this is proportionate to the risk in the circumstances detailed above. This will take the form of forcibly restraining GW with the minimum degree of force needed to achieve the intended therapeutic benefit and for the least time required.

CALL 999

*6. **For the Unit**, treatment for GW's wounds should be considered **urgent** and she should be sent to hospital as an emergency, if she is:*

- *a. properly symptomatic i.e. very short of breath, SBP <100 or HR consistently above 110. GW tolerates a low Hb because she is chronically anaemic; or,*
- *b. Has new self-harm wounds for which bleeding cannot be controlled; or,*
- *c. Her Hb is less than 50.*

7. Otherwise, and if in any doubt, the Unit should speak to the APIC on the day to discuss the need for transfusion, or the EPIC overnight, in order to discuss the transfer.

CIRCUMSTANCES IN WHICH PHYSICAL OR CHEMICAL RESTRAINT IS PERMITTED

*8. Only if GW refuses treatment, verbal encouragement has failed and oral anxiolytics (as detailed below at paragraph 17) have not been effective, then **physical and chemical restraint (in the form of rapid tranquilisation) is authorised to enable her to have treatment in the following circumstances:***

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[1] The wording in the treatment plans was revised by the parties, following receipt of, and in accordance with, the draft judgment.

> a. *Active bleeding from a self-harm wound – treatment would involve applying pressure and occasionally suturing to stop blood loss;*
> b. *Symptoms of heart failure as a consequence of low haemoglobin requiring same day treatment – shortness of breath, chest pain or a fast heart rate >120/min or very low blood pressure <80mmHg systolic. In this situation it is possible that 2 units of blood would be required for GW to be made safe. If GW already has a cannula in place in this situation, it may be necessary to use restraint to prevent her pulling a cannula out;*
> c. *Self-harm with chemicals or materials requiring immediate washout to prevent corrosive tissue damage;*
> d. *Sepsis (i.e. life threatening systemic infection) from wound contamination requiring urgent IV antibiotics and fluids;*
> e. *Severe cellulitis with complications or at risk of complications requiring urgent intravenous transfusion of antibiotics.*
> f. *Below 50 Hb.*
>
> 9. *Only if verbal encouragement has failed and GW has refused oral anxiolytics (as detailed below at paragraph 17), physical restraint or chemical restraint (namely rapid tranquilisation) is also permitted in the following circumstances:*
>   a. ***For physical wound care** only if:*
>   i. *it is not possible, based upon GW's clinical presentation alone, to delay the physical care of her wounds AND*
>   ii. *oral anxiolytics have not been effective.*
>   b. ***Transfer:** She meets the criteria for urgent treatment above and she is refusing to be transferred to hospital.*
>
> 10. *A short period of restraint to administer sedation may be less restrictive than prolonged physical restraint.*
>
> 11. *If the physical restraint is only used for a brief period of time, then it will be undertaken by acute hospital or CPFT. The use of physical force will be the minimum needed to achieve the therapeutic purpose required, for example, safe holds, and will be a last resort.*
>
> 12. *If, however, GW is actively resisting and putting nurses at risk of injury, then security (trained in PMVA) will be called to allow for the clinically indicated necessary treatment to be undertaken.*

62. The Trusts say this plan provides the right balance of when restraint can be used. Without it GW's treating clinicians will not be able to take the necessary steps. The Trusts say the restraint now proposed is proportionate to the high risks involved in each of these scenarios, relying on the evidence of Dr H and Dr C, in particular. The Trusts submit in these situations there would be insufficient time for an application to be made to the court.

63. Whilst not detracting from the seriousness of the scenarios outlined PW remains concerned about the lack of clarity in the plan for the reasons outlined below, when Ms Roper's closing submissions are considered.

64. This plan has the support of the Official Solicitor, on behalf of GW, due to the level of risks involved and the concern about the lack of recognition by GW of the magnitude of the risks involved, which contrasts with GW's position regarding her MS treatment.

