THE HIGH COURT

WARDS OF COURT

[2022] IEHC 738

Record No: WOC11507

IN THE MATTER OF BW

RESPONDENT

EX TEMPORE JUDGMENT OF Ms. Justice Niamh Hyland delivered on 16 November 2022

1. This is an application made by way of Notice of Motion of 10 November 2022. That Notice of Motion seeks various reliefs but, in particular, a relief that the respondent, who is Ms. W, a 20 year old woman, be transferred to a specialist hospital in London and that when she is in the specialist hospital that the responsible clinician and other associated persons be permitted to detain her and to treat her, pending further Order of the Court.
2. There are many other associated Orders, including that the specialist hospital be permitted to administer nasogastric tube feeding, despite the absence of consent on the part of respondent, as well as other linked reliefs, such as the use of reasonable force and/or restraint to the extent which it may be necessary.
3. In those circumstances, it will be necessary that the Court of Protection of the United Kingdom considers the terms of the Order that I am going to make and the reasons for my Order[1]. Therefore, I am going to set them out in a little bit of detail. I should say that this is a hearing that is being heard *in camera* pursuant to s.45 and, therefore, it is not a hearing that the public are able to access.
4. I should say, first of all, that this is a case where there has not yet been an inquiry held

[1] See the judgment of Mr. Justice Mostyn in *The Health Service Executive of Ireland v Florence Nightingale Hospitals Limited* [2022] EWCOP 52.

into the question of Wardship for the respondent. She has not yet been made a Ward of Court, pursuant to the procedures set out in the Lunacy Regulation (Ireland) Act 1871 but, nonetheless, I am exercising my protective Wardship jurisdiction, as identified by the Supreme Court in the case of *AC v Cork University Hospital* [2019] IESC 73 in 2019, under the provisions of s.9 of the Courts (Supplemental Provisions) Act 1961, and also pursuant to the inherent jurisdiction of the Court. In the case of Ireland, that inherent jurisdiction derives from Article 40.3.2 of the Constitution and the power of the Courts to protect the property and person of every citizen. In those circumstances, I am quite satisfied I have the jurisdiction to make the Orders sought.

5. Now, turning to the particular issues arising in respect of this application. I should say, first of all, that I must consider the capacity of the respondent and whether or not she is capacitous because obviously if she is, then I would not have any jurisdiction to make the type of Orders that have been made.
6. This case has, I suppose, a relatively short but intense history in this Court. An application was first made to me on 28 September 2022, in relation to Orders which would necessitate Ms. W staying in hospital and being detained in hospital for the purposes of weight restoration. There was a further Order made on the 30 September by Mr. Justice O'Connor. There was a further Order made by me on 19 October 2022, after hearing the evidence of Dr. C and, indeed, I heard the evidence of Dr. C, Consultant Psychiatrist, on the earlier occasion. There was a further Order on 2 November 2022 and I made an inquiry Order directing an inquiry hearing and the steps necessary for that on the 2 November 2022.
7. Ms. W has now been served with the Notice of Inquiry. In this particular case that was done by her Guardian *ad litem*, Ms. P. I should add that, of course, a Guardian *ad litem* has been appointed in order to make sure that her voice is heard. In fact, in this particular

case, on each occasion that the matter has been before me, Ms. W has been able to attend the hearing remotely and has made submissions to me, and on each occasion I have been able to hear her particular views, as well as having the assistance of Ms. P, who has given detailed affidavit evidence in relation to her discussions with Ms. W.

8. So, turning now back to capacity. I should say that I have had evidence up to today and prior to today's date in relation to a lack of capacity on the part of the respondent in relation to matters relating to her eating disorder. In particular, I am going to refer to the report of 12 October 2022 of Dr. C. In that report she identifies the reasons for which Ms. W was taken into hospital and I'm going to come to those shortly. She also assesses her capacity issues and says that Ms. W has the cognitive inflexibility and thinking mistakes inherent in eating disorders, such as anorexia nervosa, and that they continue to interfere with her ability to understand the information given to her, particularly regarding the risks to her health and life. She said that she did not appear to appreciate the risks to her physical health were she to continue to engage with self-induced vomiting, and to severely restrict her oral intake, and she did not appear to appreciate the risks to her physical health due to medical complications associated with starvation and severely low BMI. She said she did not demonstrate the ability to understand the information given to her at the time of assessment or, indeed, the previous information she had been provided with to date regarding the risks to her physical health.

