Neutral Citation Number: [2019] EWHC 2306 (Fam)

Case No: F90LS161

IN THE HIGH COURT OF JUSTICE
FAMILY DIVISION
IN THE MATTER OF THE INHERENT JURISDICTION
AND IN THE MATTER OF THE MENTAL CAPACITY ACT 2005

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 05/09/2019

Before :

THE HONOURABLE MR JUSTICE COBB

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Between :

(1) Wakefield Metropolitan District Council **(2) Wakefield Clinical Commissioning Group**	**Applicant**
- and -	
DN **MN**	**Respondents**

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- -

Brett Davies (solicitor-advocate instructed by Liz Ogden, Interim City Solicitor, **WMDC**) for the Local Authority and the Clinical Commissioning Group
Neil Allen (instructed by **Switalskis**) for DN
John McKendrick QC (instructed by **Bindmans**) acting *pro bono* for MN

Hearing dates: 8 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.

....

THE HONOURABLE MR JUSTICE COBB

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 subject and members of his 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 Cobb :

Introduction and identification of the issues

1. This case concerns DN. He is 25 years old. He has a severe form of autistic spectrum disorder, together with a general anxiety disorder, and traits of emotionally unstable personality disorder. That said, he is not significantly intellectually impaired, and he is capable of clear thinking. He has been treated in the relatively recent past for his mental ill-health under the *Mental Health Act 1983* ('*MHA 1983*') and is currently in receipt of after-care support under *section 117 MHA 1983*.

2. In April 2019, DN was sentenced in the criminal (Magistrates) court in respect of a range of public order, and related, offences. A Community Order with a two-year Mental Health Treatment Requirement ('MHTR') under *section 207 Criminal Justice Act 2003* ('*CJA 2003*') was imposed. At the time of the sentence, DN had been bailed to a supported living accommodation in the area of the Applicants called Stamford House[1], a complex containing several individual 1-bedroom flats. At the time of this judgment, DN continues to reside there. Under *section 207* of the *CJA 2003* (which must be read with *section 148* ibid.) those providing accommodation under a Community Order imposed by the criminal courts have the power only to *restrict*, and not *deprive*, a person of their liberty.

3. There is little doubt that the regime at Stamford House, as may be apparent from a review of the outline regime set out as a schedule to this judgment (see especially (3) and (6)), goes further than 'restricting' DN of his liberty. Objectively, features of the regime *deprive* him of his liberty, contrary to his rights under *Article 5 ECHR*. From the moment that Stamford House was first proposed for DN, the Applicants took the view (and remain of the view) that DN was/is unable to give his consent[2] to his care regime at Stamford House, as his decision-making powers have been vitiated by his vulnerability and circumstance. The Applicants therefore issued an application in the High Court, seeking (i) the court's approval under the inherent jurisdiction for ensuring that DN's need for care and support was delivered under a lawful framework, and (ii) authorisation for the deprivation of DN's liberty for as long as he remains/remained at Stamford House.

4. DN was initially joined as the sole respondent to the application; as the evidence reveals that DN has capacity to litigate, and make all other relevant decisions in his life, he did not need a litigation friend (see *CPR 1998 rule 21.2*). He has been represented by Mr Neil Allen. At a subsequent case management hearing, I joined MN, DN's mother, who has been represented at this final hearing *pro bono* by Mr McKendrick QC instructed by Bindmans solicitors. I am particularly grateful to them for their assistance offered in this way.

5. By this judgment, I consider three main issues:

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[1] This is a pseudonym.

[2] One of the key considerations in *Article 5*: reference *Storck v Germany (Application No 61603/00)* (2005) 43 EHRR 96, para 71, and 74.

i) Whether DN is a person who falls in the category of 'vulnerable' adults (as that term is understood in the context of the judgment in *Re SA (Vulnerable Adult with capacity: Marriage)* [2005] EWHC 2942 (Fam) ('*Re SA*') and *A Local Authority v DL* [2012] 3 All ER 1064 *('Re DL')* (*sub nom Re L (Vulnerable Adults with Capacity: Court's Jurisdiction)* [2013] Fam 1) for whom the inherent jurisdiction is available to offer protection and/or to facilitate decision-making;

ii) Whether, if DN is a vulnerable adult over whom the court can exercise its inherent jurisdiction, it can or should do so to authorise his deprivation of liberty at Stamford House;

iii) Whether the court could or should make anticipatory declarations as to DN's capacity and best interests under the *section 15* and *16* of the *Mental Capacity Act 2005*, to cover those occasions when he has 'meltdowns' and is (at that point, it is agreed) unable to make a capacitous decision as to his care.

The hearing

6. For the purposes of determining this application I received and read the statements filed by the parties (which *inter alia* described in detail the regime at Stamford House), and received very able written and oral submissions on behalf of each of the parties. I heard the oral evidence of Dr Patrick Quinn, Consultant Forensic Psychiatrist with a special responsibility for learning disability, at the Yorkshire Centre for Forensic Psychiatry; he had assessed DN on 2 April 2019. I also spoke at some length with DN himself on the telephone, by arrangement, prior to the hearing; we were in conversation for a little under an hour. He was engaging, clear thinking and articulate.

Background facts

7. For most of his life DN has lived with his mother, MN. He has previously resided in a caravan outside her home. The relationship between DN and his mother has at times been fraught with difficulty, as she has struggled to keep DN safe, and manage his complex behaviours. For a period of 18 months or so, when he was about 19/20 years old, DN was an inpatient at a hospital in accordance with *sections 2* and *3* of the *MHA 1983*. As earlier indicated ([1]) he has a diagnosis of autism, and has experienced life-long difficulties in social communication; he has a general anxiety disorder and poor emotional regulation but not a learning disability. He has led a somewhat socially isolated life. In the view of Dr. Quinn, DN is a vulnerable man in that:

> "… some of his behaviours to date particularly in the community would render him vulnerable to retaliatory behaviour. He is also likely vulnerable to exploitation were he to encounter unscrupulous others. His vulnerability does not… deprive him of the capacity to conduct the proceedings or to make decisions as to his care and residence."

8. Occasionally, DN experiences 'meltdowns', which tend to occur when he is particularly stressed, anxious and/or aroused. The current care plan for DN, prepared for this hearing, describes this situation in this way:

> "When DN is in 'meltdown' he displays high levels of agitation, uses extremely threatening and violent language, intimidating behaviour, throwing furniture, displays a confrontational aggressive stance, running away from the scene into the road with no awareness of danger. DN does not always target specific individuals, he threatens whom he comes across; …. DN has assaulted his mother, friends and wider family historically. DN has assaulted police officers in response to feeling cornered and out of control."

At the point of a 'meltdown' DN easily becomes overloaded and over-stimulated with information. It is considered by Dr. Quinn that DN does not then have the capacity to manage his behaviours; he loses the ability to think rationally and weigh up his decisions.

