IN THE COURT OF PROTECTION

Case No: 12715633

First Avenue House
42 – 49 High Holborn
London WC1V 6NP

Date: 17 December 2015

Before:

District Judge Glentworth

Between:

P — **Applicant**

- and –

A Local Authority — **Respondent**

Ms Sophy Miles (instructed by **Richard Charlton**) for the **Applicant**
Ms Winsome Levy (instructed by **A Local Authority**) for the **Respondent**

Hearing date: 10 December 2015

JUDGMENT

District Judge Glentworth:

1. This is an application by P (the Applicant) acting through his litigation friend, the Official Solicitor, for an order under section 21A of the Mental Capacity Act 2005 (MCA) discharging the standard authorisation made on 24 June 2015 which authorises a deprivation of liberty in his current accommodation (The Placement). The Respondent to the application is a Local Authority.

2. The Applicant attended the hearing and had expressed a wish to talk to me. By agreement between the parties I saw him in the courtroom in the presence of his solicitor and counsel but in the absence of the local authority representatives and his support workers. Our meeting was recorded and his solicitor made a note which it was agreed would be shared with the Respondent. He spoke about those issues which have been addressed in the documents and, in particular, in his meeting with his solicitor, Ms Gidoomal (see her attendance note of their meeting of 9 November 2015 exhibited to her witness statement which appears at G6 onwards in the bundle). I explained that I would not be able to give my decision that day and that I would provide a written judgment.

Background to the application

3. The Placement is a residential service with psychological, nursing and psychiatric provision together with social care support which provides a 24-hour support service. The Applicant has lived there since 9 April 2014. From 2001 to 2009, he was detained pursuant to section 37 of the Mental Health Act 1983 (MHA) following his conviction for common assault on 25 July 2001. The assault was on a child who had made an allegation of indecent assault by the Applicant on that child and his younger sister. The Applicant has a number of previous convictions for minor offences. He is said to have accepted two cautions for indecent assault on children in 1993 and 1995 which do not appear in the antecedents obtained from the police records. The Applicant himself referred to having received a caution (see the mental capacity assessment at F41 in the bundle).

4. At the time of the move to The Placement, the Applicant was the subject of a community treatment order pursuant to section 17 of the MHA. That was allowed to lapse with effect from 28 October 2014. In the interim, on 30 April 2014, the first standard authorisation under the MCA was granted. A second standard authorisation was granted on 25 June 2015 and that has been continued by this court to the conclusion of these proceedings.

These proceedings

5. This application was made on 16 July 2015. The question of the Applicant's capacity to make the relevant decisions was not clear-cut and for that reason the parties were given permission to obtain a report from Dr Barker, Consultant in Old Age Psychiatry. His report is dated 28 September 2015 and he attended court and gave evidence. I read the documents comprising the hearing bundle and also heard evidence from Ms T, Senior Practitioner with the

respondent's Learning Disability Team who provides support to the Applicant. Her statement dated 4 November 2015 addresses the question of the care and support available to the Applicant in the event of certain specified possible outcomes.

The law

6. The principles which apply for the purposes of the Mental Capacity Act 2005 ("the MCA") are set out at section 1 and in particular section 1(2) which provides that *"a person must be assumed to have capacity unless it is established that he lacks capacity"*. The burden of proof lies on the party asserting that a person does not have capacity, in this case the Respondent, and the MCA provides that "*... any question whether a person lacks capacity within the meaning of this Act must be decided on the balance of probabilities*" (section 2(4)).

7. A person may have capacity in respect of certain matters but not others. 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"* (section 2(1) MCA). 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 (section 3(1) MCA).

8. In *CC v KK and STCC* (2012] EWHC 2136 (COP) Mr Justice Baker set out what is required of the court when assessing capacity at paragraph 24 as follows, "*... when assessing the ability of P to (a) understand the information relevant to the decision (b) retain that information, and (c) use or weigh that information as part of the process of making the decision, the court must consider all the evidence, not merely the views of the independent expert. In many cases, perhaps most cases, the opinion of the expert will be confirmed by the other evidence, but inevitably there will be cases where the court reaches a different conclusion. When taking evidence from P herself, the court must plainly be careful about assessing the capacity to understand, retain and use and weigh up information, but, whilst acknowledging the important role for expert evidence, the assessment is ultimately a matter for the court*".