Legal framework

65. The parties have helpfully collaborated and prepared a joint document setting out the agreed relevant legal framework. I only need highlight the salient points.

66. There is no issue that this application falls within the parameters of the Serious Medical Treatment Guidance [2020] EWCOP 2 which states at paragraph 12 *"an application to court may also be required where the proposed procedure or treatment is to be carried out using a degree of force to restrain the person concerned and the restraint may go beyond the parameters set out in sections 5 and 6 Mental Capacity Act 2005. In such a case, the restraint will amount to a deprivation of the person's liberty and thus constitute a deprivation of liberty. The authority of the court will be required to make this deprivation of liberty lawful."*

67. Whilst the proceedings were commenced in the Court of Protection it was agreed the circumstances of this particular case made it more appropriate to consider under the inherent jurisdiction and section 8 Children Act 1989. As a consequence a transfer was made pursuant to article 2 of The Mental Capacity Act 2005 (Transfer of Proceedings) Order 2007. Under the inherent jurisdiction the High Court has the power to determine the case regardless of whether GW had the mental capacity to decide to consent or to refuse treatment. It would therefore be unnecessary to reach a conclusion as to her capacity.

68. The principal authority in respect of medical treatment in children and young people is *In re W (A Minor) (Medical Treatment: Courts Jurisdiction)* [1993] Fam 64. The decision of Sir James Munby in *Re X (no 2)* [2021] 4 WLR 11 confirms that this remains good law and governs the principles to be adopted in the exercise of the High Court's inherent jurisdiction relating to those under 18.

69. As to the principles that should govern the court's exercise of this jurisdiction, Nolan LJ stated in *Re W* as follows (page 93):

> *"In my judgment, those principles are to be found in section 1 of the Children Act 1989. The child's welfare is to be the paramount consideration: see section 1(1). In giving effect to that consideration, the court is to have particular regard to the factors set out in section 1(3). This subsection … requires the court to have regard in particular to: (a) the ascertainable wishes and feelings of the child concerned (considered in the light of his age and understanding); (b) his physical, emotional and educational needs; (c) the likely effect on him of any change in his circumstances; (d) his age, sex, background and any characteristics of his which the court considers relevant; (e) any harm which he has suffered or is at risk of suffering; (f) how capable each of his parents, and any other person in relation to whom the court considers the question to be relevant, is of meeting his needs; and (g) the range of powers available to the court.*
>
> *"In other words, in the circumstances of the present case the wishes and feelings of W, considered in the light of her age and understanding, are the first of the factors to which the court must have regard, but the court must have regard also to such of the other factors as may be relevant when discharging its overall responsibility for W's welfare."*

70. To this extent, the principles are therefore identical to those set out in the welfare checklist at section 1(3) Children Act 1989.

71. In *Re X (no 2)*, Sir James Munby stated that both statute (CA 1989 and MCA 2005) and the inherent jurisdiction require the Court to pay *'great attention'* to the wishes of a child *'old enough to be able to express sensible views, even if not old enough to take a mature decision'* [22], which he described as a *'profoundly important principle'* [23]. The weight to be attached to such wishes and feelings is '*both case-specific and fact-specific'* [24]. Sir James also considered that the *'possible impact on P of knowledge that her wishes and feelings are not being given effect to'* is a particularly important part of the welfare analysis of best interests [25].

72. Those wishes can, it is accepted, be overridden where following the minor's wishes would "*in all probability lead to the death of the child or to severe permanent injury":* per Balcombe LJ in *re W* at p 88.