9. Then today Dr. C gave relatively extensive evidence of the current state of play. Ms. W has been in the hospital now for 60 days since she entered in September. Dr. C identified that she was of the opinion that Ms. W is still lacking capacity in respect of the issues relating to her eating disorder and, in particular, she said that Ms. W does not have the ability to understand the risks that she is presenting including those to her physical health, the risk of starvation, of the vomiting, of the electrolyte abnormalities. She has identified

certain actions that took place when Ms. W was recently on leave in respect of the taking of medication that was not prescribed for her and how that demonstrated a disregard for her cardiac risk. She identified that there has been no change in her thinking in relation to treatment. She identified that Ms. W has never said to her that she wants treatment. She is agreeing to go to the United Kingdom because she believes that the Court will tell her to do so. There is no evidence that she understands the risks that she is facing.

10. Dr. C also identified the repeated requests for leave by Ms. W so that she could go home, and she considered that those requests were driven by her eating disorder whereby she wanted to lose weight under the guise of wanting to prepare for her trip to London. She noted that, in fact, Ms. W hasn't actually packed a bag or prepared for the trip on the trips home. In those circumstances she indicated that she did not believe that Ms. W had capacity.

11. Now, the Court has the facility of obtaining independent medical evidence from a medical visitor. In this particular situation that was availed of, and Dr. Rachael Cullivan of the Department of Psychiatry in Cavan General Hospital went and met with Ms. W. She reviewed her on 27 October 2022, and she says her assessment was of approximately one hour.

12. Dr. Cullivan goes through the various requirements of capacity that are now identified in the Assisted Decision-Making (Capacity) Act 2015, which is not yet in force but, nonetheless, these tests are being used frequently by medical practitioners when assessing capacity. She identifies that the first requirement of the test of capacity is the ability to understand the information relevant to a decision. She comes to the conclusion that Ms. W was superficial in her considerations and not able to fully understand or distinguish between short-term, long-term or evidence-based versus non-evidentially based issues. She, therefore, failed on this aspect of the test.

13. In the course of that consideration, Dr. Cullivan identified in particular that in the past before Ms. W was admitted on this occasion, she had been admitted to hospital nineteen times in the previous ten months on a voluntary basis but had continually discharged herself. She also noted that Ms. W had been admitted voluntarily to a Dublin hospital for treatment in March 2022 but, again, had discharged herself after three weeks.
14. She then considered the second requirement, the ability to retain information relevant to the decision and she noted that while Ms. W was unable to fully understand or appreciate the information relevant to her decision, she was not cognitively impaired and she was satisfied that she had the ability to retain relevant information, although not able to fully understand it. She concluded she did not, therefore, fail on that aspect of the test.
15. She then noted that the third requirement was the ability to weigh information in order to reach a decision and that because Ms. W was unable to fully understand the relevant information, it was not possible for her to weigh up, balance, or appreciate the potential interactions or consequences of her decision, specifically the pros and cons of her receiving treatment at a specialist centre. She could not meaningfully balance or weigh up evidence from her experiences of her illness and its treatment to date. She identified that given the mortality rate of this illness and the serious risks already identified to her life, it was significant she placed little or no weight on this information in her considerations and she, therefore, failed the third aspect of the test.
16. She identified in relation to the fourth aspect, i.e., the ability to communicate a decision, that Ms. W was able to do that. In all of those circumstances, it was concluded that she did not have capacity in relation to the question of her eating disorder.
17. I am quite satisfied here that there is evidence before me in relation to a lack of capacity and, therefore, I am going to proceed to consider now whether it is in Ms. W's best interests to grant the reliefs that are sought in the Notice of Motion and, in particular, the

transfer to the United Kingdom. In this respect I am going to summarise some of the evidence of Dr. C and also some of the evidence that has been used by Dr. M, Consultant Psychiatrist, in grounding this application. A lot of that evidence is not just coming from today's hearing but is coming from the very beginning of Ms. W's interaction with the Court process in September.