9. In this case the court is concerned with a deprivation of liberty. The starting point is section 4(A) MCA which states that, subject to the provisions of that section the MCA *"does not authorise any person (D) to deprive another person (P) of his liberty"*. Section 4A (5) qualifies that by providing that, *"D may deprive P of his liberty if the deprivation is authorised by Schedule A1 (hospital and care home residents: deprivation of liberty)"*.

10. Schedule A1 sets out the requirements which must be met before a supervisory body (the Respondent) can grant a standard authorisation to the managing authority (The Placement) to deprive a person (the Applicant) of his liberty. Six qualifying requirements must be met (schedule A1 para 12) namely:

(a) the age requirement;
(b) the mental health requirement;
(c) the mental capacity requirement;
(d) the best interests requirement;
(e) the eligibility requirement; and
(f) the no refusals requirement.

11. Paragraphs 14 – 16 inclusive of schedule 1A set out the requirements to be met as follows:

(1) The relevant person meets the mental health requirement if he is suffering from mental disorder (within the meaning of the Mental Health Act, but disregarding any exclusion for persons with learning disability).

(2) An exclusion for persons with learning disability is any provision of the Mental Health Act which provides for a person with learning disability not to be regarded as suffering from mental disorder for one or more purposes of that Act. (Paragraph 14)

Paragraph 15 provides:

> *The relevant person meets the mental capacity requirement if he lacks capacity in relation to the question whether or not he should be accommodated in the relevant hospital or care home for the purpose of being given the relevant care or treatment.*

Paragraph 16 states:

1) The relevant person meets the best interests requirement if all of the following conditions are met.

2) The first condition is that the relevant person is, or is to be, a detained resident.

3) The second condition is that it is in the best interests of the relevant person for him to be a detained resident.

4) The third condition is that, in order to prevent harm to the relevant person, it is necessary for him to be a detained resident.

5) The fourth condition is that it is a proportionate response to:

(a) the likelihood of the relevant person suffering harm, and

(b) the seriousness of that harm, for him to be a detained resident.

The powers of the court when an application is made to challenge a standard authorisation are set out at section 21A MCA. Counsel for the Official Solicitor on behalf of the Applicant has set them out in detail in her Position Statement and I do not intend to repeat them here. There is no dispute between the parties about the relevant law to be applied.

Evidence as to capacity

12. I have considered the mental capacity assessment of Ms H, Registered Nurse (Learning Disability) dated 25 June 2015. It is clear from her very careful assessment that she found this a difficult exercise. At F40 she says that having consulted his consultant psychiatrist and the section 12 psychiatrist she has concluded that, "*... no one is able to say with any certainty that [the Applicant] does not have capacity. It was suggested by both the clinical psychologist and deputising manager that [the Applicant] has fluctuating capacity 'because he keeps making the same mistakes and does not learn from them'. Given that [the Applicant] has been detained by the state for the last 14.5 years I do not find this a particularly convincing argument. I also found very limited written evidence to support this supposition, other than a few incident reports relating to him becoming angry and upset when planned activities were cancelled. Changes to planned activities have occasionally resulted in him becoming verbally abusive and challenging of his care and detention. It should be noted that [the Applicant] has a diagnosis of ASD and it is likely that he finds the emotions generated by such disappointments difficult to manage. Given the sensitivities of his previous offences and the overriding imperative to protect vulnerable children, it is understandable that there continues to be significant anxieties amongst those charged with his care. I was also unable to confidently state one way or the other whether in my opinion [the Applicant] did or did not have capacity to weigh the risks to self*". It was for that reason that she arranged a repeat assessment.