73. The authorities are agreed that there is a strong presumption that it is in a person's best interest to stay alive: *Aintree University Hospitals NHS Foundation Trust v James* [2014] A.C 491 [24]. As to the human rights of a young person aged 17½, Baker J (as he then was) in *An NHS Foundation Hospital v P* [2014] EWHC 1650 (Fam), [2014] Fam Law 1249, observed (at paras [15]):

> "*In this case, balancing the competing factors, I have no hesitation in concluding that the balance comes down firmly in favour of overriding P's wishes. I recognise that this is not to be taken lightly. The wishes of a young person aged seventeen and a half are important. They are, of course, entitled to be taken into account as part of her Article 8 rights under ECHR. On the other hand, those rights are not absolute. Here, they are outweighed by her rights under Article 2 – everyone's right to life shall be protected by law. The court is under a positive or operational duty arising from Article 2 to take preventative measures to protect an individual whose life is at risk: Osman v UK (1998) 29 EHRR 245: […]*

74. In *Re X (no 2)*, Sir James Munby considered that as to an interference with a young person's Article 8 rights, it is a legitimate aim to preserve the lives of children until adulthood [134].

75. Whilst the court is generally reluctant to rule on future or hypothetical questions it will do in an appropriate case (see *Re X [15]*, although in *Re X* the court declined to do so on the facts of that case [167] – [169]).

Submissions

76. The Trusts submit in relation to the MS treatment plan whilst they recognise the recent compliance by GW, she is also known to act compulsively and impulsively and whilst she might agree to treatment there is also a significant risk she will change her mind at the last minute.

77. Ms David submits PW is overoptimistic and unrealistic to suggest GW won't refuse again. Ms David relies on the events of 19 May to demonstrate the risks that are still present. She submits the Trusts record the 19 May as a refusal by GW to attend her

appointment, she accepts the rearranged one on 21 May could not take place due to GW's temperature and accepts GW had the treatment on 28 May. As Ms David describes *'..the events on 19 May 2021 demonstrate the real risk that GW will refuse (even if not actively) further infusions, whether that is because she is tired due to late night transfusions, her MS fatigue or as a result of her depressive state of mind – these points all inform the risk that she will refuse again and miss the critical window for her infusion…'*

78. Ms David submits Dr G's views are limited to his expertise and need to be considered in the context that he met GW once in January 2021, and has not spoken to her since. He recognised in his oral evidence that it was not known what the impact of the court order would be on GW, as there had been no such previous order.

79. Ms David submits the MS treatment plan, including provision for restraint is in GW's best interest as this is the treatment GW chose, there is a limited timeframe for it to be given and there are very real consequences for GW's health if she does not have this treatment. Professor C in his evidence demonstrated the reluctance of his team to use restraint, but he remained supportive of it being included. GW's attitude to the treatment is closely linked to her mental presentation, in particular her depressive state which means she gives little significance to herself. She draws a distinction between the option and use of restraint, submitting that the option of restraint *'might provide a protective framework for GW in which she can take responsibility for her treatment and could provide a more effective therapeutic relationship'*. She submits if there is a clear plan then there will be the benefits that clarity will bring, together with a significantly reduced risk of matters escalating to require its use. Finally, she submits the court needs to factor in the risks that the hospital may not be able to arrange an appointment for GW within the necessary timeframe, due to the demands on the department.

80. Ms David submits the risks of refusal and the severe consequences of the risk of not having the treatment in the timeframes mean that the MS treatment plan, including provision for restraint, is necessary to protect GW's best interests.

81. If the application is refused and the Trusts are left with the option of making an urgent application this has risks as to whether the Trusts should make that application prior to any rearranged appointment, or wait until after that, when the timeframes may be more difficult with increased risks for GW. Dr M considered there was little difference between this application being granted and the prospect of an urgent application, which could increase GW's anxiety. The Trusts would be concerned that such an application would take away the focus from GW's mental health at a time when she is refusing the treatment. In addition, an urgent application is contrary to GW's best interests as it would undermine the rationale of the treatment plan to have a clear framework for GW and her treating team, not having this provision is more likely to increase GW's anxiety.

82. In turning to the wound management treatment plan Ms David places reliance on the evidence of Dr H and Dr C. Each of the situations outlined in paragraphs 8 and 9 the risks for GW of serious harm, or death are high and the situation can escalate very quickly. Whilst Ms David recognises some of the situations outlined have not yet arisen, due to the history of GW's wounds and the circumstances in which they arise, and the level of harm GW would be at risk of, the balance comes down in favour of them being provided for in the plan.