18. Ms. W is a 20-year-old woman. She has a severe eating disorder that is also linked with binging and purging behaviours. She has been in hospital for 60 days. It was a medical admission and the aim of it was weight restoration and medical stabilisation. She made progress in the first number of weeks but there has been a notable drop in weight in recent weeks. Her weight now is lower than at any time other than four days post admission.
19. Dr. C, very helpfully, did a chart identifying the days she has been in hospital and the weight over those days; and one can see a particular pattern whereby her weight first increased, then declined and then there was a steady climb upwards until she had reached a BMI of about 14. At that point her weight then dropped, then peaked again, then dropped and then peaked again and the same pattern repeated itself three times and now it has dropped very significantly again, and she is now at a weight of just about 35.5 kilos.
20. Those peaks and drops were associated with her leave home, where on three occasions she was given leave to go home but on occasion when she went home, her weight dropped. Then she would go back to the hospital, her weight would be restored to a certain extent and then it would drop again. Dr. C also said that it was likely that the weight drop was not just because of her leave home but was also because at a certain BMI, which she identified as 14, it would become very difficult for Ms. W to see herself putting on weight and reaching that level of BMI.
21. She has also noted that at present she is now back to having daily bloods and ECG's,

which was the approach taken at the start and that Ms. W is reasonably stable, from a medical point of view, but that she has not made any progress in relation to her thinking, that she is very inflexible. She then has identified some of the issues in relation to her home leave and she has also identified for me the state of play in respect of nutrition. There is at present a nasogastric tube in place. It is, from time to time, pulled out by Ms. W but usually she will allow it to be replaced. She is taking oral food and there are certainly restrictions around that. Again, Dr. C identified the very rigid thinking on the part of Ms. W in relation to how she deals with that.

22. Turning then to the evidence in relation to transfer. Dr. C has made it clear that the hospital admission has not been a success in that they have not been able to achieve a weight restoration and to maintain it. She says that the hospital is not able, being a general hospital, to provide Ms. W with the kind of specialist care that she needs. She has also identified that she spoke to Dr. H of the specialist hospital and that she, Dr. C, was impressed with the course of treatment described in the specialist hospital and she has confidence that the specialist hospital would be able to adequately treat Ms. W, given her complex needs.

23. I want to now turn to the evidence of Dr. M. Some of that evidence derives from Dr. C's reports but she also, at paragraph ten, identifies the evidence of Dr. W, Consultant Psychiatrist, who assessed the respondent on 3 November 2022. He confirmed that the respondent continued to lack capacity regarding her treatment and care. In relation to the respondent's wishes, Dr. M has addressed that. I think I have already noted that Ms. P is the Guardian *ad litem* and that she has provided evidence to this Court.

24. Now, in relation to the approach of the respondent to the transfer, it is fair is to say that there is a mixed approach. At certain points she has said she does not wish to go to London, but she has also said, most recently to me today, that she is willing to go to

London. It seems to me that her rationale is that she wishes to go to the hospital in London so that she can start her treatment there. She is impressed by the range of options that will be available to her in respect of addressing the psychological causes of her illness and she wants to, as it were, get going on that treatment.

25. Therefore, I am faced with a situation where there is an application to move the respondent and it is not being opposed, at this point in time, by the respondent, although I think it's fair to say she does have considerable reservations about the proposed course. I have dealt with the question of capacity. In relation to the suitability of the specialist hospital and the position in Ireland, at paragraph 18, Dr. M identifies that: *"It is the view of the Respondent's treating community psychiatry team and her own opinion that her needs have exceeded that which is available within the mental health services in Ireland."*. That is a very important averment because obviously if Ms. W's needs could be met in Ireland, they should be met in Ireland. It is more challenging in many different ways for her to be treated abroad and it also means she will not be able to see her family in the same way as she can at present. Nonetheless, I have been given evidence that there isn't the possibility of treating her complex situation in Ireland and I must give that significant weight.