13. Ms H summary following the repeat assessment appears at F44/5. She said, "*[The Applicant] was able to demonstrate a sufficient level of knowledge regarding the rights and wrongs of sexually abusing children, he has retained this knowledge and was able to weigh it when provided with hypothetical situations and arrive at the right decision, regarding actions he would need to take. [The Applicant] articulates his understanding clearly. However, [the Applicant] continuously puts his own consequences before that of his hypothetical victim and when questioned further about the effects of unlawful molestation on the victim, was unable to demonstrate any empathic understanding for the victim ... [The Applicant] continues to refuse to engage with the professionals that would be able to help him move toward greater independence, this refusal in my opinion indicates that he is unable to weigh the risks to self and use the appropriate support mechanisms that are made available to him. It would also support that there is a dissociation between what he says and what may be his reality*". She concludes that the Applicant does not have the capacity to decide where he should be accommodated for the purpose of being given care and treatment.

14. Dr Barker is the jointly instructed expert whose report is dated 28 September 2015 and is included in the bundle at 11 – 25. He records at 4.3 that the Applicant has had extensive assessment over many years, including at specialist centres. He has a diagnosis of mild mental retardation (IQ of 60) and Dissocial Personality Disorder. He says "*Dissocial Personality Disorder, as defined in the World Health Organisation's International Classification of Diseases version 10 (current version), is characterised by at least three of the following features: a disregard for the feelings of others and social norms, rules and obligations; gross and persistent irresponsibility; incapacity to maintain relationships; a low tolerance to frustration and a low threshold for aggression and violence; incapacity to experience guilt or learn from experience (including punishment); and a tendency to blame others or offer rational explanations for antisocial behaviour*". He goes on to say that these mental disorders are life long, "*... though with full engagement with therapy and support it is possible to minimise the risk associated with them*".

15. At paragraph 4.5 of his report Dr Barker comments that the use of DOLS in this clinical situation as a way of managing the Applicant's risk to himself as opposed to the MHA to manage the risk to himself and others, "*is an unusual one*" and goes on to say, "*It would be interesting to know what consideration was given to the appropriateness of the different approaches when discharging him from the Community Treatment Order (or allowing it to lapse)*". He goes on to comment that his task is "*to consider his capacity to manage his risk to himself, and perhaps the Best Interests consideration is the one that should determine whether the risks to himself justify the deprivation of liberty*". He notes a reference to the need to protect the Applicant in earlier records (cited in paragraph 3.2.8, [I6] from records in 2009 which refer to his vulnerability from exploitation). He continues in 4.6, "*Relevant information for decisions on residence with associated care would, in my view, include information on what the different residential options are and how they differ in the support offered; what care and support needs he has and how he will access these; what would happen if he fails to seek out the necessary support; and the rules and obligations he would have to adhere to in the different establishments and how he will be able to meet these.*" At paragraph 4.10 he said, "*With lacking acknowledgement of his past and present difficulties, and impaired understanding or acknowledgement of the support he continues to need, it is difficult to conclude that he is able to use or weigh relevant information in coming to valid decisions on residence for the purposes of care that he might require. While he considers that he might continue to live at The Placement while a more appropriate placement is found, I find no evidence that he would be able to consistently comply with the rules and boundaries necessary for the safe and effective running of the establishment*".

16. Dr Barker summarises his conclusions at paragraph 5 and gives his opinion that the Applicant, "... *lacks capacity to decide whether to be accommodated at The Placement for care and treatment; and to make decisions as to his future residence*". He concludes by saying that the Applicant, "... *lacks capacity to make decisions concerning the conduct of these proceedings, as he lacks subject matter capacity*".

17. When Dr Barker gave his evidence the question of the use of the DO Ls regime in this situation was explored further with him. He was clear that he had not come across a case quite like this. When asked to elaborate he explained that most members of the public would be more concerned about risks posed *by* the Applicant rather than the risks *to* him. He was asked whether, given that a CTO would be based on concerns about a risk to the public he would expect the identified risks in this case to be managed by a CTO rather than under the DOLs regime. In that context it is noted that the CTO was allowed to lapse. Dr Barker commented that the treatment the Applicant is receiving did not look unlike the sort of care which he would expect to see under the MHA. Although he accepted that this was an unusual case it was a situation in which he felt confident that the Applicant lacked capacity in relation to the question whether or not he should be accommodated in the relevant accommodation for the purpose of being given the relevant care or treatment.

