Neutral Citation Number: [2024] EWCOP 60 (T3)

Case No: 13398706

COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 01/11/2024

Before :

THE HONOURABLE MR JUSTICE HAYDEN

- -

Between :

The Health Service Executive of Ireland

Applicant

- and -

SM

Respondent

- -
- -

Henry Setright KC and Stephen Broach KC (instructed by **Bindmans LLP**) for the **Applicant**

Hearing date: 24th October 2024

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APPROVED JUDGMENT

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This judgment was delivered in public but a transparency order is in force. 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 protected party and members of their family must be strictly preserved. All persons, including representatives of the media and legal bloggers, must ensure that this condition is strictly complied with. Failure to do so may be a contempt of court.

Mr Justice Hayden :

1. This application concerns SM, an Irish citizen, aged 24. I delivered an earlier judgment in this case in which I reviewed the framework of applications for recognition and enforcement under Schedule 3 to the Mental Capacity Act 2005 (MCA). I also set out extensively SM's treatment in Ireland, the circumstances in which she became a ward of the court in Ireland and the reasons underpinning her transfer for treatment in England.

2. SM has diagnosis of Anorexia Nervosa, Complex PTSD, Mixed Depressive and Anxiety Order. More recently, she has developed what is termed Pervasive Arousal Withdrawal Syndrome. The earlier judgment is reported as ***The Health Service Executive of Ireland v Ellern Mede Moorgate [2020] EWCOP 12***. I do not propose to rehearse the background history here. SM has been treated in the UK at a specialist facility, Ellern Mede for which there is no equivalent in Ireland. She has made considerable progress, though that that has not been linear. Her progress has been punctuated with very significant periods of regression.

3. SM is an Irish citizen who remains habitually resident there. Accordingly, she falls under the responsibility of the Applicant Health Service Executive of Ireland (HSE). In this application, the HSE are represented by Mr Setright KC and Mr Broach KC. The HSE seeks recognition and enforcement of an order made by the Irish High Court on 14th October 2024 by Barniville P, the President of the High Court of Ireland.

4. That order provided for the continued detention of SM at Ellern Mede for the purposes of assessment and treatment. SM remains at that facility where she continues to receive treatment. She was transferred there on 3rd January 2024, under the aegis of a previous order of the Irish High Court dated 25th April 2023. That order was recognised and enforced by this Court on 24th May 2023. The previous order dated 29th April 2024, was recognised and enforced by this Court on 17th May 2024. At that hearing, I expressed my concern about the extensive history of this case and the repeated orders depriving SM of her liberty. It is that provision which brings the case before me today.

5. It is plain from the documentation that I have received in the supplemental electronic bundle that the Irish Court has considered this case with great care and in scrupulous detail. Although it does not do justice to the complexity of her situation, SM can properly be described as making continuing progress, notwithstanding a recent and significant period of regression.

6. The judgment of the President on 29th April 2024 provides a convenient point from which to track SM's recent history. The President noted that the HSE's application was supported by SM's Committee in wardship, the General Solicitor and by her social worker. The following paragraphs of the judgment require to be set out in full:

> *"The basis on which the application is made by the HSE is that [SM] is making slow but steady and very significant progress since she was admitted to Ellern Mede. That progress is evidenced by a number of reports which are before the Court and they include the first report from [Dr R], a consultant psychiatrist… and her report is dated 12th April 2024. She provides a very detailed report on [SM]'s progress since she moved to Ellern Mede…It does show some significant positive changes and improvements, including [SM]'s acceptance of some food and also her increased preparedness to communicate with members of staff. Also, as [Dr R] notes, [SM] has been showing forward thinking in terms of wanting to consider discharge options and she has been engaging in that.*
>
> *Now [Dr R] does set out her assessment and recommendations at the end of her report. She notes that [SM]'s mental state has improved significantly since she was admitted in January 2024, and she says that in her opinion continuing or ongoing in-patient treatment for [SM] for a number of months, she says, as least a further six months is warranted on the evidence. She also*

expresses the view that [SM] does lack capacity to consent to this treatment in care and that she does need the framework, the legal framework in place in order for them to continue to provide the treatment and care that they've been providing to [SM] since she moved to Ellern Mede.

