

**THE HIGH COURT**

[2021] IEHC 836

**High Court Ref. WOC10345**

**WARDS OF COURT  
IN THE MATTER OF A  
HEALTH SERVICE EXECUTIVE**

**APPLICANT**

**- AND-  
MS. A**

**A WARD OF COURT**

**JUDGMENT OF Ms. Justice Niamh Hyland delivered on 20 December 2021**

**Summary**

1. Ms. A is aged 44. Unfortunately, Ms. A has suffered from severe treatment resistant anorexia nervosa for over 25 years. Ms. A is married, and her husband has clearly been an enormous support to her throughout the course of her long and intractable illness.
2. Because of the very serious risks posed by this illness, Ms. A was made a ward of court on 29 January 2020. Pursuant to the wardship jurisdiction, she has been treated on a coercive basis, including involuntary admission to both a psychiatric unit in Ireland and a specialist hospital for the treatment of anorexia in the UK. I heard Ms. A give evidence on three different occasions. On each occasion, I was impressed by her fierce determination and keen intelligence, and the strength of personality she displayed.
3. For the reasons I explain below, I am making the Orders sought by the HSE, which will have the effect that her treating team will no longer provide treatment to her on a coercive basis. Given Ms. A's extremely fragile state of health, this may well result in her early death from anorexia. However, having carefully considered the best interests test, I consider these Orders are in her best interests.
4. I should add that despite Ms. A's history to date, I am hopeful that following the making of these Orders, Ms. A may agree to follow the advice of her medical team, and thus maximise her chances of avoiding premature death.

**History and Background**

5. Ms. A has attended local mental health services and Hospital X over the past decade for the management of her eating disorder, although her history of disordered eating in fact goes back 25 years. Between 2011 and 2019 her admissions to hospital were typically prompted by severe emaciation and acute medical concerns. During those admissions Ms. A complied only partially with recommended care (including meal plans and bed rest) until her weight and medical status were sufficiently stable to allow her to be discharged or for her to discharge herself from hospital against medical advice.

**Worsening of Medical Condition**

6. On 2 November 2019, Ms. A was admitted to Hospital X as an acute medical inpatient following her presentation with collapse, hyponatremia and hypoglycaemia secondary to malnutrition. Following her admission, she complied only variably with medical recommendations for re-feeding and physical activity restriction and refused food and naso-gastric re-feeding ("NG feeding") while requesting to leave the hospital.

7. On 19 November 2019 Ms. A's treating consultant psychiatrist, Doctor B, wrote a report seeking an endorsement by the High Court to allow for the delivery of necessary acute medical care and NG feeding to Ms. A. The report noted the extensive history of her condition and stated that her compliance with her recommended care had deteriorated despite the best efforts of the multidisciplinary team ("MDT") in the acute hospital and the daily support of her husband. The report noted that she continued to exercise against advice, she refused or delayed feeding to the extent that her cumulative weekly caloric intake was well below optimal calorie requirements and that she refused oral supplements and offers of anxiolytic medication to facilitate refeeding.
8. In those circumstances, in the opinion of her MDT, re-feeding and acute inpatient care was in her best interests. In the opinion of Doctor B, Ms. A lacked the capacity to refuse re-feeding as, because of her severe anorexia nervosa, she was unable to use and weigh the information necessary to make the decision. The MDT further indicated that once Ms. A was medically stabilised they intended for her to be transferred to an inpatient mental health care facility, possibly a specialist inpatient eating disorder treatment unit in the UK.
9. On 10 December 2019 Doctor B reported that Ms. A had stabilised somewhat with acute inpatient care and NG feeding but she remained severely underweight with a BMI of 11.8 and an ongoing medical need for re-feeding and further weight gain. He reported that her compliance with feeding and exercise recommendations remained sub-optimal and that she had requested to discontinue feeding and to leave the hospital on multiple occasions but had been persuaded to stay. It was confirmed that no facility in Ireland could meet Ms. A's needs.