83. The circumstances outlined relate to urgent and immediately life-saving treatment and, as a result, the plan provides for restraint in circumstances where it is necessary and proportionate.

84. With the prospect of discharge on the horizon, Ms David submits PW's view about what lays ahead for GW is unrealistic. Dr M was clear in his oral evidence that discharge can be unsettling in itself due to the inevitable changes that will result. GW wanted to return to the Unit following a period at home in May, and there are logistical difficulties in PW's current home for GW to be able to have effective access in the property.

85. In her closing submissions on behalf of PW, Ms Roper does not support the inclusion of the restraint option in the MS treatment plan, as it is not in GW's best interests and deprives GW of her autonomy. The current plan, she submits, is in any event unworkable in the community.

86. Ms Roper submits the evidence does not establish the inclusion of restraint for MS treatment is necessary. She relies on the evidence about the refusal in July 2020, the consequences of that with the hospital admission in September and the events that have taken place since. She submits this demonstrates a change in GW's attitude about this treatment and has better informed GW about the consequences of not having the treatment. She states Dr M recognised in oral evidence that the severity of the position may not have been appreciated by the psychiatric team or GW in July or the importance of the timescales, whereas it is now. That view was echoed in PW's evidence.

87. Ms Roper relies on the evidence that demonstrates the impact on GW of the relapse in September, what GW experienced and the consequences it has had on her. She relies on what GW has said to her solicitor in January and in her email to me on 7 June, when she stated *'I realise the consequences of refusing my ms treatment. I was absolutely humiliated in September. I had every bit of dignity stripped from me, and am still suffering with the consequences'.* This was supported by PW's evidence and Dr G's evidence about GW's increasing maturity.

88. This change is reflected in the compliance with the MS appointments since September, which Ms Roper submits demonstrate GW's recognition of the need for this treatment to continue. She submits the evidence now available about the events in May 2021 demonstrate that GW asked for the appointment to be deferred, PW made that request, the records demonstrate an appointment was offered on 21 May but that GW had a temperature on 20 May. The appointment was then booked for 28 May, which GW attended. Ms Roper submits there is a distinction between GW's position regarding her MS treatment and other treatment.

89. Consequently, she submits, the risk of GW not accepting her treatment is *'vanishingly low'*, GW does not want provision for restraint included and PW considers it would take away GW's sense of control, that she has responsibility for herself, if it was. It would risk GW's relationship with her treating team and whilst acknowledging it would ensure GW received her treatment there is no, what Ms Roper describes as, *'collateral benefit'* as PW, supported by Dr G, does not consider its inclusion would incentivise GW to co-operate as it risks increasing her sense of alienation. There is uncertainty about what would amount to a refusal and when an appointment would be a rearranged

appointment as the events in May 2021 demonstrated. There would be time, if required, to make an urgent application to the court.

90. Ms Roper takes issue with the wound management treatment plan, stating that it remains unclear in certain respects and without sufficient clarity risks GW becoming more distressed. The consequences of restraint in the past have resulted in a set-back in GW's ability to cooperate with those treating her. PW fears without the required clarity, it will hinder her cooperation rather than promote it. Ms Roper submits that in order to justify the inclusion of restraint to treat GW in any defined situation there must be a finding, with an evidential foundation, that there is a real risk of it arising and the risk must be such to justify the measures proposed to manage it.

91. Ms Roper submits PW accepts that if GW's self-harming wounds create a life-threatening situation, all other options including oral anxiolytics have been tried, and GW is still refusing to accept treatment, everything should be done to provide it, including minimal and proportionate restraint.