The second report is a from [Dr M], consultant psychiatrist with the HSE… She provides a detailed report in relation to her visit to [SM] at the beginning of March and also further developments following a CPA meeting on the 24th April of this year. And again [Dr M's] report does disclose a significant improvement and a greater degree of positivity from [SM]. She notes in her concluding section of her report that:

"[SM]'s mental state has improved since her admission to Ellern Mede."

Again she says:

"She is more forward thinking and hopeful for the future."

But, in [Dr M] view, [SM] does continue to lack capacity in all of the relevant respects. And equally, she says, that despite the positive progress that [SM] has made that she does continue to be at risk of malnutrition, self-harm, physical health complications and self-neglect and, further, that she will require psychotropic medication and high levels of specialist support in the various areas that are mentioned, physiotherapy, dietetics support, support with self-care, socialisation work and, most importantly, trauma-informed therapy and a specialised trauma therapist, … has been identified and I think will commence, if she hasn't already commenced, working closely with [SM] and it is anticipated that if [SM] were

> *to move to a step-down type placement that [the therapist] would be able to remain involved because trauma is obviously a very significant feature of [SM]'s case.*
>
> *[Dr M] does again express the opinion that there is no treatment in Ireland that could possibly meet [SM]'s needs and she has previously given evidence of efforts to find alternative placements in Ireland. So she says that the placement with Ellern Mede, which has been secured and funded by the HSE, is the only viable option at this point. She also confirms the question of capacity as I have mentioned."*

7. The President was plainly impressed by the evidence of SM's social worker who he records as telling him *"that she could detect [SM] coming back to life following her admission"*. He further noted that *"no doubt in her mind that [SM] is in the right place and she was able to come to that view after spending a day with her in Ellern Mede shortly after [SM] moved there"*. The President listed SM's case for a further review hearing on 14th October 2024. At that hearing, the HSE submitted that:

> *"she has made something of a journey out of the crisis that the Court observed over the month of December and is now demonstrating progress in terms of a transition almost entirely from nasogastric feeding to oral feeding commencing in July; mobilising now using a walking frame rather than a wheelchair; a rationalisation of her psychotropic medication."*

8. The President plainly accepted that submission. I would also add that in the context of SM's history, the significance of her achievements and progress should not be underestimated. There were other encouraging prognostic indicators:

> *"(i) A reduction in nursing observations from those reported on the last review;*

> *(ii) A resolution of some difficulties with elimination which the reporting says were tied to a previous trauma being resolved;*
>
> *(iii) Her work with the psychology service;*
>
> *(iv) Her ability to commence trauma therapy which had previously been contemplated as a proposal but has now been given effect, funded by the Applicant; and*
>
> *(v) The better channel of communication between [SM] and her treating psychiatrist and the continued clear channel of communication maintained even at the most difficult periods, with… the social worker engaged by the General Solicitor."*

9. In addition to indicating SM's progress, I note that some of these changes restored a greater degree of privacy to SM's life, and accordingly eased the extent of her deprivation of liberty. The HSE was clear, however, that SM continued to require specialist treatment and would likely do so for a minimum of 6 months.

10. Mr Setright and Mr Broach set out the following in their detailed and helpful position statement for today's hearing:

> *" (a) For the majority of this review period and up to the end of September, the overall position was that steady improvement had been made although [SM] remained very vulnerable. The examples of that progress included coming off her NG feed, engaging with the trauma therapist, engaging in psychotherapy, having all meals as food and nutritional supplements as well as other little day-to-day steps forward. Her vulnerability was emphasised in terms of sitting on the mattress for almost half of the day, remaining non-verbal and the distress caused in going to the bathroom.*

(b) [The Social worker] then reported the setback over the two weeks prior to her report. However shortly before the hearing counsel for the General Solicitor had received updating instructions to confirm that [SM] had, in [the Social worker]'s opinion, returned to baseline.