#### **Invocation of Wardship Jurisdiction**

10. On 12 December 2019 Kelly P. appointed a guardian *ad litem* to Ms. A and ordered that a medical visitor's report be prepared. On 17 December 2019 it was further ordered that Ms. A's treating medical and nursing staff could detain her for the purposes of medical and psychiatric assessment and treatment. The Order also permitted the use of reasonable force and restraint to enable that assessment and treatment.
11. On 21 January 2020 Doctor B reported that Ms. A continued to stabilise and gain weight but remained significantly underweight and required a continuation of treatment. She had refused NG feeding once but agreed to recommence it subsequently and continued variable compliance with exercise recommendations. She was reviewed by a specialist consultant psychiatrist, Doctor C, from Hospital Y in the UK on 7 January 2020 and was accepted for transfer. Doctor B noted that Ms. A had expressed that she did not wish to be treated at such a facility, but Doctor B reported that in his opinion Ms. A continued to lack capacity and requested an endorsement for continued treatment and to allow for her transfer to the specialist unit in the UK.

#### **Treatment in the UK.**

12. In January 2020 Kelly P. ordered that Ms. A be made a ward of court. He made a separate Order requiring that she be detained at Hospital Y, for the purposes of her treatment and assessment in terms similar to those set out above, including permission

to employ NG feeding and to use reasonable force and restraints. On 4 February 2020 the Court of Protection of England and Wales recognised and made legally enforceable the placement Order of the High Court in that jurisdiction. On 17 February 2020 Ms. A was transferred to Hospital Y.

13. Doctor C provided an update on Ms. A's progress on 4 May 2020 stating that she had engaged well with treatment and that the specialist unit was encouraged by this and proposed to continue her treatment. Doctor C reported that the severity of Ms. A's condition was such that he expected she would need to remain in treatment for some time. On 1 July 2020 Doctor B reported that following a meeting of the MDT it was agreed that a further period of treatment would be required to allow Ms. A to attain the skills to maintain her weight in the community. On 12 August 2020 Irvine P. continued the placement Order.
14. On 9 September 2020 Doctor C reported that Ms. A was maintaining an increased weight and was tolerating a negotiated meal plan but had not yet consolidated a meal plan that she could confidently continue at home. Doctor C recommended that Ms. A's stay continue, to consolidate her increased weight and to gradually hand over responsibility to Ms. A for her meals and exercise and to allow for a trial period at home with her husband. Additionally, it would allow for the winding down of psychological treatment in the UK and to dovetail that with the start of cognate therapy in her locality. Doctor C further recommended that post-discharge, Ms. A's treatment could proceed on an outpatient basis but that this should continue within the boundary of a court Order given the fragility of her recovery, and in those circumstances stated that if Ms. A was unable to observe the conditions of treatment on an outpatient basis then early admission to a psychiatric facility should be considered.

#### **Return to Ireland**

15. On 15 September 2020, a comprehensive community treatment Order and follow up plan to manage Ms. A's condition on her return home was identified. On 25 September 2020 Heslin J. ordered that the placement continue but further ordered that upon the agreement of both Doctor C and Doctor B, Ms. A could be discharged to her home and permitted assessment and treatment in the community with provision for her admission to, and if necessary detention in, hospital should it be deemed necessary. Such detention could include coercive NG feeding.
16. On 20 November 2020 Doctor D, a consultant psychiatrist treating Ms. A reported that the transfer process was uneventful and that following an MDT meeting it seemed that Ms. A was willing, albeit slightly despondently, to engage in treatment.
17. On 8 December 2020 the matter came before me and I made an Order directing Ms. A continue living at home. The substance of the procedure established by Heslin J. was retained with the addendum that if she was admitted on a coercive basis to hospital, her clinicians were not permitted to use force to administer NG feeding but if same was considered medically appropriate, the matter could be returned to Court for further

consideration. That modification was introduced following submissions made on behalf of Ms. A indicating her very strong opposition to any form of coerced NG treatment.

18. On 17 February 2021, Doctor E, a community-based consultant psychiatrist treating Ms. A, provided a report on her ongoing care. He noted that she had lost weight and was now below the BMI at which it was agreed she would be discharged from Hospital Y. The MDT reported mostly positive engagement with occupational therapy, family therapy and psychiatry but noted that she continued to struggle with her diet plan, having moved to two meals a day instead of the three a day as planned. Further, it was noted that she had agreed to re-engage with a clinical psychologist after initially refusing but had refused the input of a public health nurse.
19. Doctor E reported that Ms. A expressed a desire for the wardship to end and that she was concerned that if she lost weight she could be admitted to hospital against her will. Doctor E went on to note that in his opinion Ms. A continued to require the wardship as she did not have capacity in relation to the management of her anorexia nervosa, she had lost weight in less controlled environments and that NG feeding had been the treatment that had driven her weight gain and continued to be the most appropriate treatment when she was severely underweight, and should be considered as a treatment even in circumstances where she did not consent.
20. On 24 February 2021 I made an Order substantively continuing the Order I had made on 8 December 2020.