9. The key risks which require management are said to be (a) aggression (to a lesser extent, violence) on DN's part towards his mother and his sister; (b) violence and aggression towards police officers, and care and health professionals; (c) aggression towards others (i.e. the public) including children – it seems DN does not distinguish between children and adults, although risks to children from exposure to DN's behaviours are more acute due to their inherent vulnerability; and (d) sexualised behaviours. DN presents a higher risk when he is anxious, stressed, or challenged.

10. In early 2019 DN was prosecuted for a number of offences, mainly of a public order nature. Having pleaded guilty, sentencing was adjourned; he was advised by the sentencing District Judge (MC) that the disposal options for him were "stark", hinting clearly at a custodial outcome if no residential unit could be made available which could provide a setting for a mental health treatment programme. For the adjourned sentencing hearing, a psychiatric report was prepared by Dr. Y in which it was recommended that:

> "[DN] requires immediate psychiatric intervention… he has multiple issues affecting his day-to-day functioning which are namely his anxiety, somatic complaints and mood…".
>
> "The best scenario for [DN] would be a setting where he would be monitored in a residential setting without him feeling locked up and his freedom is removed. Thus, residential care might be the best option for [DN] where he can live in a communal setting but where staff are available 24 hours a day."

11. It was felt, rightly in my view, that the *MHA 1983* would not provide an appropriate framework for the outcome required. The Applicants therefore issued this application.

12. At the first hearing in the High Court on 19 February 2019, HHJ Troy, sitting as a *section 9*[3] judge, ordered the preparation of a psychiatric report as to DN's capacity to conduct the proceedings, and to make decisions as to residence and care. However, before this report was prepared, DN was arrested for breaching a community protection notice[4] and he was remanded into custody. An urgent second hearing was convened in the High Court on 13 March 2019, alongside an application for bail in the Magistrates' Court. As an emergency measure, driven in part by the recognition of the inappropriate prison environment for a man with DN's mental health difficulties and needs, HHJ Troy took interim protective measures while his mental capacity could be further investigated. The order made on that day records:

> "… the court being invited to approve a plan that [DN] may, lawfully, move to reside at [Stamford House], on the basis that [DN] may not have capacity to make decisions as to his residence and care, and may be unable to give lawful consent, freely and effectively, although does wish to move to live at [Stamford House] and the court approves of the placement move, and authorises any deprivation of liberty arising from the placement, under its inherent jurisdiction, pending final determination of the applications in these proceedings."

13. The following day, on 14 March 2019, the Magistrates' Court bailed DN to that placement, and DN left prison. During his two-week remand in custody, it is said that his physical and mental wellbeing had become seriously compromised. The Applicants maintain that his inability to make a free and meaningful decision as to his sentencing option (given his autism and personality traits) was rendered "even clearer" when considered that he was then temporarily in the inhospitable environment of prison; the Applicants rely further on the fact that DN later presented to Dr. Quinn as an "aggrieved innocent" who had not accepted the placement at Stamford House "on a voluntary basis". Dr. Quinn further opined (2 April 2019):

> "He spoke about his feeling "like I don't have a choice… I don't really have a choice" …. This was driven by his sense of frustration that is not likely to return home in the immediate future. The reality is he understands he has choices but that choices can bring adverse consequences".

It is notable, however, that Dr Quinn later added this:

> "It is very clear from his comments that he does not wish to be "confined". However, he has actually weighed up the options available to him namely residence at his current address, returning to the family home and has concluded that it is more likely of benefit to him at least in the short term to remain at his current address…."

[3] *Section 9(1) Senior Courts Act 1981.*

[4] Issued following warnings on 6 June 2018 under *section 43 of the Anti-Social Behaviour, Crime and Policing Act 2014.*

14. The Applicants have hoped, and continue to hope, that the placement at Stamford House will give DN "the opportunity to develop a sense of individuality" and "independence"; he has his own flat within Stamford House, and receives 12 hours of direct care per day (1:1 or 2:1). DN is clear that he would like less restriction on his life, but he wishes the placement to continue. He told Dr. Quinn that he could see the benefits of remaining where he can receive "person-centred care", and worries what will happen if the placement does not work. The frequency, intensity and duration of the meltdowns have decreased since moving to Stamford House.

Capacity

15. DN is orientated to time and place and appears able to make his own decisions and choices. However, this is often affected by symptoms of his anxiety. DN needs time and space to be able to process and absorb information. As indicated at [4] above, there is no issue in this case about DN's capacity to litigate, or to make decisions about his residence or care. Dr Quinn concluded that "he has capacity to make decisions about the options which the criminal court [was] considering as part of its sentencing powers", and his capacity to make decisions as to residence and care is not impaired. Although vulnerable, such vulnerability was said *not* to deprive him of capacity in these regards. Dr Quinn subsequently clarified that DN also had capacity to conduct these High Court proceedings.

Community Order: Sentence under the Criminal Justice Act 2003

16. As earlier indicated ([2] above), in April 2019, DN was sentenced by the Magistrates Court in relation to five offences (mostly summary offences). The sentence imposed was a Community Order with a MHTR, specifically "to have mental health treatment by or under the direction of Dr. W at or as directed by Dr. W or his team as a resident patient for 2 years."

17. The sentence was imposed pursuant to the powers given to the court by *section 207 CJA 2003* which reads as follows:

> "(1) In this Part, "mental health treatment requirement", in relation to a community order or suspended sentence order, <u>means a requirement that the offender must submit, during a period or periods specified in the order, to treatment by or under the direction of a registered medical practitioner or a [registered psychologist] (or both</u>, for different periods) with a view to the improvement of the offender's mental condition.
>
> (2) The treatment required must be such one of the following kinds of treatment as may be specified in the relevant order— (a) treatment as a resident patient in [a] care home . . . [, an independent hospital] or a hospital within the meaning of the Mental Health Act 1983 (c 20), but not in hospital premises where high security psychiatric services within the meaning of that Act are provided; (b) treatment as a non-resident patient at such institution or place as may be specified in the order; (c) <u>treatment by or</u>

> under the direction of such registered medical practitioner or [registered psychologist] (or both) as may be so specified; but the nature of the treatment is not to be specified in the order except as mentioned in paragraph (a), (b) or (c).
>
> (3) A court may not by virtue of this section include a mental health treatment requirement in a relevant order unless— (a) the court is satisfied. . . that the mental condition of the offender— (i) is such as requires and may be susceptible to treatment, but (ii) is not such as to warrant the making of a hospital order or guardianship order within the meaning of [the Mental Health Act 1983]; (b) the court is also satisfied that arrangements have been or can be made for the treatment intended to be specified in the order (including arrangements for the reception of the offender where he is to be required to submit to treatment as a resident patient); and (c) the offender has expressed his willingness to comply with such a requirement.
>
> (4) While the offender is under treatment as a resident patient in pursuance of a mental health requirement of a relevant order, his responsible officer shall carry out the supervision of the offender to such extent only as may be necessary for the purpose of the revocation or amendment of the order." (emphasis by underlining added).

