Neutral Citation Number: [2019] EWHC 2311 (Fam)

Case No: FD19P00421

IN THE HIGH COURT OF JUSTICE
FAMILY DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 22/08/2019

Before :

THE HONOURABLE MR JUSTICE HAYDEN

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Between :

X Health Authority	**Applicant**
- and -	
D	**Respondent**
(Child acting through their Children's Guardian)	

- -
- -

Mr Andrew Bagchi QC (instructed by **X Health Authority**) for the **Applicant**
Ms Ruth Kirby (instructed by **Gamlins**) for the **Respondent**

Hearing dates: 20th & 23rd August 2019

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Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

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THE HONOURABLE MR JUSTICE HAYDEN

This judgment was delivered in private. The judge has given leave for this version of the judgment to be published on condition that (irrespective of what is contained in the judgment) in any published version of the judgment the anonymity of 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.

Mr Justice Hayden :

1. This is an application by the X Health Authority [XHA] in relation to a 12-year-old girl, born in June 2007. The XHA applies for continuation of orders made first by Mrs Justice Theis on 9th August 2019 and renewed on 13th August 2019.

2. The case came before me earlier this week, where the objective of the parties and the XHA was, to identify a specialist unit which is better equipped and experienced in treating D's acute and chronic condition. D has been represented by a guardian. The father has attended at court, via video link, earlier this week and today. He advises me that he speaks on behalf of both parents.

3. D has a very longstanding problem relating to her consumption of food. It began without any apparent cause in September 2017 and the short chronology that has been prepared narrates symptoms of gastroenteritis, crampy stabbing pain and general abdominal symptoms almost continuously since.

4. A vast array of experts has been involved: paediatricians; paediatric gastroenterologists; paediatric neurologist; paediatric cardiologist and a haematologist. In May last year, Professor Whorwell from the Department of Gastroenterology at Wythenshawe Hospital provided a report stating, *"there is no doubt in my mind that there is a strong behavioural component to D's problem"*. There was a feeling that a real and muscular engagement with the Child and Mental Health Services team (CAMHS) was needed in order to address the problem.

5. Whilst the enquiry and investigations have been extensive, I am left with the clear impression that therapeutic and/or psychological input has not been consistent or focussed. This is not to criticise any of the professionals involved or the parents. It simply reflects the clinical anxiety and confusion that has surrounded D's condition, absent the identification of any organic cause.

6. D is currently an inpatient at Y Hospital. She was admitted there as long ago as 9th July 2019 complaining, at that stage, of constipation and vomiting. Because of her consistent refusal to take food and the deterioration in her condition, such that it was considered to be a threat to her life, the XHA made the application on 9th August 2019.

7. Theis J authorised an agreed feeding regime which required reasonable and proportionate restraint to prevent D from obstructing the staff with the administration of food. It's not inaccurate to describe it as *'force feeding'*. It is profoundly distressing to D and to her parents and, I have no doubt, that it is deeply unsettling to all those who are charged with this unenviable responsibility.

8. The sad reality, however, is that while she has been in the hospital, D has continued to lose weight. D's weight is now disturbingly low. D has been subject to the regime for something in the region of two weeks plus. It has had the effect of stabilising her condition but it requires to be highlighted that she is receiving, at most, 50% of her required calorific intake. This is illustrated by the stark fact that her admission weight was 33.3kgs and when she was last weighed, it had reduced to 27.9kgs. In one week, she lost in excess of a kilogram, notwithstanding the feeding regime. I have been told that her present weight, though alarming, is not such as to present an immediate risk of failure to the vital organs. That said, it is plainly a very grave situation. More widely,

D is suffering both psychologically and emotionally. She does not only resist the feeding regime but she is also physically resistant to ancillary support, by which I mean, for example, physiotherapy or toileting. I am left with the clear impression that the X hospital, whilst it has been sensitive and conscientious in the care that it has provided is, nonetheless, beyond the parameters of its expertise.

9. On Tuesday I indicated that the case should come back today, mandating the Trust and the parties to strain every sinew to identify a suitable unit. I am happy to say such unit has been identified. It was not possible to find a unit local to where D lives. The father said the priority was to find a unit and the family would accommodate the geography.