#### **Involuntary Admission to Mental Health Unit**

21. On 14 April 2021 Ms. A was admitted to the Acute Mental Health Unit of Hospital X on a compulsory basis, with her treating team using the facility provided by the Order to compulsorily admit her if they deemed it necessary. On 21 April 2021 a hearing took place at which Ms. A gave evidence. She was extremely distressed at being admitted to hospital on an involuntary basis and being compelled to stay in hospital and made very strong representations that she be permitted to go home. I directed that the matter come back before the Court on 5 May 2021.
22. By a report on 30 April 2021 Doctor F, consultant psychiatrist, set out that Ms. A expressed disagreement with her admission but that generally she was eating her meals with minor complaints and complying with the recommended exercise restrictions. Since admission her weight had increased slightly but progress plateaued at the time of writing. Doctor F opined that Ms. A still lacked capacity in relation to her illness and recommended she stay in hospital for at least another week to consolidate any gain made.
23. A further hearing took place on 5 May 2021, at which point Doctor E indicated in oral evidence that he had come to the view that in fact coerced admission was not in her best interests. I heard further evidence from Ms. A who remained extremely distressed at being detained in hospital on a compulsory basis. She was discharged the same day and following Ms. A's discharge from the mental health unit, having regard to the evidence I had heard, I made a new Order allowing for the ongoing assessment and treatment of her

condition on an outpatient basis alone, removing the permission for her clinicians to admit or detain her against her wishes. I further ordered that a medical visitor attend Ms. A and report back to the Court.

24. On 17 May 2021 the medical visitor, Doctor G, a specialist in eating disorders based in Hospital Z, met Ms. A and provided a report on 22 May 2021. I deal with the contents of same below.
25. On 16 July 2021, Doctor E reported that Ms. A's weight had remained relatively steady following her latest discharge and that despite her initial upset at her coercive admission her engagement with her MDT had subsequently improved. She was attending fortnightly with her GP for monitoring, with family therapy, occupational therapy, psychiatry and had attempted, regrettably unsuccessfully, to incorporate meat into her diet and was attending with her dietician. She declined to attend with her clinical psychologist stating that she had lost trust, but Doctor E believed she was unable to therapeutically engage due to her overwhelming anorexic beliefs.
26. Doctor E went on to report that in his opinion Ms. A continued to demonstrate impaired judgment due to her anorexic condition and failed to appreciate the severity of her illness or the cause of her weight loss. He noted that coercive inpatient treatment had resulted in weight gain and electrolyte stabilisation but that these had plateaued following a lengthy admission before her weight declined again post-discharge and further there was significant damage to the therapeutic relationship in the context of coercive treatment. He concluded that coercive inpatient treatment, while potentially life-saving in the short term, did not provide a lasting benefit to Ms. A. Despite this he considered that wardship should continue as it facilitated a multidisciplinary approach that was imperative to the treatment of such a severe and enduring eating disorder.
27. At the hearing in July 2021 Ms. A gave evidence. She remained very distressed and indicated her desire to be out of the wardship process, which she perceived as affording her no benefit. I ordered that Ms. A should reside at home and permitted Doctor E and the relevant clinicians and services to manage Ms. A's outpatient and community care only and removed any mechanism for the admission of Ms. A to hospital against her wishes. I further ordered that the matter should be listed for review on 15 December 2021.

#### **Nature of Application**

28. At the review date, the HSE sought the following substantive Orders:

*"That the ward be provided with care, therapeutic services, and medical and/or psychiatric treatment both in the community and as an-patient, including but not limited to assessments, medication and naso-gastric feeding, provided that (a) it is considered to be in her best interests by the treating registered medical practitioner and (b) the Ward is agreeable to accepting the said care, therapeutic services and/or treatment."*

In other words, a very different approach is now being adopted to that previously adopted up to mid-2021, in that it is proposed that no more coercive treatment will be provided.

29. The evidence presented at the review hearing was that Ms. A is now in Hospital X again, but this time by way of voluntary self-admission. On 12 October 2021 Ms. A self-presented to Hospital X with abdominal pain and was assessed by Doctor H, consultant gastroenterologist, as having constipation, low blood sodium and further weight loss as a likely result of self-induced restriction of nutritional intake. While an inpatient, Ms. A fell and sustained a fracture of the right leg.