92. She submits that active bleeding or wound washout or the situation set out in paragraph 9 (a) regarding physical wound care should not be included in the plan, as they have never arisen and are not necessarily life threatening. Ms Roper submits there are alternatives if the court does not include these matters as they would be covered if those circumstances arise and a proportionate response meets the provisions in sections 5, 6 and 4B MCA 2005. Dr H in her evidence confirmed the use of restraint in life threatening situations, which is the necessary and proportionate restraint that is permitted under section 6 MCA 2005 if the criteria are met.

93. Ms Roper submits PW takes issue with paragraphs 8 (a) and (c) and 9 (a) of the wound management treatment plan. In relation to active bleeding, the definition is too wide, it has not arisen as an issue to date and there are alternatives in case of emergency. As regards harm through chemicals she makes the same points as to active bleeding. The situation has simply not arisen. Turning to paragraph 9 (a) Ms Roper states the purpose is unclear, it is not supported by the evidence of Dr M who described GW as *'generally compliant'* and there has been no explanation as to why it has been included and was not explored in the oral evidence. If it is to cover events not included in paragraph 8 it will leave much to the discretion of a wide range of people and risks being used as a 'catch all' provision to justify restraint in circumstances that were not properly considered by the court.

94. As regards the provision in paragraph 9 (b) regarding restraint to transfer, Ms Roper submits it is unclear when it would come into operation and by whom. Would it include, for example, ambulance staff and is there any requirement for PMVA (Prevention and Management of Violence Aggression) training. Also, it remains unclear whether it is limited to paragraph 9 (a) or includes situations in paragraphs 6 and 8, as well. Without the necessary clarity being provided this provision, submits Ms Roper, should not be included. PW accepts in principle that restraint to transfer is justified in the situations described in paragraph 6 and paragraph 8 (with the exception of (a) and (c)) but there would need to be clarification if it is to apply to the staff at the Unit in relation to (d) and (e); they are not qualified to identify whether GW is suffering from sepsis or cellulitis in the way described, who would be doing the restraining and what information those people would have about GW and what training they would have.

95. The Official Solicitor, on behalf of GW, confirms there is no issue about the treatment GW needs for her MS, or that the deterioration GW suffered in September 2020 was attributable to the substantial delay in the administration of Tysabri following her refusal to have the treatment in July.

96. Ms Powell sets out GW has stated clearly she wants to have the Tysabri infusions and she intends to have them. This is borne out by what GW has said; for example to her solicitor when they spoke on 7 January 2021 when she described the consequences of not having the treatment and she *'fully acknowledged without prompting that she is now reliant on a wheelchair to mobilise because she has previously refused treatment…she was quite clear that this is her belief and understanding and the motivation for her to continue with the treatment going forward'*.

97. Ms Powell submits the evidence supports the conclusion that GW knows and understands the importance of receiving the Tysabri treatment within the 8 week time limit, she recognises the consequences if she doesn't because she has experienced the consequences of that in September and has described feeling humiliated by the loss of dignity, as a result of her physical deterioration and did not want to experience that again. GW has put that into practice since September by accepting her Tysabri infusions since then. Any reliance on the events surrounding the infusions on 30 October, 3 December and 19 May does not stand up to close scrutiny and no reliance should be placed on them as justifying a contention that restraint should be authorised to compel GW to receive this treatment. She submits Professor C acknowledged in his evidence that a request for a deferral, or for an appointment to be re-arranged due to GW not feeling well should be accommodated. If that is right it is difficult to see how those requests can be relied upon to support the Trust's application.

98. The risks of future refusal by GW if based on her past refusals need to be looked at in the wider context. The refusals prior to July 2020 need to be looked at in the light of GW's circumstances then, her experience and actions since September and her increasing maturity. Ms Powell describes the risk of GW refusing her Tysabri infusions as *'now very low'*.