18. It will be noted that in *section 207(3)* the court requires satisfaction of three components including (at *section 207(3)(c)*) that the defendant has "expressed his willingness to comply with such a requirement". *Section 207* has to be read with *section 148 CJA 2003* which provides that the community sentence must (per *section 148(2)(a)*) be "the most suitable for the offender", and (per *section 148(2)(b)*) "the restrictions on liberty imposed by the order must be such as in the opinion of the court are commensurate with the seriousness of the offence[s]" (emphasis added). These important requirements fall within the governing principle that:

> "(1) A court must not pass a community sentence on an offender unless it is of the opinion that the offence, or the combination of the offence and one or more offences associated with it, was serious enough to warrant such a sentence."

'Vulnerability' and the inherent jurisdiction

19. The Applicants invite the court to exercise what is "in substance and reality, a jurisdiction in relation to incompetent adults which is for all practical purposes indistinguishable from its well-established *parens patriae* or wardship in relation to children": *Re SA* at [37] per Munby J (as he then was; emphasis by underlining added). This jurisdiction, they emphasise, is "a 'protective jurisdiction' in relation to vulnerable adults" which can be deployed rather as it does towards wards of court

(ibid.). The Applicants rightly claim that the Court of Appeal has put beyond doubt that the inherent jurisdiction ("the great safety net" as Lord Donaldson described it in *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1), has survived the coming into force of the *Mental Capacity Act 2005* ('*MCA 2005*'): see *Re DL* at [1] and [8]. Mr Davies argues (again rightly in my view, and supported by Mr Allen and Mr McKendrick) that the court has power to make a wide range of declaratory, injunctive, and other orders, designed to fill the gaps of law where necessary, providing a facilitative, as opposed to dictatorial, approach aimed at re-establishing an individual's autonomy to make decisions, thereby enhancing their *Article 8 ECHR* rights: see again *Re DL* at [67].

20. I have been referred to the evolving caselaw[5] in this area, which has tested what Munby J referred to as a jurisdiction with "probably no theoretical limit"[6]. For my part, the principal point of reference remains McFarlane LJ's judgment in the Court of Appeal in *Re DL* which itself draws heavily from the judgment of Munby J in *Re SA*[7]. In short, as Munby J made clear in *Re SA* (at [76]) the inherent jurisdiction is no longer correctly to be understood as confined to cases where a vulnerable adult is disabled by mental incapacity from making his/her own decision about the matter in hand (as in, for instance, *Re PS (Incapacitated or Vulnerable Adult)* [2007] EWHC 623 (Fam)) ('*Re PS*'), and cases where an adult, although not mentally incapacitated, is unable to communicate his decision: on the contrary, "[t]he jurisdiction extends to a wider class of vulnerable adults".

21. While drawing back from defining a 'vulnerable adult' for these purposes, Munby J nonetheless discussed (in *Re SA* at [82]/[83]) the circumstances in which the inherent jurisdiction could/should be deployed for such a person:

> "In the context of the inherent jurisdiction I would treat as a vulnerable adult someone who, whether or not mentally incapacitated, and whether or not suffering from any mental illness or mental disorder, is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation, or who is deaf, blind or dumb, or who is substantially handicapped by illness, injury or congenital deformity. This, I emphasise, is not and is not intended to be a definition. <u>It is descriptive, not definitive; indicative rather than prescriptive</u>.
>
> The inherent jurisdiction is not confined to those who are vulnerable adults, however that expression is understood, nor is a vulnerable adult amenable as such to the jurisdiction. The significance in this context of the concept

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[5] See for example (though this is not intended to be an exhaustive list) *Southend on Sea Borough Council v Meyers* [2019] EWHC 399, *Hertfordshire County Council v AB* [2018] EWHC 3103 (Fam), [2019] 2 WLR 1084, *London Borough of Wandsworth v AMcC and others* [2017] EWHC 2435 (Fam), [2018] 1 FLR 919, *OH (A minor by his Litigation Friend TA) v Craven; AKB (A Protected Person by his Litigation Friend JB) v Willerton* [2016] EWHC 3146 (QB), *Redbridge London Borough Council v G* [2014] EWHC 485 (COP), *A NHS Trust v Dr A* [2013] EWHC 2442 (COP), [2013] COPLR 605, *XCC v AA & Anor* [2012] EWHC 2183 (COP), [2012] COPLR 730 at [54].

[6] *Re SA* at [45].

[7] For the citations for these authorities, see [5](i) above.

> of a vulnerable adult is pragmatic and evidential: it is simply that an adult who is vulnerable is more likely to fall into the category of the incapacitated in relation to whom the inherent jurisdiction is exercisable than an adult who is not vulnerable. So it is likely to be easier to persuade the court that there is a case calling for investigation where the adult is apparently vulnerable than where the adult is not on the face of it vulnerable. That is all."

22. This approach was adopted and developed by the Court of Appeal in *Re DL* at [64] wherein McFarlane LJ also resisted the invitation to do more than *describe* or *indicate* the class to whom the jurisdiction extends:

> "…it is not easy to define and delineate this group of vulnerable adults, as, in contrast, it is when the yardstick of vulnerability relates to an impairment or disturbance in the functioning of the mind or brain. Nor is it wise or helpful to place a finite limit on those who may, or may not, attract the court's protection in this regard. The establishment of a statutory scheme to bring the cases in this hinterland before the Court of Protection would … represent an almost impossible task, whereas the ability of the common law to develop and adapt its jurisdiction, on a case by case basis, as may be required, may meet this need more readily".

23. In *O v P* [2015] EWHC 935 (Fam), Baker J (as he then was) reflected these and other earlier judicial pronouncements on the importance of the inherent jurisdiction being a "sufficiently flexible remedy to evolve in accordance with social needs and social values"[8]; Baker J again referenced Munby J in *Re SA* (this time at [45]) wherein there was (explicitly) no intent to provide an exhaustive description of the potential reach of the jurisdiction, as "[n]ew problems will generate demands and produce new remedies… Indeed, there is probably no theoretical limit to the jurisdiction."