### **Medical Evidence**

30. In a report of 8 December 2021, Doctor B identified that Ms. A had sub-optimal adherence to treatment recommendations, including restricting her compliance with meal plans provided. Ms. A has expressed her wish not to receive NG feeding now or in the future. Doctor B observed that the short-term stabilisation of her weight in Hospital Y had not been followed by meaningful progress towards recovery. He went on to say that it was unlikely to be in her best interests to be detained in hospital for NG feeding and other medical treatment. He gave his opinion that coercive treatment was very unlikely to be of any enduring benefit and was very likely to be experienced as traumatic and would also not be without its own risks medically, given her frailty.
31. A separate report was presented by Doctor H of 9 December 2021 who noted that Ms. A was treated on a voluntary basis with NG tube feeding for 6 days in the beginning of her stay in the hospital, had been on oral feeding since and had expressed a wish not to receive any further NG feeding. He notes that a multidisciplinary approach has been adopted including teams from gastroenterology, psychiatry, dietetics, orthopaedics, rheumatology, physiotherapy, endocrinology, and occupational therapy.
32. A joint report was then prepared by Doctor B and Doctor H on 14 December 2021 whereby they observed as follows:

*"[Ms. A] remains a medical inpatient with ongoing severely low body weight and the medical sequelae of persistent hyponatremia, intermittent hypoglycemia as well as the general frailty of chronic malnutrition.*

*[Ms. A's] adherence with our multidisciplinary treatment recommendations remains very impaired and her calorific intake remains very inadequate although she herself minimises this.*

*Because of this, we have significant concern for further deterioration and mortality risk.*

*[Ms. A] has consistently refused the option of naso-gastric feeding to stabilise the ongoing acute medical effects of malnutrition.*

*In our opinion, [Ms. A] lacks capacity to refuse re-feeding because of her severe eating disorder.*

*In our opinion, it is not in [Ms. A's] best interests to treat her coercively (i.e. to be detained in hospital for re-feeding and other medical treatment). Given her history of severe and enduring treatment-resistant anorexia nervosa, coercive treatment is highly unlikely to be of any enduring benefit, is highly likely to be experienced as traumatic and is also not without its own risks medically given her frailty.*

*We are seeking to bring to the court's notice that it is our intention not to engage in coercive care of [Ms. A] i.e. 1) not to detain [Ms. A] in hospital if she decides to take her discharge against medical advice; and 2) not to give coercive naso-gastric feeding in the event of urgent medical needs/threat to life arising in the future"*

33. It is important to note that similar conclusions had separately been reached by Doctor G in her report in May 2021, where she indicated that Ms. A has found coercive detention very distressing and is strongly resistant to same, so the use of coercion would need to have a genuine benefit to subject her to such treatment. However, she observed that her admission history has demonstrated that, while coercive treatment may allow for some medical stabilisation, Ms. A is unlikely to experience any lasting benefit from coercive admission and feeding. Doctor G suggested that it might be agreed that an elective course of admission due to ongoing deterioration would not occur.

**Report on Behalf of the Committee for the Ward**

34. As part of this application, a detailed report was also provided by Solicitor I, who has been engaged by the General Solicitor (being the Committee of Ms. A) to assist the Committee. I should note that Solicitor I has discharged her role in this case in a deeply committed fashion and has provided very significant assistance to Ms. A in her difficult journey through wardship, given the enduring nature of her eating disorder.
35. Solicitor I provided an affidavit sworn 13 December 2021 in which she reflected the various concerns of Ms. A particularly in relation to issues with her mobility, as related to her during a conversation with the ward on 8 December 2021. At that point, Ms. A indicated that she would like to go home.
36. She also identifies a conversation with Ms. A's husband, Mr. A, on 9 December 2021 where he expressed the view that Ms. A was not well enough to go home and identified his concern about her coming home without a care package given that he works full time and cannot be with her all the time. He explained that the hospital is considering palliative care being the care provider when Ms. A is discharged, though he worried about what impact this might have on her mental health. He confirmed that he might not be able to login for the hearing scheduled for 15 December 2021 and indeed he was not at the hearing.
37. Solicitor I records her further conversation with Ms. A on 10 December 2021 during which she indicated she would not consider NG feeding or supplements and she indicated her immediate intention to go home upon completing a course of antibiotics. She indicated she did not wish to attend at the hearing on 15 December remotely.