10. EM is a unit specialising in eating disorders which provides physical and medical care as well as mental health care. It has been established for nearly 20 years. Its entire focus is on eating disorder treatments and its services range from intensive residential to partial residence and outpatient care. In the material provided from EM, it is stated that the first consultation is a *'comprehensive assessment with a Specialist in eating disorders'*, who is a consultant psychiatrist. It is undoubtedly the case that, in the absence of an organic explanation, following a raft of extensive investigations, the preponderant evidence points to some kind of psychological cause. It is the obligation of the doctors, experts, lawyers and the judge to focus on the most likely explanation particularly where the situation has become so grave.

11. I emphasise, as does the guardian, that, in the opinion of the doctors, some of the conventional indicators of anorexia nervosa are not considered to be present and, alongside the prevailing hypothesis, it is essential to keep an open mind as to other possible explanations.

12. In authorising the move to EM, which without any hesitation I identify as being in D's best interests, recording that the parents agree to this, I make it clear that I am endorsing a plan which involves a very significant interference with the autonomy of a young girl. She therefore enters this establishment with the direct authority of the Court. She will be nursed to level 4 standard. She will be observed *'at all times'*. The observations will include monitoring her personal care. She will have daily showers. She will wear day clothing during the day. She will be fed by NG tube with physical intervention from trained staff if needed.

13. It is the ambition of the professionals to increase the volume of nutritional supplement but to achieve that by devising strategies to minimise the impact and distress to her both physically and psychologically consequent on the feeding regime. D will be encouraged to use the toilet. The emphasis is on returning her to independence. She will have a daily seating plan for an hour to start and to build up incrementally. She will be prompted to move and not to remain for long periods in one position to prevent bed sores. Physical examination will be necessary.

14. Changes of mood, behaviours and thoughts will be monitored, in particular, physical and mental state, by the nursing team and the medics on a daily basis. Alongside this, unavoidably, there will be psychometric testing, physiotherapy, individual and family therapy.

15. I would add that I regard the family therapy as particularly important. It is a horrible irony sometimes that when children or young people require intrusive and distressing

medical intervention, it is the parent who is least equipped to help. The danger is that parental distress, which must be almost unendurable in this situation, communicates itself to a child in a way that a professional may have learned to conceal. Family therapy might, in its broad ambit, assist with that. In due course, it is intended that D will attend group therapies and ward activities when physically and mentally able to do so.

16. Alongside this, in conjunction with the clinical lead at EM, there will be such further organic investigations as may be identified. I wish to emphasise on the evidence I have heard, I consider the move to EM to be pressing. In my assessment of the evidence, it requires to take place immediately or as soon as practically possible. Prognosis in these cases can be very grim and it is important again to emphasise that one of the most propitious indicators to success is a collaborative and cooperative approach by all concerned.

17. There has been some talk, predicated on a misunderstanding, of D being made a ward of court. She will not be. What I have just said indicates why she should not be. The importance here is cooperation and collaboration even where sometimes that might involve a parent yielding to that which is painful and counterintuitive. At times when cases come before the Court, there is a false tendency to identify competing sides. This process is investigative, non-adversarial, sui generis. Every party is here to promote D's welfare, not least me as the judge.

18. There should be a period away from litigation now. Much of August has been spent preparing for it. Too often it can be a distraction. If further decisions need to be taken by the Court, the application can be listed in October. I will reserve the case to myself, having made two significant welfare decisions.

19. Below the surface of the evidence, lies an impression of a young girl with character and talent. This is almost entirely submerged by the voluminous medical reports. I hope that by the time the case comes before me next, something more of her personality, character and interests will have been identified and risen plainly to the surface. It is important that D understands what is being discussed, at least in general terms, what is happening to her and why. That responsibility I delegate to her guardian to visit her and to explain, gently, why the Court has taken the course it has, giving her the outline of my remarks in this judgment.

20. The purpose of this judgment is primarily to ensure that there will be no ambivalence amongst the professionals, or indeed anybody else, as to the contemplated treatment. Importantly, it is delivered in order that D may understand the reasoning underpinning the decisions I have taken today.

21. The law framing this decision is easy to state, though frequently difficult to apply. The lode star which guides the Court's approach remains throughout "the best interests of the child" (see **Aintree University Hospital NHS Trust v James [2013] UKSC 67**; **Yates and Gard v Great Ormond Street Hospital for Children NHS Foundation Trust [2017] EWCA Civ 410**; **Alder Hey Children's NHS Foundation Trust v Evans and Others [2018] EWHC 308 (Fam)**). I repeat, I am entirely satisfied that the treatment proposed is in D's best interests.