(c) There was a very detailed record of [SM]'s wishes and feelings at section 4 of [the Social worker]'s report. She was aware of her entitlement to participate in the hearing, but did not wish to do so. Counsel for the General Solicitor emphasised that [SM] does want to have her trauma treated. She was frustrated that this is taking time. In the absence of it being dealt with in the short-term, she feels the only way to end the pain is to end her life. However she has said that if she has to stay alive, she doesn't want to stay in Ellern Mede for a long time. Counsel for the General Solicitor invited the President to note that this was not the plan, and that all parties are working towards progress forward for [SM].

(d) In relation to family contact, the position is somewhat complicated, but some small progress has been made. [SM] has disclosed her place of treatment to her mother, she has accepted a present from her but she continues to express a very clear wish to [The Social worker] that [she] doesn't speak with her mother and indeed doesn't try to explain to her mother the depth of her feelings and the reason for their falling-out, which is being respected …"

11. The Order made by the President provides substantively for the Medical Director of Ellern Mede, to be permitted to detain SM for the purpose of providing assessment, treatment, welfare, and therapeutic services for her, pending further Order. The Order also permits the Medical Director to:

> *"take all necessary and/or incidental steps (including the provision of consent for any medical psychiatric psychological or other assessment treatment or assistance whether at Ellern Mede or (if necessary and appropriate) at some other location or facility) and to use such reasonable force and/or restraint as may be necessary in so doing to promote and/or ensure the care protection safety and welfare circumstances of [SM] and to provide [SM] with such hydration, sustenance, medication and treatment as may be clinically and /or medically indicated in accordance with the operational policies of Ellern Mede, including for the avoidance of doubt the provisions of nasogastric feeding."*

12. The next review in the Irish High Court is listed for 7th April 2025.

Legal Principles

Joinder and hearing of P in Schedule 3 proceedings

13. In ***Re SV [2022] EWCOP 52*** Mostyn J reviewed the authorities on Schedule 3 applications (including ***HSE Ireland v PD [2015] EWCOP 48, "Re PD"***) and produced a helpful checklist to assist applicants and the Court of Protection with such cases. Under item 3 in his checklist, *"It is necessary that P is joined as a party?"*, he provided the following guidance: *"Normally, necessity [for joinder] will be shown only where P is actively contesting the application* ***and*** *where there are other valid reasons to review the process of the foreign court"* (our emphasis added).

The general legal background to Schedule 3 applications for recognition and enforcement

14. Section 63 of and Schedule 3 to the MCA has given effect to the central provisions of the 2000 Hague Convention on the International Protection of Adults ("the Convention") as a matter of English law and has done so on a very wide basis. Schedule 3 makes provision for the recognition, enforcement and implementation of protective measures imposed by a foreign Court regardless

of whether that Court is located in a Convention country.

Definitions

15. Part 1 of Schedule 3 provides a definition of terms that apply for purposes of the Schedule. Importantly, paragraph 2(4) of Schedule 3 provides that "[a]*n expression which appears in this Schedule and in the Convention is to be construed in accordance with the Convention*."

16. The most important of these definitions for present purposes are:

    (i) First, the definition at paragraph 4 of Schedule 3 that, in respect of a person over 18, an "*adult*" in the context of Schedule 3, is a person who "*as a result of impairment or insufficiency of his personal faculties, cannot protect his interests.*"

    (ii) Second, paragraph 5 defines a "*protective measure*" as "*a measure directed to the protection of the person or property*," and gives a non-exhaustive list of examples which includes (at Paragraph 5(a)): "*the institution of a protective regime*;" (at Paragraph 5(e)) "*placing the adult in a place where protection can be provided*; and (at Paragraph 5(g)): "*authorising a specific intervention for the protection of the person or property of the adult*." It is clear that a protective measure can include a measure provided for by the order of the Irish Court in this instant case: see ***Re PA & Ors [2015] EWCOP 38*** at paragraph 47.

Recognition and enforcement

17. By paragraph 20(1) of Schedule 3, an interested person may apply to the Court of Protection for a declaration as to whether a protective measure taken under the law of a country other than England and Wales is to be recognised in England and Wales. Paragraph 19(1) of Schedule 3 establishes the general rule that "*a protective measure taken in relation to an adult under the law of a country other than England and Wales is to be recognised in England and Wales if it was taken on the ground that the adult is habitually resident in the other country*."