### **Submissions of Counsel**

38. At the hearing, counsel for the HSE indicated that Ms. A remained an inpatient on a voluntary (although reluctant) basis. He submitted that she was not fit for discharge, that her capacity remained impaired and that she was not accordingly able to adhere to medical recommendations.
39. Counsel drew my attention to the medical reports that I have referred to above and identified relevant case law, in particular the Supreme Court decision of *In the matter of JJ* [2021] IESC 1 and the High Court decision of *A v Hickey* [2021] IEHC 318. I discuss those cases in more detail below.
40. He noted that there were a range of Orders that medical practitioners could seek in circumstances involving medical treatment. They could seek Orders that they be permitted to coercively treat a patient, they could seek declarations that it was lawful for doctors not to provide such a course of treatment (although he identified that there is no obligation to seek such a declaration) or they could seek a ruling in relation to the best interests of the patient.
41. He submitted that in this case there was no objection to a best interest review but observed that no-one was supporting the making of coercive Orders. He observed that the Orders sought are, in substance, a continuation of the existing Order, although he accepted that variation of the terms was being sought.
42. Counsel for the Committee for the ward indicated that she did not take issue with any of the submissions made by counsel for the HSE and observed that the issues were stark. She noted that there was no application for a declaration by the HSE. She observed it was for the Court in the context of its inquisitorial function to consider the best interests of Ms. A if that was thought appropriate.

### **Attitude of Ms. A's Husband**

43. Ms. A is obviously very close to her husband and he has been a source of continued support and encouragement to her throughout the last number of years. It is important that his views be considered in the context of the HSE's application. I specifically put a question to counsel for the Committee as to the attitude of Ms. A's husband and whether he required to be heard on this issue. Counsel for the Committee identified in response that Solicitor I was satisfied that he is aware of the nature of the Orders being sought and, specifically, that the medical team are proposing not to offer any coercive course of treatment despite Ms. A's state of health. However, he is not proposing any alternative approach. In those circumstances there is no opposition from any party as to the proposed approach by the HSE.

### **Analysis**

44. I cannot agree that the Orders now sought from the Court are in substance the same as the previous Orders. It is true that the existing Order of July 2021 does not provide for any form of coercive treatment or indeed any in-patient treatment. However, that form of Order was first made in May 2021 when Ms. A was discharged from Hospital X and when her weight was at a relatively stable level, although still extremely low. No evidence was



presented either at the hearing in May or the hearing in July that her health situation was critical. Therefore, in making those Orders, I was not envisaging that same could lead to a situation where Ms. A might die as a result of a decision not to provide life-saving treatment. I anticipated if that situation was imminent and Hospital X decided coercive treatment was required to save her, and thought it was appropriate to provide same, it would come back to Court to have further Orders made. The matter has indeed come back to Court, and although Ms. A's death is not stated to be imminent, the import of the Orders sought are that, if and when Ms. A gets to that point, no coercive life-saving treatment will be administered by her medical team.

45. It must be acknowledged that the health situation of Ms. A is now very precarious indeed. For over 25 years Ms. A has suffered from severe anorexia. Back in October 2019, her psychiatrist, Doctor B observed that

*"Going forward it is hard to be optimistic about [Ms. A's] outcome given her illness severity and her wishes. When acutely medically ill we have always managed to coax her to accept acute medical care in [Hospital X] and she has complied with NG feeding during more recent admissions for longer periods. This has allowed her to no longer be an acute medical risk at which point she typically balks at offers of ongoing feeding and/or further inpatient treatment for her eating disorder and then takes her discharge".*

46. More recently in May 2021, Doctor G observed that Ms. A had a severe and enduring illness and that persons like that are often managed by focusing on improving quality-of-life rather than the expectation of recovery. When Doctor G gave oral evidence to the Court, she expressed pessimism about Ms. A's future prospects given her profile of illness.
47. Unfortunately, those concerns have been borne out. I am aware that if I grant the Orders sought, it is possible that Ms. A will not consent to inpatient treatment and NG feeding (although I do note that Ms. A submitted voluntarily to NG feeding for six days in early October when she was first admitted to Hospital X and that she has remained in hospital since October of this year). I note in this respect that Doctor G observed in her report that Ms. A has been kept alive in the past number of years by repeated admissions to hospital, because it has not been possible for her to keep her weight at a safe level. Without such admissions, given the physical condition of Ms. A, in particular her chronic malnutrition and the proposal by the hospital that a palliative care team be involved at this stage, the consequence for Ms. A is likely to be her premature death. Therefore, the significance of this application from Ms. A's perspective cannot be overstated.
48. In those circumstances it seems to me that I must consider the case law on the circumstances in which life-saving treatment may be withheld, particularly in the context of wardship, and associated issues of substituted consent and best interests.
49. In *In the matter of JJ* [2021] IESC 1, a recent Supreme Court decision, an 11 year old boy had suffered a catastrophic accident involving very serious brain injuries. The child