99. As regards the consequences if that risk did eventuate, Ms Powell recognises they could be severe but not, she submits, immediate as there is a two week window and there would be time, if required, for an urgent application. Such an application is, she submits, both practicable and preferable to authorising restraint on a hypothetical basis that GW may at some point in the next few months, contrary to the settled expression of her views, refuse to undergo treatment. Ms Powell submits there is a clear risk that if restraint is authorised in the event of a refusal to have the MS treatment, this will have a negative impact on GW. Whilst she recognises the view of Dr M that there may be benefits from the relative certainty from restraint being authorised, that had to be balanced with Dr G's view, as expressed in his evidence, that he did not consider it would help GW co-operate and may risk further alienation. This has to be considered with GW's views, and whilst her capacity/competence is not in issue in this application, she is entitled to some respect for her autonomy. GW has decided to accept this treatment, it is her decision and if the application is granted it could be viewed as treatment to be imposed on her regardless of her own decision. To grant the application would as Hayden J observed in *University Hospital Coventry and Warwickshire NHS Trust v K* [2020] EWCOP 37 '*compromise her dignity and be inimical to her best interests'*.

100. Ms Powell considers the current MS plan is unworkable more generally, as it remains unclear how it would operate in the community and joining the CCG would not necessarily result in such issues being resolved without further delay. The application should be refused and a further version of the MS treatment plan should be resubmitted for approval omitting references to restraint and related issues.

101. Turning to the wound management treatment plan Ms Powell submits this is different as GW is at significant risk in the situations described of suffering a sudden, serious deterioration in her condition. Ms Powell states it is doubtful GW fully understands the level of risk she is at in these situations. It is recognised there are some aspects that have either not yet arisen or where, to date, GW has not previously refused (such as treatment for active bleeding or washout of wounds) but it is considered artificial to separate these out.

102. Ms Powell recognises the evidence that demonstrates a deterioration in GW's behaviour following the recent incident of restraint on 24 May, however she submits this has to be looked at in the context of the level of risk. The evidence demonstrates that the current risk of GW refusing necessary treatment for her self-harm wounds is high. As she submits *'the reality is that, by reason of her self-harm, GW is at physical risk in a number of ways, all of which are capable of leading to a clinical emergency when there could well be insufficient time to make an urgent application to the Court to authorise use of restraint and provision of treatment, and where GW's understanding of the risks of refusing treatment is far from clear, in part, at least, probably because the risks are more complex to assess…and because they have not yet materialised, leading to a false sense of security.'*

103. The situation is made more complex as it is likely that GW has self-harmed because she is distressed and, as Dr G explained in his first report, GW is unable to weigh the information about the treatment of her wounds and injuries in such acutely challenging circumstances. In addition, the evidence demonstrates that GW's repeated refusal of blood transfusions means that her long term low haemoglobin level is potentially putting a strain on her heart and kidneys, thereby increasing risk of organ failure.

104. In supporting the plan being approved, the Official Solicitor refers to situations being included where they are clinically *necessary*.

105. Ms Powell submits that the Trusts should be required to notify the Official Solicitor of any occasions on which physical or chemical restraint are used.

Discussion and decision

106. There can be little doubt that GW has had to, and is managing a dynamic and difficult situation caused by her complex mental health position, as well as her MS diagnosis and treatment. The history has demonstrated that she has, at times, become overwhelmed by what she has to deal with. The consequences of her actions have meant she has required intensive support and treatment for a number of years, not only from the mental health services but also the medical clinicians who have needed to treat her.

107. GW attended each day of the hearing, supported by someone from the Unit. She is to be commended for doing so and it demonstrates her wish to understand decisions that are being made about her, and why. I have no doubt she would have found some of the

evidence difficult and the court was able to have breaks when requested by Ms Powell. The fact that GW was able to do this perhaps reflects GW's increased maturity that was referred to in the evidence. I have read with great care the email from GW that was sent to the court on 7 June, as well as the notes of her meetings with her solicitor. In each of those documents GW is able to articulate her position powerfully and what she says has been very carefully weighed in the balance when reaching the court's decision. GW is opposed to any provision for restraint being in either of the treatment plans.