18. Paragraph 22(1) then provides that an interested person can apply to the Court for a declaration that a protective measure taken in a foreign country is to be enforced in England and Wales. The same principles then apply as regards recognition: see paragraph 22(2). In the event that the order is declared to be enforceable, it is "*enforceable in England and Wales as if it were a measure of like effect taken by the Court"*: paragraph 22(3).

19. The power of the Court to review the substance of the protective measures in question is limited by the statute:

    a. Paragraph 21 provides that any finding of fact relied upon when the measure is taken is conclusive, including as to whether the individual is habitually resident in the country (see ***Re PA & Ors*** at paragraph 52);

    b. By paragraph 24, the Court may not review the merits of a measure taken outside England and Wales "*except to establish whether the measure complies with this Schedule in so far as it is, as a result of this Schedule, required to do so*."

20. Paragraphs 19(3) and 19(4) set out the only circumstances in which the general rules set out in Paragraph 19(1) and Paragraph 22(1) may be disapplied:

    a. Paragraph 19(3) provides that the Court may decline to recognise (or, in turn, declare to be unenforceable) the measure on essentially procedural grounds, if it thinks that: (a) the case in which the measure was taken was not urgent; (b) the adult was not given an opportunity to be heard; and (c) that omission amounted to a breach of natural justice. The requirements are cumulative: ***Re PA & Ors*** at paragraph 55; and

    b. Paragraph 19(4) provides that a Court may decline to recognise (or, in turn, declare to be unenforceable) a measure if it thinks that: (a) recognition of the measure would be manifestly contrary to public policy; (b) the measure would be inconsistent with a mandatory provision of the law of England and Wales, or; (c) the measure is inconsistent with one subsequently taken, or recognised, in England and Wales in relation to the adult.

21. In ***Re PA & Ors***, Baker J (as then he was) held that:

"93. First, by including Schedule 3 in the MCA, Parliament authorised a system of recognition and enforcement of foreign orders notwithstanding the fact that the approach of the foreign courts and laws to these issues may be different to that of the domestic court. These differences may extend not only to the way in which the individual is treated but also to questions of jurisprudence and capacity. Thus the fact that there are provisions within the Act that appear to conflict with the laws and procedures of the foreign state should not by itself lead to a refusal to recognise or enforce the foreign order. Given that Parliament has included section 63 and Schedule 3 within the MCA, clearly intending to facilitate recognition and enforcement in such circumstances, it cannot be the case that those other provisions within the Act that seemingly conflict with the laws and procedures of the foreign state are mandatory provisions of the laws of England and Wales so as to justify the English Court refusing to recognise the foreign order on grounds of such inconsistency. In such circumstances, it is only where the Court concludes that recognition of the foreign measure would be manifestly contrary to public policy that the discretionary ground to refuse recognition will arise. Furthermore, in conducting the public policy review, the Court must always bear in mind, in the words of Munby LJ that "the test is stringent, the bar is set high".

94. Secondly, there is likely to be a wide variety in the decisions made under foreign laws that are put forward for recognition under Schedule 3. As the Ministry of Justice has observed, inevitably there may be concerns about some of the foreign jurisdictions from which orders might come. But as the Ministry also observes,

taking account of such concerns is surely the purpose of the public policy review. Although no wide-ranging review as to the merits of the foreign measure is either necessary or appropriate, a limited review will always be required as indicated by the European Court in Pellegrini. That will be sufficient to identify any cases where the content and form of the foreign measure, and the processes by which it was taken, are objectionable. It also seems to me that the circumstances in which Schedule 3 is likely to be invoked, and the number of countries whose orders are presented for recognition, are likely to be limited. In oral submissions, Mr Rees pointed out that, in theory, the Court could be faced with applications to recognise and enforce orders from any country in the world, including, for example, North Korea or Iran. That may be right in theory, but common sense suggests it is, to say the least, unlikely in practice, at least in the foreseeable future. And if such orders were to be presented for recognition, the public policy review would surely lead swiftly to identifying grounds on which recognition would be refused. It is much more likely that the orders presented for recognition will be those of foreign countries whose legal systems, laws and procedures are closely aligned to our own. Concerns of this nature can be addressed by admitting evidence of the process by which the foreign protective measures were made and general evidence relating to the legal system of the state that made the order.