was made a ward of court. The hospital sought declaratory Orders as to whether it could, *inter alia*, lawfully withhold aggressive life-sustaining measures if the boy suffered a crisis in which his life could only be sustained by admission to ICU. The Supreme Court held that in cases involving the withholding of treatment in accordance with the relevant Guide to Professional Conduct:

*"... the legal issue is not whether the patient or the patient's family consents to the course proposed by the doctors, but rather whether it is lawful for the doctors to do so; i.e., whether the judgment is one to which they can properly come".*

However, the Supreme Court went on to observe that;

*"In practical terms, however, it would normally be the case that the hospital and treating doctors would want to bring a patient and family to the same position so that they could be said to "consent" to the course of treatment, and, in cases where that was not possible, it is prudent to seek confirmation, if necessary, from a court that it is permissible to do so" (paragraphs 156-157).*

50. In the subsequent decision of *A v Hickey*, the ward in question was 28 years old and in 2011 she suffered irreversible hypoxic/anoxic brain injuries following a major cardiac arrest. She had been severely brain-damaged since then and was in a permanent vegetative state. She became a ward of court in February 2020. Her mother brought an application seeking the Court's permission to terminate the artificial delivery of nutrition and hydration to her daughter so that she could pass away. In that case the doctors treating her had not proposed this course of action, but they indicated they would comply with any steps identified in a court Order.

51. At paragraph 57 the President observed as follows:

*"The general rule in relation to medical treatment is that the consent of the patient is required. In a case such as this, where it is the court that has to give substituted consent, it must decide whether to give that consent by reference to a set of well-established principles. First, the court has to have regard to the sanctity of life which gives rise to a strong but, in recognition of the right to die a natural death, a rebuttable presumption in favour of sustaining life-prolonging treatment. ...Therefore, whilst the court, in the exercise of its discretion as to whether to give or withhold consent to a medical intervention, must take as its starting point that the ward's life should be maintained, this may be rebutted".*

52. At paragraph 72 it was noted that:

*"A doctor's principal duty is to save lives and do no harm. For a doctor to come to the view that this duty is best exercised by withdrawing life-sustaining treatment without any express direction from the patient, unusual circumstances must prevail i.e. that it would be unethical to continue treatment. It is only in those exceptional*

*circumstances that the court can dispense with the prerequisite of consent, as was the case in In re J.J.”*

53. The President observed that in the instant case, on the other hand, the clinicians did not seek to rely upon their right not to carry out treatment they considered unethical. In those circumstances she found that the declaration of lawfulness route could not be availed of and she therefore distinguished the case from JJ and held the case was better dealt with under the general rule that consent needed to be obtained as set out in the judgment of *In Re a Ward of Court (No. 2)* [1996] 2 IR 79.
54. In this case, I have not received evidence that the doctors consider it unethical to continue treating Ms. A. However, they have indicated that for the reasons set out above they propose to only engage in care if they consider it in her best interests and if she agrees to same, even though the context of this application makes it clear that if no agreement is given by her, life-saving treatment will not be provided.
55. Because Ms. A continues to lack capacity, the Court is placed in the position of giving or withholding substituted consent, as it has already done in relation to the making of Orders detailed above, that permitted treatment to be provided to Ms. A on a coercive basis. Now that it is proposed to abstain from providing such treatment even where same is required to save Ms. A's life, the HSE has sought further Orders in relation to such an approach. No declaratory relief has been sought by the HSE. In those circumstances it seems entirely appropriate to approach the matters in the first instance on the basis of the best interest test, as was done in *A v. Hickey*. This is of course the normal obligation of any court exercising the wardship jurisdiction whenever an Order is made in respect of a ward of court.
56. I do not interpret the Supreme Court decision in *JJ* as either absolving me from that responsibility or indeed preventing the exercise of such a jurisdiction. Indeed, I believe that approach is consistent with the decision in *JJ*, given the passage identified above where it is noted that in practical terms generally a hospital will seek consent to discontinuing treatment, and if that is not forthcoming, will seek the confirmation of the Court that such an approach is permissible. Moreover, at paragraph 174 of that judgment, the declarations made by the Supreme Court that specified life-saving treatments may be withheld are subject to the proviso that they will only become effective if, in each instance, the prior consent of John's parents had been sought and refused. Thus, in my view, both pre and post the decision in *JJ*, the question of consent remains relevant (although clearly not determinative) where medical practitioners wish to withdraw or not offer a course of treatment (including life-saving treatment).
57. In determining what is in a ward's best interests when deciding on whether substituted consent should be given for the course of action, the Court is required to have regard to all the circumstances of the case. A (non-exhaustive) list of circumstances were identified by Denham J. in *In Re a Ward of Court (No. 2)* as follows:

"(1) *The ward's current condition.*

- (2) *The current medical treatment and care of the ward.*
- (3) *The degree of bodily invasion of the ward the medical treatment requires.*
- (4) *The legal and constitutional process to be carried through in order that medical treatment be given and received.*
- (5) *The ward's life history, including whether there has been adequate time to achieve an accurate diagnosis.*
- (6) *The prognosis on medical treatment.*
- (7) *Any previous views that were expressed by the ward that are relevant and proved as a matter of fact on the balance of probabilities.*
- (8) *The family's view.*
- (9) *The medical opinions.*
- (10) *The view of any relevant carer.*
- (11) *The ward's constitutional right to:*
  - (a) *Life.*
  - (b) *Privacy.*
  - (c) *Bodily integrity.*
  - (d) *Autonomy.*
  - (e) *Dignity in life.*
  - (f) *Dignity in death.*
- (12) *The constitutional requirement that the ward's life be (a) respected, (b) vindicated, and (c) protected.*
- (13) *The constitutional requirement that life be protected for the common good. The case commences with a constitutional presumption that the ward's life be protected.*
- (14) *The burden of proof is on the applicants to establish their application on the balance of probabilities, taking into consideration that this Court will not draw its conclusions lightly or without due regard to all the relevant circumstances."*

58. For the reasons I set out below, I believe it is in the best interests of Ms. A to consent to the approach proposed by the HSE.

### **Best Interests Test**

59. Applying the above factors, I have set out above Ms. A's current condition and her current medical treatment and care. In respect of the degree of bodily invasion that the medical treatment at issue requires, coerced NG feeding is enormously invasive. It involves the insertion of a feeding tube that generally remains in place 24 hours per day and food (in a liquid form) will usually be inserted through the tube a number of times per day. The patient must leave the tube in place and may have to be restrained from pulling it out. The patient may also require to be restrained from preventing the feeding taking place. The patient has no control over how many calories he or she is imbibing. In this case, I have heard Ms. A give evidence on a number of occasions in the course of the last year and on each occasion, she has forcibly expressed her absolute opposition to NG feeding on a compulsory basis. She has become very distressed on each occasion when she gives evidence on coercive treatment. I therefore conclude that for Ms. A, coercive NG feeding would involve a serious degree of bodily invasion. Compulsory admission to hospital of Ms. A is of a lower magnitude from the point of view of the right to bodily integrity. Nonetheless, for obvious reasons, long periods of detention in hospital, as have been experienced by Ms. A, impact negatively upon her right to bodily integrity also.
60. Moving on to the next consideration, the legal and constitutional context in which the coercive medical treatment would be provided is through wardship. That does not present any particular issues given that coercive treatment has already been provided for on a number of occasions in that context. The existence of the Committee and Ms. A.'s active participation in some of the hearings and written communications to the Court on other occasions mean that her voice has been fully heard throughout these proceedings.
61. In relation to Ms. A's life history, there has undoubtedly been adequate time to obtain a diagnosis and indeed an important factor here is the long-standing nature of her anorexia and the pessimism of the medical practitioners as to the prospect of recovery.
62. In respect of the next factor, being prognosis, as I have identified above, I am acutely conscious of her prognosis both if she is treated in a coercive way and if she is not. If no coercive treatment is provided, she is likely to die prematurely; but if she is treated coercively, her prospects of recovery are not enhanced since the underlying condition is so pervasive that it will continue to affect her life expectancy as soon as the coercive treatment is discontinued. Moreover, as identified above, some members of her treating team are of the view that coercive treatment damages her relationship and engagement with clinicians. In short, coercive treatment is not in any way improving the prospects of recovery.
63. In respect of the views of the family and Ms. A herself, I have identified same above. Ms. A is implacably opposed to coercive treatment and is very distressed by it; and her husband is not opposing the application by the HSE.
64. The relevant medical evidence is identified above. Importantly, there are no dissenting voices. A range of doctors, including Doctor B, the consultant psychiatrist in Hospital X who has treated her since 2011, Doctor E, the community psychiatrist who treated her in 2021, Doctor H, the gastroenterologist who is currently treating her in Hospital X, and