108. GW has been supported throughout by her mother, PW, who also attended the hearing and gave oral evidence.

109. It is clear from the evidence the court has read and heard that whilst GW has at times found it challenging, she has been supported by a dedicated team of professionals who have sought to support her to manage the difficulties she has faced and helped her to navigate them. It is right that, at times, GW has found this very challenging and, at times, overwhelming.

110. The legal framework the court is considering in this application is set out above. Essentially the court is required to assess the evidence and balance the competing considerations and reach a decision whether the declarations sought by the Trust are in GW's best interests.

111. The Trust were right to bring this application, as it has enabled the parties and the court to consider the issues raised and reflect on the evidence that has been given. Whilst they are right to do so, that does not mean that the court should be tempted to depart from the rigour required to undertake the best interests analysis to underpin its decision.

112. Looking at the MS treatment plan first. It is right that since her diagnosis GW has been involved in decisions about her treatment. In consultation with Professor C and his team she decided to proceed with the Tysabri treatment, even though it would be administered by infusions and require attendance at hospital. As Professor C observed in December 2019 when discussing the MS treatment options, GW *'understood it brilliantly…better than most adults'*. The Trust, through the evidence of Dr M and Professor C, base their position on the history of GW's compliance with this treatment, the comparative risks of both compliance in the future and the consequences of not having the treatment and the advantages of clarity a plan would give.

113. Both PW and the Official Solicitor, on behalf of GW, submit that on closer analysis the history of compliance is not as set out by the Trust, they have not given sufficient weight to GW's increased maturity on this issue, the advantages of her autonomy being respected and the fact that there is an opportunity for an urgent application to be made, if required.

114. Having considered the evidence and the written and oral submissions of the parties I have reached the conclusion that the provision for restraint in the proposed MS treatment plan is not in GW's best interests and it should be re-submitted with those parts removed.

115. I have reached that conclusion for the following reasons:

(1) The evidence demonstrates that GW has complied with her Tysabri infusions since September. Whilst there has been some anxiety around the treatment, that has been managed by the clinical team. The hospital evidence demonstrates that on 30 October the infusion was completed, as Professor C observed he would have been informed of any difficulties, and he wasn't. On 3 December GW allowed the infusion to be completed after further discussion. In relation to May 2021 I am satisfied, having regard to the text from GW to PW, and her evidence about discussions with the Unit this was a request for a deferral, rather than a refusal and the treatment took place on 28 May. Professor C's position was, in part, influenced by the way the Trust portrayed events in May and he recognised that if that was not the case that put a different picture on the position.

(2) It is right there is evidence that GW can act compulsively and impulsively however I accept the evidence about GW's increased maturity in relation to this issue, coupled with her recognition from her own experience in September of what the consequences of not having the MS treatment would be. Whilst I have considered the difficulties caused by GW's underlying mental health, GW has made clear on a number of occasions that she now understands the consequences. In her email to the court she eloquently describes the impact this had on her; the consequences of her not having the treatment are a living reality for her which has been demonstrated by her continued compliance with the treatment over an extended period of time.

(3) The evidence from Dr M and Professor C, as well as PW, suggested that the need for the treatment to take place in the timeframes described was perhaps not fully appreciated in July/August 2020. It is now.

(4) Whilst I understand the point about the clarity a plan would give that is to a large extent unknown. What is known is that this is a treatment GW wants to have, she has complied with it for a period of time and has first-hand knowledge of the consequences if she doesn't have it.

(5) Whilst the court can't rule out the risk of GW refusing to have this treatment, I share the view of the Official Solicitor that it is now very low. The evidence is accepted that if this risk did manifest itself the consequences would be serious but there is a two week window when, if required, an urgent application to the court could be made. It is recognised that there are risks with that course in that it could increase the anxiety for GW and could risk delays in appointments being fixed at the hospital, however I am satisfied when balancing the risks that an urgent application could be convened at short notice, with the benefit of the knowledge from this hearing, this judgment and the evidence to date has shown that the hospital have been effective in managing re-arranged appointments.