95. Thirdly, most orders presented for recognition are likely to be of short duration, and/or in respect of persons whose capacity may fluctuate, and/or who are in receipt of a progressive form of treatment. As a result, in such cases there is likely to be repeated requests to scrutinise

> *a succession of orders. Recognition and enforcement is likely to require close co-operation, not only between the medical and social care authorities of the two countries, but also between the Courts and legal systems. The Convention provides a mechanism using the Central Authorities but, pending ratification of the Convention, there may well be the need for direct communication between judges of the two jurisdictions."*

22. At paragraph 98 of ***Re PA & Ors***, Baker J also confirmed that an order recognising and enforcing a foreign measure under Schedule 3 is not a welfare order as defined in s.16A(4)(b) MCA 2005. The rules as to ineligibility in Schedule 1A and s.16A therefore do not apply. This means that the Court will be obliged to recognise and enforce orders of a foreign court depriving an individual of his liberty in circumstances in which it would not able to do so under the domestic jurisdiction under the MCA, on the grounds that the individual is being treated or is treatable under the MHA as defined in Schedule 1A of the MCA. Once again, however, this is subject to its discretion to refuse recognition and enforcement where that would be manifestly contrary to public policy.

23. In ***Health Service Executive of Ireland v Ellern Mede Moorgate* [2020] *EWCOP 12***, I considered (*inter alia*) the extent to which the Schedule 3 regime safeguards an adult's ECHR rights (notably those under Article 2, Article 5(4), Article 6 and Article 8), even in circumstances where the adult may remain at a placement in England for a lengthy period of many years. I accepted the HSE's submissions in this regard, agreeing that the Schedule 3 regime provides effective protection of an adult's rights, even where it may apply for long periods. Indeed, I recognised that the arrangements between the HSE and English health care providers, via Schedule 3, have many advantages (see paragraphs 44-51). I noted that a *"striking benefit"* of the Schedule 3 regime is that *"it provides clarity of responsibility. There is a clear, unbroken chain of command from patient to court. It also provides an avoidance of "jurisdictional confusion", which ought always to be regarded as inherently dangerous and potentially inimical to the welfare of the adult concerned"* (paragraph 49).

24. The High Court in both jurisdictions has been vigilant to safeguard SM's fundamental rights and freedoms. It is always troubling to every judge to see the protracted restriction of individual liberty in cases of this kind, particularly so where that concerns a vulnerable young person. The obligation of the courts is to make such restrictions only where identifiably necessary and for the shortest period possible. SM has expressed herself as *"satisfied to be receiving treatment at Ellern Mede"*. She expresses herself carefully and with much thought. She is not prepared to say that she consents to the treatment. Instead, she observes that it is difficult to say she wants to be there as she does not want her experience to be perceived as positive. Plainly, it is not. The regime is, of necessity, challenging and distressing.

25. In a hearing in January 2024 in the High Court of Ireland, Mr Justice Heslin had a report before him from a Dr C, Consultant Psychiatrist which contained the following paragraph:

> *"[SM] is a 23 year old young woman with a long history of low mood, depressive thoughts and suicidal ideation, fluid and food restriction leading to significant weight loss with a morbid fear of weight gain predating to the age of 14. Her diagnosis in my opinion is in keeping with a depressive disorder, post traumatic stress disorder and eating disorder namely anorexia. Over the last six months [SM]'s presentation has deteriorated again to the point where she is isolated now in her room and has stopped talking, electively mute, walking eating and caring for herself.* ***[SM] needs assistance with the very basics of daily living and appears to be in a state of learned helplessness.*** *(my emphasis)*
>
> *It appears that [SM] presents in this way when overwhelmed. Given this is now the second time [SM] has presented in this way, my impression is that her current presentation appears to have shifted from a typical eating disorder, anorexia nervosa, to one that is*

> *more severe and in keeping with pervasive arousal withdrawal syndrome or PAWS as her functional disabilities have extended to domains other than feeding, including walking, talking and caring for herself. [SM]'s mental state remains very unwell and fragile. The nature and degree of her mental disorder is in my opinion one warranting ongoing inpatient treatment on a specialist eating disorder unit for at least the next 12 months. This will need further review depending on mental state and level of risk nearer the time."*

26. It is plain that the medical evidence before Mr Justice Heslin in January, presented a very different picture of SM's circumstances. The troubling phrase *"learned helplessness"* describes something very different from the significant but cautious progress recorded more recently (see Paragraph 6 above).