The mental capacity requirement

18. On behalf of the Applicant it is submitted that the mental capacity requirement is not met. As set out above, there is a presumption of capacity. In order to show that a person lacks capacity to make a specific decision it is necessary to establish a causal link between the ability to make the decision and the *"impairment of, or disturbance in the functioning of, the mind or brain"* for the purpose of s2 MCA. I was referred to the decision of the Court of Appeal in *PC v NC and CYC* [2013] EWCA Civ 478 in support of this submission.

19. It is not necessary for the person to comprehend every detail of the relevant information as long as the "salient details" are understood. This is set out in *CC v KK* (a decision which I have already referred to above) where at paragraph 22 Baker J refers to the judgment of Macur J in *LBL v* RYJ[2010] EWHC 2664 (Fam) identified the question as being whether the person under review can, *"comprehend and weigh the salient details relevant to the decision to be made"* (paragraph 58) and made it clear at paragraph 24 that, *"it is recognised that different individuals may give different weight to different factors"*.

20. I was also referred to the need to set a reasonable limit to the information that must be understood, retained and weighed and reliance was placed on the decision of the Court of Appeal in *RB v Brighton and Hove City Council* [2014] EWCA Civ 561 at para 42 when it was said that, *"All long term decisions are made on the basis of peering into an unknown future. Any court applying the test set out in section 3 is imposing an impossible burden if it requires the person to understand and weigh up all information relevant to such decision"*.

21. On the Applicant's behalf the following points are made in relation to the capacity assessments of Ms H and Dr Barker

    i) Neither explains the causal link between the Applicant's impairment of, or disturbance in the functioning of, the mind or brain and his perceived lack of capacity;

    ii) Dr Barker appears to reverse the presumption of capacity in his conclusions at page 119;

iii) Both assessments may appear driven by the outcome rather than the functional approach. Ms H interprets lack of empathy as inability to use or weigh [F44]; Dr Barker interprets the Applicant's minimising of risk as inability to use or weigh [119]. Materially the psychologist at The Placement characterised his lack of engagement as being "in denial" [J33].

22. For the Respondent I am asked to take into account the fact that a number of professionals have assessed the Applicant as lacking capacity in relation to making decisions about his placement at The Placement. Dr Barker confirmed that whilst the Applicant understands what The Placement provides he does not understand why it is the appropriate placement for him. He has no understanding of the use of therapy and is not open to the suggestion that in order to manage future behaviour it is necessary to look at what has happened in the past. The Placement is a residential therapeutic unit and although the Applicant says he is willing to remain there he has not reached the stage where he could manage in the community in a way that would be safe for him.

23. The Respondent points to the fact that Ms H acknowledged the difficulties presented by the assessment because although the Applicant demonstrates a level of knowledge and is able to articulate some sophisticated concepts and ideas relating to actions and behaviours, when challenged to explain the thinking behind the ideas it becomes apparent that his understanding is not based on a firm foundation. Her view was that the Applicant is able to articulate the issues having learned to do that over time whilst he has been in institutions but his understanding is not sufficient to enable him to be able to put it into practice.

24. I was also referred to Dr Barker's conclusion that the Applicant is unable to make these decisions because of his learning disability. He relied on his own assessment and what was set out in previous assessments, specifically that of Dr Elias which appears at F6 – 8. His conclusion was that due to his mental disorder the Applicant is unable to weigh up the information necessary to enable him to decide whether to be accommodated at The Placement now or in the future.

25. I have read the reports very carefully and have been assisted by the oral evidence of Dr Barker. I am satisfied that the Applicant does lack capacity in relation to the question of whether or not he should be accommodated at The Placement for the purpose of being given the relevant care or treatment. The evidence in relation to the diagnosis is clear and not contested.