(6) I do not consider these factors tip the balance in favour of the application being granted which is effectively authorising restraint on a hypothetical basis that, as Ms Powell describes, GW may *'at some point in the next few months, contrary to the settled expression of her views, refuse to undergo treatment'*. Such an outcome would deprive GW of her autonomy in relation to this issue which, when considered in the wider context would not accord with her best interests.

116. Turning to the issue of the wound management treatment plan. This has a different evidential background due to the long history of GW's self-harming behaviour and the number of occasions when GW has resisted treatment.

117. There is some agreement between the parties as to the need for this plan, to try and bring about some clarity in often difficult situations.

118. The issues between the parties centre on whether occasions that have not yet arisen should be included or where there has been no history of refusal. PW's concern, in particular, is the risk of an unclear plan being implemented contrary to GW's best interests, bearing in mind the risk of a deterioration in her behaviour, as was experienced in May.

119. Having considered the evidence and the submissions of the parties I have reached the conclusion, subject to the observations in (7) below, that the wound management treatment plan should be approved for the following reasons:

(1) The situations provided for in paragraph 6 and 8 of the plan are situations where there is likely to be limited time to make any application to the court due to the high risks to GW's health caused by those situations.

(2) Whilst it is right that some of the scenarios in paragraph 8 have not been encountered to date the evidence has demonstrated that if they did arise and GW refused treatment the consequences to GW's health would be very serious.

(3) Taking the evidence as a whole regarding wound management treatment there have been repeated occasions when GW has refused treatment and I agree with the assessment of the Official Solicitor that it is likely GW does not understand the magnitude of the risks to which she is exposed by her refusal to accept treatment related to her wounds. She appears to have an ambivalent attitude to the need for treatment, when an objective analysis of the clinical picture points in the opposite direction of the need for the treatment to be administered in her best interests.

(4) Whilst it is recognised that some aspects of the treatment in paragraph 8 of the plan GW have not previously been refused, I agree it would be artificial to separate out different aspects of the treatment for her self harm injuries and her low Hb levels. I agree with the analysis Ms Powell put in her closing submissions *'The reality is that, by reason of her self-harm, GW is at physical risk in a number of different ways, all of which are capable of leading to a clinical emergency when there could well be insufficient time to make an urgent application to the Court to authorise the use of restraint and provision of treatment, and where GW's understanding of the risks of refusing treatment is far from clear, in part, at least, probably because the risks are more complex to assess and understand than the risks in relation to the delayed Tysabri infusions, and because they have not yet materialised, leading to a false sense of security'.*

(5) Whilst it is right the evidence has demonstrated a connection between the use of restraint and a deterioration in GW's condition or her therapeutic

relationship with staff and GW's wishes are that she does not want provision for restraint included, however, the evidence shows the current risk of GW refusing necessary treatment for her self-harm wounds and injuries is high, as demonstrated by the repeated occasions in the records when she has done so.

(6) It is very likely that when GW self-harms that she has done so because she is distressed and as Dr G set out in his first report in such circumstances GW is unable to effectively weigh the information about the treatment in such difficult circumstances.

(7) I agree with Ms Roper there needs to be further clarity about certain aspects of the proposed plan, namely: (i) Paragraphs 8 (a) and (c): the concern expressed about lack of clarity could be resolved by including the Official Solicitor's suggestion of such treatment being clinically *necessary;* (ii) How the Unit staff are to identify the conditions in paragraphs 8 (d) and (e); (iii) further clarity about who would be doing the restraining and what training they have; (iv) clarity about what paragraph 9 (b) refers to, just paragraph 9 (a), or paragraphs 6 and/or 8 as well.

(8) The provision for the Official Solicitor to be notified of any occasion on which physical or chemical restraint are used provides a proportionate safeguard.

(9) It would not be in GW's best interests to leave the Trusts to rely on statutory defences under ss 5 and 6 MCA 2005, or the common law of necessity, which would provide less clarity and more uncertainty than the proposed wound management treatment plan.

120. The court invites the parties to liaise and submit revised treatment plans together with a draft order for approval.