27. It is also clear that SM has a strained relationship with her mother. She has strenuously resisted her mother's relatively recently resurrected wish to be joined in the Irish proceedings. Mr Setright tells me that SM guards her privacy and believes that her mother would wish to go to the press to highlight her situation. SM decidedly does not want that. I consider her position to be entirely well reasoned. Indeed, I am bound to say, it does not sit comfortably with the conclusion that she lacks capacity to litigate. Similarly, her recognition of the benefit of treatment at Ellern Mede and her careful navigation of the issue of consent also show indications of, at very least, some degree of capacity or potential for decision taking in this sphere. In the President's Judgment of 29th April 2024 (see Paragraph 6 above), it was noted that Dr R, in that period, thought SM had been showing *"forward thinking in terms of wanting to consider discharge options"* which she had been *"engaging in"*. Nonetheless, I note Dr R concluded that SM lacked capacity to consent to treatment.

28. In his January Judgment, Heslin J made the following observation:

> *"this is an application to ensure the continuation of vital treatment in the context of a necessary care regime for*

> *[SM], plainly in her best interests and the evidence makes clear, looking at it through the lens of the inherent jurisdiction that this is someone who lacks capacity and that the orders sought today constitute a necessary and proportionate response by the court to ensure that [SM]'s fundamental and constitutionally protected rights are vindicated and protected."*

29. Evaluating capacity *"through the lens of the inherent jurisdiction"* appears to be a very different exercise from that required by the MCA in this jurisdiction. I emphasise 'appears' because the jurisprudence regulating the application of the inherent jurisdiction in the Irish Court may serve, as I strongly suspect it does, to deliver a similar approach to our own. It is necessary here to set out the important fundamental principles of the MCA. They are conveniently encapsulated in Section 1:

> *"**1. The principles***
>
> *(1) The following principles apply for the purposes of this Act.*
>
> *(2) A person must be assumed to have capacity unless it is established that he lacks capacity.*
>
> *(3) A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.*
>
> *(4) A person is not to be treated as unable to make a decision merely because he makes an unwise decision.*
>
> *(5) An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.*
>
> *(6) Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action."*

30. Each of these principles is important, but the most important is that embodied in Section 1(2), which erects a presumption of capacity which requires to be

displaced by evidence meeting the civil standard of proof (i.e. the balance of probabilities). This fundamental safeguard is the gateway to the jurisdiction of the MCA. If the test is not met, the court's duty to identify P's best interests is not engaged.

31. The test for capacity is defined thus:

> *"**2 People who lack capacity***
>
> *(1) For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.*
>
> *(2) It does not matter whether the impairment or disturbance is permanent or temporary."*

32. Evaluating capacity is issue specific; it emphasises using and weighing information, and it imposes an obligation effectively to promote capacity by the use of language tailored to P's particular challenges in communicating and understanding:

> *"**3 Inability to make decisions***
>
> *(1)For the purposes of section 2, a person is unable to make a decision for himself if he is unable—*
>
> *(a)to understand the information relevant to the decision,*
>
> *(b) to retain that information,*
>
> *(c) to use or weigh that information as part of the process of making the decision, or*
>
> *(d) to communicate his decision (whether by talking, using sign language or any other means).*
>
> *(2) A person is not to be regarded as unable to understand the information relevant to a decision if he is able to understand an explanation of it given to him in a*

> *way that is appropriate to his circumstances (using simple language, visual aids or any other means).*
>
> *(3) The fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him from being regarded as able to make the decision.*
>
> *(4) The information relevant to a decision includes information about the reasonably foreseeable consequences of—*
>
> *(a) deciding one way or another, or*
>
> *(b) failing to make the decision."*

33. Key to the understanding of the philosophy of this legislation is recognition that central to the Act is the obligation to safeguard individual autonomy and protect human dignity.