24. The arguments presented to me on these facts have caused me to consider with care the circumstances in which the inherent jurisdiction can indeed be deployed for someone who is 'vulnerable'. The evolving caselaw was neatly and helpfully summarised neatly by Baker LJ when refusing permission to appeal in the case of *Southend-on-Sea v Meyers* [2018], and reproduced by Hayden J in his later judgment at [2019] EWHC 399 (Fam) at [28]. I do not propose to reproduce that summary once again here, but it plainly a most useful reference point in cases of this kind. For the purposes of deciding this case, on these facts, I have focused on some of the key messages from the Court of Appeal's decision in *Re DL*, and the predecessor authorities, thus:

    i) "[T]he inherent jurisdiction can be exercised in relation to a vulnerable adult who, even if not incapacitated by mental disorder or mental illness, is, or is <u>reasonably believed to be, either (i) under constraint or (ii) subject to coercion or undue influence or (iii) for some other reason deprived of the capacity to make the relevant decision, or disabled from making a free choice, or</u>

[8] Particularly citing Singer J in Re SK [2004] EWHC 3202 (Fam)

incapacitated or disabled from giving or expressing a real and genuine consent" (emphasis by underlining added) (Munby J in *Re SA* at [77]: this description was expressly endorsed by McFarlane LJ in *Re DL* at [53]);

ii) The inherent jurisdiction should be "targeted solely at those adults whose ability to make decisions for themselves has been compromised by matters other than those covered by the *2005 Act*" (McFarlane LJ in *Re DL* at [53]);

iii) The inherent jurisdiction can be used to "supplement the protection afforded by the *Mental Capacity Act 2005* for those who, whilst 'capacitous' for the purposes of the Act, are 'incapacitated' by external forces—whatever they may be—outside their control from reaching a decision" (Macur J as she then was in *LBL v RYJ* [2010] EWCOP 2665 [2011] 1 FLR 1279 at [62]). Macur J added (*op cit*.), materially: "… the relevant case law establishes the ability of the court, via its inherent jurisdiction, to facilitate the process of unencumbered decision-making by those who they have determined have capacity free of external pressure or physical restraint in making those decisions" (also at [62]: emphasis added).

iv) The inherent jurisdiction can be used to authorise intrusions into the human rights of the individual (esp. under *article 8 ECHR*) where it is necessary and proportionate to protect the health and well-being: see McFarlane LJ in *Re DL* at [66] and Davis LJ (ibid.) at [76].

25. With reference to the quotation at [24(i)] above, it is important and material – again with specific reference to these facts – to consider what Munby J himself further said in *Re SA*:

> "[78] I should elaborate this a little:
>
> (i) Constraint: it does not matter for this purpose whether the constraint amounts to actual incarceration. The jurisdiction is exercisable whenever a vulnerable adult is confined, controlled or under restraint, even if the restraint is only of the kind referred to by Eastham J in *Re C*. It is enough that there is some significant curtailment of the freedom to do those things which in this country free men and women are entitled to do.
>
> (ii) Coercion or undue influence: what I have in mind here are the kind of vitiating circumstances referred to by the Court of Appeal in *Re T (an adult: medical treatment)* [[1992] 4 All ER 649, [1993] Fam 95], where a vulnerable adult's capacity or will to decide has been sapped and overborne by the improper influence of another. In this connection I would only add, with reference to the observations of Sir James Hannen P in *Wingrove v Wingrove* (1885) 11 PD 81, of the Court of Appeal in *Re T (an adult: medical treatment)* [[1992] 4 All ER 649, [1993] Fam 95], and of Hedley J in *Re Z* [[2004] EWHC 2817 (Fam), [2005] 3 All ER 280, [2005] 1 WLR 959], that

where the influence is that of a parent or other close and dominating relative, and where the arguments and persuasion are based upon personal affection or duty, religious beliefs, powerful social or cultural conventions, or asserted social, familial or domestic obligations, the influence may, as Butler-Sloss LJ put it, be subtle, insidious, pervasive and powerful. In such cases, moreover, very little pressure may suffice to bring about the desired result.

(iii) Other disabling circumstances: what I have in mind here are the many other circumstances that may so reduce a vulnerable adult's understanding and reasoning powers as to prevent him forming or expressing a real and genuine consent, for example, the effects of deception, misinformation, physical disability, illness, weakness (physical, mental or moral), tiredness, shock, fatigue, depression, pain or drugs. No doubt there are others[9].

[79] I am not suggesting that these are separate categories of case. They are not. Nor am I suggesting that the jurisdiction can only be invoked if the facts can be forced into one or other of these headings. Quite the contrary. Often, indeed, the facts of a particular case will exhibit a number of these features. There is, however, in my judgment, a common thread to all this. The inherent jurisdiction can be invoked wherever a vulnerable adult is, or is reasonably believed to be, for some reason deprived of the capacity to make the relevant decision, or disabled from making a free choice, or incapacitated or disabled from giving or expressing a real and genuine consent. The cause may be, but is not for this purpose limited to, mental disorder or mental illness. A vulnerable adult who does not suffer from any kind of mental incapacity may nonetheless be entitled to the protection of the inherent jurisdiction if he is, or is reasonably believed to be, incapacitated from making the relevant decision by reason of such things as constraint, coercion, undue influence or other vitiating factors." (emphasis by underlining added).

26. The application in this case was launched primarily (if not exclusively) by the Local Authority because it sought the court's authorisation to deprive DN (as a vulnerable person) of his liberty. The right protected by *Article 5 ECHR* is the right "to liberty and security of person", with its complementary right not to be "deprived of … liberty". That right is qualified within the *ECHR* in specified respects, none of which are applicable on the facts of this case; to be clear, I am satisfied that DN is *not* a person of 'unsound mind' as that phrase has been recently considered and interpreted in *Secretary of State for Justice v MM* [2018] UKSC 60 [2018] 3 WLR 1784 at [8] ("he must reliably be shown to be suffering from a true mental disorder, established

[9] The Applicants rely specifically on this sub-paragraph.

on the basis of objective medical expertise; the disorder must be of a kind or degree warranting compulsory confinement; and the validity of continued confinement would depend upon the persistence of such a disorder").