Doctor G, consultant psychiatrist, and medical visitor, have all concluded that on-going coercive treatment should not continue to be provided.

65. I have considered the constitutional right to life and the presumption that the ward's life should be protected, and indeed this has been the approach that has informed this Court since Ms. A came into wardship, whereby she has been the subject of ongoing coercive Orders. In this context, it is relevant that the medical team has expressed the view that given the ward's frailty, coercive treatment may have its own risks medically. Therefore, the right to life does not necessarily point exclusively in the direction of the provision of coercive treatment: the coercive treatment itself may negatively impact upon the right to life.
66. I have also considered Ms. A's constitutional right to privacy, bodily integrity and autonomy. I am satisfied that all of these would be deeply adversely affected should she be coercively treated, both in relation to compulsory admission and NG feeding.
67. Next, I have considered Ms. A's dignity in both life and death. Given the seriousness of her condition, the fact that the medical team have concluded that coercive treatment is highly unlikely to be of any enduring benefit and the impact of the coercive treatment on her, I conclude that Ms. A's dignity would be adversely affected by continuing coercive treatment.
68. Having regard to all those factors, I have no hesitation in concluding that Ms. A's best interests are that no further coercive treatment should be provided to her in relation to her eating disorder. That does not necessarily mean no further treatment will be provided: I discuss below the implications of the Order that I propose to make.
69. Finally, I should say that my conclusion on Ms. A's best interests is very much informed by the length of time over which she has suffered from this disease. In the specific context of anorexia, even where a ward has had repeated coercive interventions without benefit, and there was sustained objection by a ward to compulsory admission and/or NG feeding, a very different view might be taken by a court where the duration of the illness was shorter and/or the person was younger. The facts here are stark given the length of time Ms. A has suffered from severe anorexia. As always, each case must be decided on its own facts.

**Form of Order**

70. At present the draft proposed Order makes the continuation of all care conditional on it being considered to be in Ms. A's best interests by the medical practitioners involved and Ms. A being agreeable to accepting the said care. I have concluded that this is an appropriate form of Order.
71. I should immediately observe that this Order does not in any way alter the conclusions that were reached by the President of the High Court on 29 January 2020, when Ms. A was admitted into wardship on the basis that she lacked capacity in respect of decisions relating to her illness. Acceptance of treatment does not equate to capacity to consent. I

am satisfied that she continues to lack capacity, as confirmed by the medical evidence referred to in this judgment. The reference in the Order to her being agreeable to accepting treatment is not a recognition that she has capacity to make such decisions but rather an acceptance of the impact that coercive treatment imposed against her wishes will have on her. The HSE's application has been informed by the distress such coercive treatment imposes upon Ms. A, as well as the limited benefits of such treatment and the possible risks. If, on the other hand, the treatment is provided on an agreed rather than coercive basis, then some of those risks are modified. The distress is greatly lessened, the long-term benefit of the treatment may be improved if it is chosen freely by Ms. A, and the risk to her physical state imposed by coercion is removed. It is for that reason that agreement is relevant. That does not of course mean that all risk to her life is gone where she consents to treatment, since sadly Ms. A's health is now very fragile. Nonetheless, the justification for only providing treatment where she accepts same is obvious.

72. In relation to my acceptance of the exercise by the clinicians of a best interests test in deciding whether to provide treatment, given Ms. A's history, the ongoing deliberate evaluation and choice of treatment options by the team, as well as the long-standing nature of Doctor B's relationship with Ms. A, I am satisfied that the clinicians are best placed to decide what treatment should be offered to Ms. A. At this point, I do not believe it is either necessary or appropriate for the clinicians to have to seek the leave of the Court to approve whatever treatment they deem appropriate at a given point in time.

73. Accordingly, I will make the Orders sought.