34. All who have been involved with SM, in both jurisdictions and across a wide range of disciplines are aware that her liberty has been, necessarily, restricted over a considerable period. This is justified by the identified objective of saving her life. She has not been able to consent to her treatment, nor should *"learned helplessness"*, exhibited as exhausted compliance, be conflated with consent. It is an entirely different concept. Indeed, it comes very close to being its polar opposite.

35. Schedule 3 of the MCA is a provision which embodies the conventional principles of international comity. It authorises the recognition and enforcement of foreign orders, factoring in that the approach of the foreign courts may be very different from that of the domestic court. In ***PA (supra)***, Baker J recognised that these differences may be extensive. It is not difficult to contemplate that they might cover the entire gamut of approach to the way in which an individual is treated, ranging from issues of capacity to the identification of best interest. It follows, axiomatically, in my judgement that conflict of law, procedure and even philosophy of approach does not, of itself, require the domestic court either to refuse to recognise or enforce the foreign order.

36. Baker J considered that it should only be where the court concludes that *"recognition of the foreign measure would be manifestly contrary to public policy"* that the discretionary ground to refuse recognition, pursuant to Section 63 and Schedule 3 of the MCA, arises. This is broadly analogous to the approach taken by The Hague Convention on the Civil Aspect of International Child Abduction 1980, with which judges of this Division are familiar. In analysing that test, Baker J considered that *"most orders presented for recognition are likely to be of short duration, and/or in respect of persons whose capacity may fluctuate, and/or who are in receipt of a progressive form of treatment"*. Cases involving people who are suffering with anorexia present their own particular challenges. The prognosis of anorexia nervosa must always be guarded. Morbidity rates range from 10-20%, with only 50% of patients making a complete recovery. Of the remaining 50%, 20% remain emaciated and 25% remain thin. The seriousness of the condition is not always fully understood by the wider public. Treatment may be intermittent or, as here of protracted duration. It is highly intrusive, and it may deprive the protected party of their liberty. This last point is evident in the order made by the President and the extent of his order made to the Medical Director:

> *"to take all necessary and/or incidental steps (including the provision of consent for any medical psychiatric psychological or other assessment treatment or assistance whether at Ellern Mede or (if necessary and appropriate) at some other location or facility) and to use such reasonable force and/or restraint as may be necessary in so doing to promote and/or ensure the care protection safety and welfare circumstances of [SM] and to provide [SM] with such hydration, sustenance, medication and treatment as may be clinically and /or medically indicated in accordance with the operational policies of Ellern Mede, including for the avoidance of doubt the provisions of nasogastric feeding."*

37. Authorisation of a power of restraint, particularly over a protracted period, requires vigilant scrutiny and review, both as to its continuing necessity and its proportionality. SM's capacity to consent to treatment requires equally scrupulous review, recognising that it may fluctuate. Into such review, must

always be factored the recognition that a refusal of treatment, whilst it might objectively be regarded as unwise, will not always be an incapacitous decision.

38. The order recognising and enforcing a foreign measure under Schedule 3 is not a welfare order, as defined by Section 16A (4)(b) MCA, thus the rules as to ineligibility in Schedule 1A and s.16A do not apply. Baker J summarised the position:

> *"98. As for the alleged conflict with other provisions of the MCA, I conclude, as already stated, that, by including Schedule 3 in the MCA, Parliament must be assumed to have permitted orders to be recognised that did not comply with other laws and procedures under the statute. As the definition of "adult" in Schedule 3 para 4 plainly extends to persons who may not be incapacitated within the meaning of section 2, it follows that the Court will be obliged to recognise and enforce orders of a foreign court in terms that could not be included in an order made under the domestic jurisdiction under the MCA. This is subject, however, to its discretion to refuse recognition and enforcement where that would be manifestly contrary to public policy. I agree and adopt Hedley J's conclusion in Re MN that a decision to recognise under paragraph 19(1) or to enforce under paragraph 22(2) is not a decision governed by the best interests of the individual so that those paragraphs are not disapplied by paragraph 19(4)(b) and section 1(5) of the Act. Thus it follows that the Court will be obliged to recognise and enforce a measure in a foreign court order even where applying a best interests test it would not be included in an order made under the domestic jurisdiction under the MCA. Again, however, this is subject, to its discretion to refuse recognition and enforcement where that would be manifestly contrary to public policy."*