27. The issue before me (specifically the use of the inherent jurisdiction to authorise deprivation of liberty) generated considerable research and scholarly submissions on the part of the advocates. While focusing on *Re DL* and *HL v United Kingdom* (2005) 40 EHRR 32 (the *Bournewood* case) (see [48(i)/(ii)] below) I was also referred to the judgment of Munby J in the case of *Re PS*, to which I have already made reference[10]. I pause to deal with and dispose of this decision at this juncture. It should be noted that *Re PS* was a decision about an *incapacitous* woman[11]; she was in her late 80s, and the issue was whether she could or should be living at a residential care and elderly mentally infirm unit (T unit). While the comments at para.[16] of that judgment at first blush may seem to give some support for the proposition that the inherent jurisdiction can be used to deprive an adult of their liberty, this paragraph must (I consider) be read together with [23] (ibid.) which significantly qualifies the earlier remarks:

> "[16] It is in my judgment quite clear that a judge exercising the inherent jurisdiction of the court (whether the inherent jurisdiction of the court with respect to children or the inherent jurisdiction with respect to incapacitated or vulnerable adults) has power to direct that the child or adult in question shall be placed at and remain in a specified institution such as, for example, a hospital, residential unit, care home or secure unit. It is equally clear that the court's powers extend to authorising that person's detention in such a place and the use of reasonable force (if necessary) to detain him and ensure that he remains there: see *Norfolk and Norwich Healthcare (NHS) Trust v W* [1996] 2 FLR 613 (adult), *A Metropolitan Borough Council v DB* [1997] 1 FLR 767 (child), *Re MB (Medical Treatment)* [1997] 2 FLR 426 at page 439 (adult) and *Re C (Detention: Medical Treatment)* [1997] 2 FLR 180 (child).
>
> [23] … if the inherent jurisdiction is to be invoked to justify the detention of someone like PS in somewhere like the T unit, the following minimum requirements must be satisfied in order to comply with *Article 5*:
>
> i) The detention must be authorised by the court on application made by the local authority and *before* the detention commences.
>
> ii) Subject to the exigencies of urgency or emergency the evidence must establish unsoundness of mind of a kind or degree warranting compulsory confinement. In other

[10] See citation at [20] above.
[11] [1]: "The evidence currently available to the court indicates that she lacks capacity".

words, there must be evidence establishing at least a prima facie case that the individual lacks capacity and that confinement of the nature proposed is appropriate.

iii) …" (emphasis by underlining added).

In fact, having reviewed all of the relevant caselaw, by the time of the hearing before me, the parties agreed (having particular regard to [23] of *Re PS* and the points discussed by me at [47] and [48] below) that on these facts the inherent jurisdiction *cannot* properly be deployed to authorise a deprivation of DN's liberty (as opposed to a restriction of his liberty).

The Arguments of the parties

28. On behalf of the Applicants, Mr Davies contends that DN is a vulnerable adult who (even though authorisation for deprivation of liberty is not required) still warrants the intervention of the High Court exercising its inherent jurisdiction to ensure that his need for care and support is delivered under a lawful framework. He maintains that DN is not at Stamford House truly voluntarily, given that at the point when he made his election to reside there his only real alternative was/is imprisonment, or indefinite detention in a psychiatric hospital. Mr Davies referred to DN as having been 'between the devil and the deep blue sea' in facing the 'stark' prospect of custody, or a community order in supported living. The pressure of this decision was/is exacerbated, in DN's case, according to Mr Davies, by DN's autistic traits, his general anxiety and his unstable personality disorder.

29. Developing these points by reference to the caselaw, the Applicants describe the pressure on DN at the time of his sentence, and to date, as an example of a "disabling circumstance" (referencing *Re SA* [78](iii)) which has had the effect of reducing this "vulnerable adult's understanding and reasoning powers as to prevent him forming or expressing a real and genuine consent" to be at Stamford House.

30. In making this argument, the Applicants assert, on the basis of *Buzadji v Republic of Moldova* [2016] 7 WLUK 76, that DN cannot give genuine and informed consent in circumstances where he must choose between a supported living placement where he will be deprived of his liberty, or a secure psychiatric facility. Where consent given in circumstances where the choice is between greater and lesser forms of deprivation of liberty – in *Buzadji* the choice was between detention in prison and detention under house arrest — consent may be no real consent at all. It is pointed out that *Buzadji* was applied and approved by the Supreme Court in *Secretary of State for Justice v MM* (citation above) at [23].

31. Thus, the Applicants wish me to find that I have power to, and should, exercise the inherent jurisdiction of the court specifically so that I can authorise the regime of care and residence at Stamford House, given its impact on DN's *Article 8* rights. This would, they say, give judicial authorisation to the package of care being delivered, and would be important to regulate DN's contact with his mother, whom he sees supervised only once per week for a period of 2 hours.

32. The Applicants maintain as a secondary position that if, as a matter of fact, DN is adjudged to be able freely to have consented, and consents, to his placement at Stamford House, then they would obviously need to consider with him the package of care and the specific components of the regime of care and contact with his mother. The Applicants have designed the package to meet his needs, and believe that the package of care they provide is a *complete* package. While they accept that there may be some scope for discussion/negotiation of some elements, there may well be 'red lines'. Mr Davies submits that the Applicants may take the view that they are not prepared to take the operational risk if DN does not accept key features of the regime. In those circumstances, if no agreement can be reached, the placement would be terminated. There are implications in the criminal process if the placement is terminated (see [55] below).

33. The Respondents join common cause in contending that DN has and at all material times has had the ability to make free, meaningful, and unencumbered decisions. This is, they contend, ultimately a question of fact (for this proposition see *Freeman v Home Office No.2* [1984] 1 QB 524 at 555F-G). The Respondents, while accepting that in many ways DN is a vulnerable person, do not agree that he is so vulnerable (or vulnerable in the *Re SA* sense) as to warrant the court's protection; they say that the prospect of facing a custodial sentence or residence in supported living under a programme of mental health treatment does not *per se* render an adult vulnerable. The Respondents challenge the analysis of the Applicants, specifically disputing that DN falls within the class of case contemplated by Munby J in [78](iii) of *Re SA* (see [29] above).

34. The Respondents argue that *Buzadji* is not relevant on these facts, and they seek to distinguish it. In *Buzadji* the consent was given:

> "… in circumstances where the choice is between greater and lesser forms of deprivation of liberty - there between detention in prison and detention under house arrest - may be no real consent at all" (per Baroness Hale in *Secretary of State for Justice v MM* at [23]: citation at [26] above).

Here the consent was given in circumstances where the choice was between custody or a community sentence which specifically does not contemplate deprivation of liberty (merely restriction) (see [10] above).

35. Mr Allen says that DN is and has been free to consent to the treatment package and relies on Dr. Quinn's comment quoted more fully above: "the reality is that he understands he has choices, but his choices can bring adverse consequences". Mr McKendrick points out that the fact that DN can accept some elements of the regime but not others suggests that he does feel he can exercise free choice over his living arrangements. Both encourage me to conclude that it would be right to respect DN's autonomous decision-making, cautioning me against the more disempowering approach – i.e. to conclude that he is too vulnerable to be able to agree.

36. They contend that there will now need to be an urgent negotiation over the terms of the regime at Stamford House (with attention on the proposed specific restrictions), and that the placement should then be allowed to proceed on a different footing, albeit ideally consensually. They accept that if DN is unable or unprepared to accept certain

restrictions which the Applicants deem essential, then it would be open to the Applicants to terminate the placement.