26. There is also an averment by Dr. M that the specialist hospital has accepted the respondent for inpatient eating disorder treatment, that the treatment is multidisciplinary based, including medical, nursing, dietician, acute medical treatment as needed and psychotherapy, including family therapy, and that on arrival Dr. H will outline with the respondent a treatment plan which is based on a multidisciplinary initial assessment of the respondent, her status at that time and needs identified.

27. I have had careful regard to the Care Quality Commission Report for the specialist hospital. It is certainly true that in many areas that report identified that there were certain

aspects of the care at the hospital that needed improvement and the report went into some detail in respect of the different headings. One of those was in relation to the facilities provided for nasogastric feeding, including the room and the chair that was being used and Dr. M has identified that this has now been addressed and there are now suitable facilities in place.

28. So, in all of the circumstances, it seems that the specialist hospital is a suitable placement. It is clear that an assisted admission will be required but, again, that is one of the issues that is identified in the Orders sought.

29. Finally, in relation to the view of the respondent, Dr. M has identified that the respondent has said she is unwilling to engage and that she wishes to be discharged home. As I already said there has been conflicting evidence from Ms. W in that respect but, I think, overall, the state of play at the present certainly is that she is willing to go, if not enthusiastic about it.

30. I am going to turn to the detail of the Orders. There is just one issue that I should address, that is the relief that is sought at paragraph 6(i). What that identifies is that notwithstanding the respondent's lack of capacity to consent, that the director, manager and/or responsible clinician would deliver such care and medical and/or psychiatric assessment as they consider to be appropriate, including nasogastric tube feeding and other PEG feeding and/or feeding by intravenous total parenteral nutrition ("TPN").

31. I am satisfied that there is sufficient evidence before me that it is necessary that the hospital have the possibility of nasogastric tube feeding. That is, unfortunately, a common way of administering nutrition to patients in this situation. It has been used in the hospital since Ms. W has been admitted, although happily I think it hasn't been necessary to use it on a non-consensual basis where restraint is needed. Nonetheless, it is clearly an important part of the treatment regime and I will authorise that.

32. But I am not satisfied in relation to PEG feeding or TPN. Both of those would require admission to a general hospital. Now I am told that there is a general hospital right beside the specialist hospital but, nonetheless, I do not have any evidence as to why it would be necessary to grant such a draconian form of relief, without any further recourse to this Court. Given the nature of the relief sought, it seems to me that I would have to have more evidence than simply a generalised statement, which I think is what Dr. M provided, which was that it would be better for them to have a full suite of available ways of feeding the respondent.

33. I think both Dr. M and Dr. C made it clear in their evidence that they were not familiar with these particular types of measures in the context of eating disorders, that they had not seen them used, and that they were extremely rare indeed. They certainly had not only not been used in the admission to date, but I do not think ever considered in the admission to date. There was concern raised by Dr. M that if it became impossible to feed the respondent by any other means but PEG feeding or TPN, that it might be necessary to resort to them. But if that is the case, of course the parties have liberty to apply here. Certainly, the situation is a little more complex because any Order would have to be recognised by the Court of Protection but, again, I'm quite sure that Court has measures to deal with extreme emergencies. In any case, given that Ms. W will be closely monitored, and she will be in the specialist hospital, it will become clear if she has stopped eating and, it seems to me, that I have not been given sufficient evidence that the measures sought are necessary in all the circumstances. So, I will not grant liberty in respect of those measures.

34. Now turning to the Notice of Motion, I am going to make an Order pursuant to paragraph 3 of the Notice of Motion, paragraph 4, paragraph 5, paragraph 6, save in relation to PEG and TPN, paragraph 7, paragraph 8 and paragraph 9, paragraph 10, paragraph 11,

paragraph 12, paragraph 13. Obviously, paragraph 13 is of particular importance because it provides that:

> *"The Respondent shall be the subject of regular intensive welfare reviews during the currency of her detention at [the specialist hospital] to enable the Court to ascertain whether there persists a basis for the continued treatment of the Respondent."*

35. I will hear from Counsel shortly as to when the review date should be. Then I am going to make an Order pursuant to paragraph 14, paragraph 15 and, obviously paragraph 16, liberty to apply at short notice and paragraph 17.