39. In ***Health Service Executive of Ireland v Ellern Mede Moorgate [2020] EWCOP 12***, I considered the extent to which the Schedule 3 regime safeguards an adult's ECHR rights (notably those under Article 2, Article 5(4), Article 6 and Article 8), in circumstances where the adult may remain at a placement in England for a lengthy period (many years). I accepted the HSE's primary submission that the Schedule 3 regime is apt to provide effective protection of an adult's rights, even where it may endure for a significant period. Indeed, I recognised that the arrangements between the HSE and English health care providers, via Schedule 3, have many advantages (see paragraphs 44-51). I observed that one *"striking benefit"* of the Schedule 3 regime is that:

> *"49. It provides clarity of responsibility. There is a clear, unbroken chain of command from patient to court. It also provides an avoidance of "jurisdictional confusion", which ought always to be regarded as inherently dangerous and potentially inimical to the welfare of the adult concerned."*

40. At that hearing, both I and the Health Service Executive of Ireland, the Applicant, were exercised about the highly intrusive nature of the order (broadly replicated here) and its continuing duration. It was for this reason, that I took time to consider the scope and ambit of SM's ECHR Convention Rights, which were, and remain, engaged. In doing so, then as now, I appreciate that recognition of a foreign measure would not be granted in circumstances where, to repeat Baker J's phrase, the order would be *"manifestly contrary to public policy"*. Moreover, in the analysis of that issue, it is necessary always to bear in mind the observation of Munby LJ, as he then was, in ***Re L (A Child) (Recognition of a Foreign Order) [2012] EWCA Civ 1157*** that *"the test is stringent, the bar is set high"*.

41. The Court of Protection, like any other Court in the United Kingdom, is bound to act compatibly with the ECHR. The Court, however, is only obliged, as I have adverted to earlier, to undertake such examination as is necessary to satisfy itself that the proceedings meet the guarantees in Articles 5, 6, and 8 of the ECHR (see e.g. ***Pellegrini v Italy (2002) 35 EHRR***). Furthermore, when the

Court considers obligations under two international instruments, there is a magnetic north attracting the court to achieve *a "combined and harmonious application"* (by parity of analysis see ***X v Latvia [2014] 1 FLR 1135***).

42. In my judgement, the obligation to act compatibly with ECHR Convention Rights when recognising and/or enforcing a foreign order exists both independently from and as a facet of public policy. Whilst, to repeat Munby LJ's phrase, *"the test in stringent, the bar is set high"*, the obligation to evaluate compatibility remains, and is not perfunctory.

43. SM's welfare has been unswervingly in focus during the Irish High Court's exercise of its inherent jurisdictional powers. It is clear, however, that SM's capacity has fluctuated over the last 6 months and may well continue to do so. Some of her recent recorded observations are, as I have commented, both measured and insightful. I consider that, in such circumstances, having emphasised both the duration and the draconian nature of the order that I am invited to recognise and enforce, I am required, properly respecting SM's rights, to satisfy myself that she continues to lack capacity in the sphere of decision taking surrounding her medical treatment. This I regard as my obligation, both under the Human Rights Act 1989 and in ensuring that this order remains compatible with public policy in England and Wales. As the papers presently stand, I am not yet able to undertake this exercise in the way that is required, as analysed above. For this reason, I propose to direct an up-to-date assessment of SM's capacity to understand and consent to her continuing treatment. For the avoidance of doubt, I do not require any assessment as to whether such treatment remains in her best interests. Like the Irish High Court, I am entirely satisfied that it is.

44. Having foreshadowed my concerns in respect of capacity, Mr Setright indicated that the HSE would instruct a psychiatrist to assess SM's current capacity relating to her treatment and extending this to litigation capacity. I am grateful to him for adopting that collaborative approach, which if I may say so, has been a feature of the history of this difficult case. That report is to be filed by 21st November 2024. For the avoidance of doubt, I am satisfied that the evidence as

it presently stands, enables me to continue to recognise and enforce the orders of the Irish High Court.