37. As I earlier indicated (at [27] above) it is in fact now agreed between the parties in this case that the inherent jurisdiction cannot (or should not) be used in these circumstances to deprive DN of his liberty. The limited circumstances in which this could be appropriate were described by Munby J (as he then was) at [23](ii) in *Re PS* (see above), i.e. where incapacity or unsoundness of mind could be shown.

38. Relevant to the stance of the parties on the issue of deprivation of liberty (arguments above), Mr Allen specifically drew my attention to the *United Nations Convention on the Rights of Persons with Disability* ('*CRPD*'). Although of no direct effect in England and Wales, as I had cause to consider earlier this year[12], it provides a useful framework to address the rights of people with disabilities, and to the interpretation and application of domestic law in a way which is consistent with the obligations undertaken by the UK. Mr Allen cautions against arbitrary use of deprivation of liberty authorisation under the inherent jurisdiction by reference to the CRPD. His submission is advanced as follows:

> "*Article 14(1)(b) CRPD* is a non-discrimination provision and provides that "the existence of a disability shall in no case justify a deprivation of liberty". The CRPD Committee's Guidelines on the right to liberty and security of persons with disabilities (A/72/55, Annex) reaffirm that "liberty and security of the person is one of the most precious rights to which everyone is entitled" and all persons with disabilities are entitled to liberty pursuant to Article 14. According to the Committee, it permits of no exceptions; thus, "*article 14(1)(b)* prohibits the deprivation of liberty on the basis of actual or perceived impairment even if additional factors or criteria are also used to justify the deprivation of liberty": para 9. The Guidelines go on to state:
>
> > "13. Through all the reviews of State party reports, the Committee has established that it is contrary to *article 14* to allow for the detention of persons with disabilities based on the perceived danger of persons to themselves or to others. <u>The involuntary detention of persons with disabilities based on risk or dangerousness, alleged need of care or treatment or other reasons tied to impairment or health diagnosis is contrary to the right to liberty, and amounts to arbitrary deprivation of liberty.</u>"

39. All parties accept that as a matter of fact DN occasionally has 'meltdowns'. When he has a 'meltdown' the evidence is that he loses capacity to weigh up decisions about his care and residence. Although I heard argument on the point (see below) in the end all parties accepted the appropriateness of the court making anticipatory declarations

[12] *Re A (Capacity: Social Media and Internet Use: Best Interests)* [2019] EWCOP 2, at [3].

under the *MCA 2005* authorising deprivation of liberty and/or lawfulness of imposing the restrictions outlined in the event of him having a 'meltdown'. It is to this point that I turn next.

Mental Capacity Act 2005: Anticipatory Declarations

40. The evidence of Dr Quinn is that when DN goes into 'meltdown' he loses the capacity to weigh up information given to him. This is attributable to his state of arousal which is caused by his Autistic Spectrum Disorder. In the circumstances, the Respondents suggest that *at that moment*, DN is likely to have lost capacity. They jointly propose that I can and should make anticipatory declarations under the *MCA 2005* which would authorise the applicants to deprive him of his liberty or lawfully impose the regime.

41. The Applicants made the point in argument, with some justification it seemed to me, that while it may *theoretically* be possible to make anticipatory declarations, *practically speaking* it will be very difficult to implement such declarations on the ground. Dr Quinn was asked to consider the local authority's evidence of identified triggers and alerting signs/symptoms. Those signs/symptoms include:

    i) DN making rapid circular motion with hands.

    ii) DN has said that he frantically chews on his lego brick which he attaches around his neck.

    iii) Increased arousal, pacing display of agitation.

    iv) DN may threaten that he will harm himself or others.

    v) DN has banged his head on the wall.

    Dr. Quinn accepted (in answer to questions from Mr McKendrick) that these signs/symptoms would alert the care workers to the possibility that DN was going into meltdown, justifying interventions required by his corresponding lack of capacity.

42. This prompted consideration of the powers available to me under the *MCA 2005*. *Section 2 MCA 2005* provides that a person lacks capacity if "at the material time" they are unable to make a decision for themselves. As to when is the 'material time', para.4.4 of the Code of Practice provides that "An assessment of a person's capacity must be based on their ability to make a specific decision at the time it needs to be made, and not their ability to make decisions in general" (see also paras.4.26-4.27 of the Code of Practice). *Section 2(2)* emphasises that it does not matter whether the impairment or disturbance is *temporary* or *permanent*.

43. I was referred to the decision of Francis J in *United Lincolnshire Hospital NHS Trust v CD* [2019] EWCOP 24 in relation to the form and circumstances in which an anticipatory declaration may be appropriate. In the end, as I said, all parties accepted the good sense and appropriateness of this proposal, as it will offer protection to staff and offers another level of protection to DN.

Conclusion

44. At [5] above I identified the three key issues for determination in this case. In respect of those issues I have reached the following conclusions.

45. *The first issue*: The question whether someone falls in the category of 'vulnerable' adult (as that term is understood in the context of *Re SA* and *Re DL'*) for whom the inherent jurisdiction is available, is essentially a question of fact, supported where relevant, by expert opinion. In confirming this essentially fact-sensitive approach, I adopt the direction given by Stephen Brown LJ in *Freeman v Home Office No.2* (see [33] above). Having reviewed the written material, and received the oral and written evidence of Dr. Quinn, I have reached the conclusion that DN is not 'vulnerable' as that term is understood in the context of *Re SA* and *Re DL*. While it is certainly true that DN is vulnerable in some ways, and particularly in some contexts which he finds challenging, I do not find as a question of fact that his decision-making in relation to his residence at Stamford House has been "vitiated"[13] or so overborne by his circumstance (even at the point when he made his commitment to receive the MHTR as part of his community order) that he should be regarded as requiring the intervention of the High Court exercising its inherent jurisdiction. I find that he was able to offer his consent to his residence and care arrangements at the Magistrates Court freely, and expressed his willingness, without coercion or constraint, to comply with the regime offered by the community order. While I accept that DN faced a 'stark' choice in the criminal court when presented with the prospect of a custodial sentence if he had not accepted a community order with MHTR, I nonetheless do not consider that this disabled him from making a free choice.