26. The Applicant is clearly able to understand and retain the information relevant to the decision. There are also no issues in relation to communication. However, I am not satisfied that he is able to use or weigh the information as part of the process of making the decision and that this is because of the impairment which has been diagnosed. I say that because I accept the very careful assessments undertaken both by Ms H and Dr Barker. They clearly found this a difficult case. In his evidence Dr Barker was asked whether it was possible to assess whether it is the case that the Applicant is unable to understand the factors that cause him to be a risk to others or that he simply

does not want to accept the position. He explained that it is the weight of the evidence including the severity of the mental disorder which led him to come to his view on a balance of probabilities. He was expressly asked how confident he was in his assessment that the Applicant lacks the relevant capacity and his response was that although this is an unusual case his large experience of personality disorders in forensic settings meant that this was a case where he was confident in his opinion.

27. On that basis, I find that the mental capacity requirement is satisfied. I consider that it is appropriate for the Applicant to receive the care and treatment available to him at The Placement. I acknowledge that the Applicant says that he is happy to remain there and that he told me that he saw himself staying where he is for the time being. However, I consider that he does not understand that he needs to live at The Placement or another placement which offers similar care and treatment in the form of both social care and psychological input. It is the latter which he rejects but which offers the key to arriving at least at a basic understanding of triggers which could compromise his safety.

Best interests

28. It is also submitted on the Applicant's behalf that the best interests requirement is not met. I have already set out the conditions which must be satisfied to meet this requirement. The point is made on his behalf that the requirement will only be satisfied if it is necessary for him to be a detained resident to prevent him from harm and that detention is a proportionate response to the risk of such harm. It is said that the primary purpose of this authorisation is managing the risk to the public. Were it not for his perceived risk to others (children) the Applicant's care and support needs could be met without depriving him of his liberty. Instead the authorisation is used to deliver treatment to P which mirrors inpatient treatment for mental disorder, normally delivered under the MHA (medication, psychological input, restrictions on leave).

29. This approach to Schedule A1 was described by Dr Barker as "unusual". I have been referred to what Charles J said about the interplay between the use of the relevant sections of the MHA and the procedure under Schedule A1 in *Secretary of State for Justice v KC and* C *Partnerships NHS Foundation Trust* [2015) UKUT 0376 where he said, *"It follows that in contrast to the MHA, the MCA does not contain express statutory powers to detain a person for defined purposes, rather its approach is to authorise a deprivation of liberty if it is in the best interests of the relevant person (and so is the least restrictive option to provide the relevant care and treatment in the best interests of that person".* Further, at paragraph 61 he said, *"It was also in my view correctly asserted before me that a best interests decision, and so a decision under the MCA, could found a different conclusion on the arrangements and protective conditions that are required to one made under the MHA that has to have regard to the protection of the public and the patient".* He went on to say at paragraph 62 that, *"the Court of Protection and the DOLs decision makers are ill-equipped to make and should not make decisions on the arrangements and*

thus the protective conditions required to provide appropriate protection to the public and the patient as and when the patient moves from hospital into the community ..."

30. It is said on behalf of the Applicant that this is precisely what this court is being asked to do because the purpose of the DOLs regime is to prevent harm to P and that is not what is happening in the Applicant's case. The best interests assessment refers to there being, *"numerous allegations of sexual abuse against children"* [F18]. Having considered the Applicant's antecedents and the information which he has provided in relation to the cautions which are not recorded there, I accept the submission that that overstates the case. The risk which has been identified is that the Applicant might behave inappropriately and be at risk of retaliatory reaction. I accept that the concern appears to be primarily the risk to the public. In her oral evidence, Ms T, Senior Practitioner with the respondent's Learning Disability Team, was asked to confirm that the principle risk which the standard authorisation was designed to guard against was the risk to the public and to children in particular. Her response was that her assessment was formulated from forensic risk assessments carried out over the 14 years along with the historical information.