46. In reaching this conclusion, I have been influenced by the following factors:

    i) *Section 207(3)* is invariably going to apply to a person who requires or may benefit from mental health treatment; that is, after all, its purpose. Those who are *prima facie* eligible for such orders are, or are likely to be (like DN) 'vulnerable' in some respects. These community-based orders are plainly contemplated as alternatives to custody. It would be likely to undermine the ethos of the sentencing regime if I were to find (without more) that the combination of mental ill-health and the stark alternative of custody were to create an atmosphere or context of coercion, constraint or other disabling condition as to vitiate the apparent "willingness" of the offender "to comply with such a requirement";

    ii) The point at (i) immediately above is illustrated by the case of *R v Singleton* [2008] EWCA Crim 468 where the Court of Appeal, Criminal Division, offered what they regarded as a *valid* choice when allowing an appeal of an appellant with mental ill-health (suffering from schizophrenia and depression) who had been sentenced to a 5-year prison term, by proposing, as an alternative, a three-year Community Order with MHTR under *section 207 CJA 2003*. There was no question that the defendant/appellant in that case would be unable to exercise free choice to accept (or reject) this proposed substituted sentence;

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[13] Per Munby J in *Re SA* at [78].

iii) I am persuaded by the point that DN has been able to articulate aspects of the regime which he does like and aspects which he does not. This suggests that he acknowledges free choice;

iv) *Buzadji* does not assist the Applicants. In that case, the claimant had the 'choice' between custody or house arrest; that was not a free choice. In this case, DN's choice was between imprisonment and a *restriction* of liberty under a community order;

v) The situation in which DN found himself was materially different from that contemplated by Munby J in *Re SA*. While the Applicants relied on [78](iii) to suggest that DN may fall into one of the "many other circumstances that may so reduce a vulnerable adult's understanding and reasoning powers as to prevent him forming or expressing a real and genuine consent", Munby J himself illustrated the categories of situation in which this would apply as including: "the effects of deception, misinformation, physical disability, illness, weakness (physical, mental or moral), tiredness, shock, fatigue, depression, pain or drugs" which are very different from the circumstances which obtained here.

47. As I have had cause to discuss in *Redcar & Cleveland Borough Council v PR & others* [2019] EWHC 2305 (Fam), especially at [14]/[16]/[38]/[46], if the evidence indicates a *prima facie* case of vulnerability, and justifies the necessity and proportionality of an order, it is entirely proper for the inherent jurisdiction to be invoked as an interim measure while proper inquiries are made, and while the court ascertains whether or not an adult is in fact in such a condition as to justify the court's intervention. That amply covers the situation which has obtained here between the making of the first order and this order. My concern is that the 'interim' order has endured somewhat longer than appropriate.

48. *The second issue*: As is apparent from my rehearsal of the parties' arguments above, in fact it was not in issue on the facts of this case that the inherent jurisdiction should not be used to deprive DN of his liberty, and rightly so. For my part:

i) This accords with the same concerns expressed by the European Court of Human Rights in *HL v United Kingdom* (2005) 40 EHRR 32 (the *Bournewood* case) which referred (at [120]) to the "striking" lack of any fixed procedural rules under the common law by which the admission and detention of compliant incapacitated persons was conducted. In concluding that the use of the inherent jurisdiction to achieve a deprivation of liberty in these circumstances was too "arbitrary"[14] (i.e. without procedural control or limits, and the lack of any formalised admission procedures which indicate who can propose admission, for what reasons and on the basis of what kind of medical and other assessments and conclusions) it expressed its disquiet about the absence of a:

> "...requirement to fix the exact purpose of admission (for example, for assessment or for treatment) and, consistently,

[14] Para.[124]: "this absence of procedural safeguards fails to protect against arbitrary deprivations of liberty on grounds of necessity and, consequently, to comply with the essential purpose of Article 5(1) of the Convention."

> no limits in terms of time, treatment or care attach to that admission. Nor is there any specific provision requiring a continuing clinical assessment of the persistence of a disorder warranting detention. The nomination of a representative of a patient who could make certain objections and applications on his or her behalf is a procedural protection accorded to those committed involuntarily under the *1983 Act* and which would be of equal importance for patients who are legally incapacitated and have, as in the present case, extremely limited communication abilities".

ii) There are strong judicial dicta to the effect that the inherent jurisdiction should be used for "facilitative rather than dictatorial" reasons (McFarlane LJ in *Re DL* at [67] citing Macur LJ in *LBL*). As McFarlane LJ had earlier explained in his judgment (*Re DL* at [54]) the jurisdiction is:

> "… in part aimed at enhancing or liberating the autonomy of a vulnerable adult whose autonomy has been compromised by a reason other than mental incapacity because they are … (a) under constraint; (b) subject to coercion or undue influence; or (c) for some other reason deprived of the capacity to make the relevant decision or disabled from making a free choice, or incapacitated or disabled from giving or expressing a real and genuine consent".

iii) For the reasons set out at [27] and [37] above, no support for the use of the inherent jurisdiction to deprive someone of their liberty can be derived in this context from *Re PS*; on the contrary, the opposite conclusion should be reached from the judgment.

49. In this regard, I recognise that I differ from the approach of Gwynneth Knowles J in her judgment in the case of *Hertfordshire County Council v AB* [2018] EWHC 3103 (Fam). In that case Gwynneth Knowles J authorised the deprivation of liberty of a vulnerable adult under the inherent jurisdiction. She recognised that it would not be right to do so on the basis of the line of authorities of which *Re DL* was a significant part (see [32] of her judgment: "the analogy between the circumstances of AB's case and those of *DL* was not so precise that I am satisfied that it would be appropriate to exercise the court's existing inherent jurisdiction in respect of vulnerable adults"). But she felt that the inherent jurisdiction could be 'extended' (following *Anderson v Spencer* [2018] EWCA Civ 100, [2018] 2 FLR 547), given the very significant difficulties which would arise for AB otherwise. It may be that the *Hertfordshire* case and the situation of DN can simply be distinguished on their facts; Gwynneth Knowles J was keen to emphasise that she was prepared to make the order so as "to encompass the particular circumstances of AB's case…where AB is subject to a plan which has been very carefully designed for his particular benefit and also to protect members of the public". However, it is otherwise notable that (a) the use of the inherent jurisdiction to deprive a capacitous adult of their liberty did not seem to be fully argued before her as it has been before me; (b) no respondent to the application attended the hearing or otherwise contributed to the arguments; and (c) the authorisation was in accordance with AB's will and preferences (see [2] and [20]:

"AB consented to these conditions in 2016 and continues to do so"). Although cognisant of the responsibilities I owe as a judge of co-ordinate jurisdiction, I do not regard it as binding on me[15].