31. The point is made that the Respondent suggested in former position statements that the risk of harm to the Applicant arises from the risk of retaliation or prosecution in the event that he were to commit an offence. In light of the clear wording of Schedule A1 and in the light of the comments above, it is submitted that this reasoning cannot stand. Moreover, following such reasoning, harm to the Applicant would only arise if he were to commit an offence that was detected, whereas plainly the aim of his treatment and thus of the authorisation is to reduce the risk of any offending.

32. Dr Barker described the use of DOLs as unusual and it is submitted on behalf of the Applicant that he plainly had some disquiet about its use in this context. He agreed that the treatment being offered to the Applicant was analogous to that which would be delivered within an MHA setting. For the Applicant it is said that that would be the appropriate framework for managing risk to the public but the CTO was allowed to lapse.

33. For the Respondent it is said that the Applicant is a vulnerable individual. He is not able to understand the impact his behaviour has on others. His expressed knowledge that he will be punished for a misdemeanour is, it is said, superficial not least because he is not willing to address the issue with the therapist. It is said that he needs to understand why he behaves in the way he does before he can move on and that the risk of the removal of the restriction on his liberty would mean that he would be free to come and go without having worked on the basics he needs to keep himself safe. The local authority accepts that the risk is a narrow one and is concerned with the risk of him reacting in such a way that he puts himself at risk of harm. His future behaviour can only be measured by his past behaviour because his ability to manage has not been tested because he has been in institutions for a number of years and now he is subject to restrictions in The Placement. The Respondent says that he is being

given the opportunity to progress but that it would be wrong to say that he should be free to come and go at this stage.

34. As far as the conditions set out at paragraph 16 of schedule A1 are concerned it is the second to fourth conditions which it is submitted on behalf of the Applicant have not been satisfied. I accept that the factors set out in the Position Statement filed on his behalf (paragraph 31) suggest that the level of restrictions may not be necessary and in particular

i) the nature of the risk posed by the Applicant;

ii) the documented progress he has made;

iii) the fact that he has asked for support and clearly values it

35. One of the things which is clear from reading the notes of the dialogue between Ms H and the Applicant at F42 is the frustration he feels at being in what he described as, "*... a catch 22 for me, because I am frustrated in the house at not being supported to make progress then the staff say I will be frustrated if I went into the community and might commit further sexual assaults*". He was asked whether he was saying that he was sexually frustrated in the house. His response was, "*No I'm angry frustrated in the house, but staff think I will he angry frustrated in the community if I am on shadowed leave and might sexually offend. I am clashing with staff in the house because I am so frustrated at the lack of progress, how long everything takes. That they won't allow me to prove I can be trusted. That I spend hours waiting to go out, when if I was allowed out on my own I wouldn't have to wait around I could just go. Even for something as simple as going for a walk, I have to add my name to a list and then wait hours for my turn*".

36. I have to consider whether there is a less restrictive option other than the continued use of the standard authorisation in its current form. I accept the submission advanced on the Applicant's behalf that there is and that is for the Applicant to continue to reside at The Placement without being subject to the standard authorisation. I am told that there are others at The Placement who reside there without authorisation and that it would not affect his ability to stay there. It is accepted that the Applicant wants to remain. In fact he is quite positive about that. He enjoys living there but does not want to be subject to the current restrictions.

37. His social worker confirmed that the Applicant recognises that he does need support. He was keen to be able to go out on his own but quite clear that he saw that freedom in the context of telling staff where he would be going and when he would be back. He would like to move on at some point but at the same time he spoke of the need to have someone around at that stage, even if was no longer living at The Placement.

38. In my judgment, for the reasons I have given, the Applicant does not satisfy all four criteria of paragraph 16 of Schedule Al. In particular, I am not satisfied that it is necessary in order to prevent harm to the Applicant for him to be a detained resident or that his being a detained resident is a proportionate response to the likelihood of him suffering harm. On that basis I will direct the

supervisory body to terminate the standard authorisation which had been continued until the conclusion of these proceedings.