50. For these reasons I reject the application of the Applicants for relief under the inherent jurisdiction.

51. *The third issue*: As indicated above, all parties agree that I could or should make anticipatory declarations as to DN's capacity to make decisions about residence and/or care (and if appropriate his best interests) under *sections 15* and *16* of the *Mental Capacity Act 2005*, to cover occasions when he has 'meltdowns' and is at that point (it is agreed) unable to make capacitous decisions. It seems to me that the outcome of an anticipatory declaration would provide a proper legal framework for the care team, ensuring that any temporary periods of deprivation of liberty are duly authorised and thereby protecting them from civil liability. In these circumstances, I propose to convene formally a Court of Protection hearing to make an order in the following terms:

> "AND UPON it being recorded that [DN] accepts, consistent with the oral evidence of Dr Quinn at the hearing on 08 August 2019, that when presenting in a state of heightened arousal and anxiety (a "meltdown"), he is unable to properly weigh and use information relevant to decisions as to his care and treatment, and at these times, lacks capacity to make these decisions
>
> IT IS DECLARED PURSUANT TO SECTIONS 15 AND 16 OF THE MENTAL CAPACITY ACT 2005 THAT:
>
> 1. [DN] has capacity to make decisions regarding his residence and care and treatment arrangements, except when presenting in a state of heightened arousal and anxiety ("a meltdown") during which episodes it is declared that he lacks capacity to consent to care and treatment provided by the applicants, their staff and/or agents.
>
> 2. In circumstances where the applicants, their staff and/or agents reasonably believe that [DN] is experiencing a state of heightened arousal and anxiety / meltdown (the triggers for which are more fully described in the attached care plan), and as such [DN] lacks capacity to make decisions about his care and treatment arrangements, it shall be in [DN]'s best interests for the applicants, their staff and/or agents to deliver care and treatment to DN in accordance with the care plan annexed to this Order.

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[15] See *Willers v Joyce & another (in substitution for and in their capacity as executors of Albert Gubay (deceased)) (2)* [2016] UKSC 44 at [9].

3. To the extent that the arrangements set out at paragraph 2 (above) and the care plan amount to an interference with [DN]'s rights and may amount to a restriction and/or deprivation of [DN]'s liberty, they are declared lawful and authorised, providing always that any measures used to facilitate or provide the arrangements shall be the minimum necessary to protect the safety and welfare of [DN] and those involved in his care and treatment, and that all reasonable and proportionate steps are taken to minimise distress to [DN] and to maintain his dignity."

52. The order is supported by a detailed care plan. Mr Davies tells me that a new manager has been recruited for Stamford House who has both experience and expertise in dealing with cases involving Autistic Spectrum Disorder. He tells me that additional training is being offered to staff in recognising the symptoms of 'meltdown'. DN is being offered Cognitive Behavioural Therapy to deal with how to manage some of the triggers.

The way forward

53. As *Article 5 ECHR* is currently engaged, and DN is objectively being deprived of his liberty, it follows that DN and the Applicants will need, urgently, to discuss and implement changes to his regime at Stamford House. Those aspects which currently deprive him of his liberty (and to which he does not agree) will need to be relaxed, essentially so that it becomes clear that he is 'free to leave'. It has been the Applicants' case that "if [DN] is to remain in [Stamford House] then he must do so in accordance with the restrictions that will be in place there to ensure his safety and the safety of other residents and staff"; they will need to reflect on this. For what it is worth, the Applicants can be reassured, I suspect, that when he spoke with me, DN showed some insight into the benefits to him of having some boundaries around the way he lives his life ("I have needed the middle approach throughout my life. My care has either been too much or not enough"), but not to the extent currently imposed at Stamford House. The contact arrangements will also need to be re-visited; the Applicants can derive no authority from the court for its current restrictions.

54. I am mindful, as no doubt should DN be, that in the event that agreement cannot be reached about the regime, the Applicants cannot impose any aspect of the regime on him; should he rail against the regime, or reject it, they may in the circumstances withdraw the support of the placement.

55. Where would that leave DN? The answers are to be found in *Schedule 8* of the *CJA 2003*. In short[16], if DN's 'responsible officer'[17] were to take the view that DN as the 'offender' has failed to comply without reasonable excuse he/she will give a warning to DN (with reasons): per *Sch 8, para 5. CJA 2003*. If, within the next 12 months following that warning, the responsible officer is of the opinion that DN (the

[16] I am grateful to all advocates for researching this issue and preparing additional submissions, at my request, following the hearing.

[17] As defined by *section 197 CJA 2003*, probably his probation officer but could be someone appointed by the probation service for this purpose.

'offender') has again failed without reasonable excuse to comply with any of the requirements of the order, the matter must be referred to DN's probation (for these purposes 'enforcement') officer: per *Sch 8, para 6. CJA 2003*. That officer then considers the case and, where appropriate, can cause an information to be laid before a justice of the peace for breach: per *Sch 8, para 6A. CJA 2003*. If it is proved to a Magistrates' Court that the 'offender' has failed without reasonable excuse to comply with any of the requirements of the community order, the court's powers are, in essence, to (a) impose more onerous requirements, (b) impose a fine, or (c) re-sentence for the original offences: per *Sch 8, para 9. CJA 2003*. Amendments to a MHTR cannot be made unless the offender "expresses his willingness to comply with the requirement as amended": per *Sch 8, para 11(2) CJA 2003*.

56. It is important that DN recognises these implications. It would be much to his benefit if he feels able to settle at Stamford House and build on the progress he has made thus far. I am heartened by, and endorse, the positive comments of the Local Authority in their final written submissions:

> "Whatever the outcome of the case, this *has already* been a success story for [DN]. He has avoided incarceration, and the very deleterious consequences which would follow to his mental and physical well-being, and for a time, made incredible progress. It is hoped that a way is found to maintain [DN]'s placement, and that strategies are successful in getting on the path to his own, independent living in a straightforward community setting." (emphasis in the original).

57. That is my judgment.

Schedule

Regime of care at Stamford House

1. His confinement consists of the following measures:
   - (1) Direct carer support for up to 12 hours per day, which is on a 1:1 basis or 2:1 basis depending upon the location, type and gender nature of the activity.
   - (2) He must allow access to his flat at all times and at times of high risks, access his bedroom area.
   - (3) He is only be able to access the community between the hours of 9am and 7pm on a 2:1 basis when staff are available.
   - (4) There is a possibility that he can access the community out of these restricted hours but only for emergency care or if an activity has been previously agreed which can be planned for.
   - (5) If he was to attempt to leave the placement without pre-planned agreement, two members of staff will follow him discreetly and allow him space. If he puts himself and others at risk, staff would intervene, initially trying to use distraction techniques and verbally deescalate him. The members of staff would call the police as a last resort.
   - (6) If he was to leave the placement after 7pm, the police would not usually be called until 30 minutes has passed, to enable him to return of his own volition.
   - (7) Family visits with his mother and sister are to be pre-arranged and to take place in the supervised living room of his flat. All visits must be agreed and pre-planned. Contact with his mother is limited to a maximum of 2 hours (1-3pm) once per week.
   - (8) It is recommended that visits to the family home do not take place within the first 3 months of him residing at his placement.
   - (9) Lone females are not allowed to enter his flat at any time until further assessments are undertaken.
   - (10) The cooker in his flat is disabled at 8pm, however this can still be used under supervision at request.
   - (11) Staff can remove his mobile phone for a short time, should all other methods have been tried, if he is distressed or using the telephone inappropriately, which will in any event never exceed 24 hours.