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Case No: 13775989

**COURT OF PROTECTION**

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 06/12/2022

**Before** :

**THE HONOURABLE MRS JUSTICE JUDD**

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**Between :**

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| **DY** | **Applicant** |
| **- and -** | |
| **A City Council** | **1st Respondent** |
| **and** | |
| **A NHS Trust** | **2nd Respondent** |

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**Joseph O'Brien KC** (instructed by **Irwin Mitchell LLP**) for the **Applicant**
**Ian Brownhill** (instructed by the First and Second Respondents)

Hearing dates: 1st and 2nd November 2022

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# Approved Judgment

This judgment was handed down remotely at 2pm on 6 December 2022 by circulation to the parties or their representatives by e-mail and by release to the National Archives (see eg https://www.bailii.org/ew/cases/EWCA/Civ/2022/1169.html).

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THE HONOURABLE MRS JUSTICE JUDD

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 incapacitated person and members of their family must be strictly preserved. All persons, including representatives of the media, must ensure that this condition is strictly complied with. Failure to do so will be a contempt of court.

**The Hon Mrs Justice Judd DBE :**

1. In this case I am concerned with DY, a young man in his 20's. He has complex needs and is living in accommodation provided by the respondent City Council.

2. The application before me is made by DY pursuant to section 21A Mental Capacity Act 2005. He is currently being deprived of his liberty pursuant to a standard authorisation which is due to expire in a few weeks' time (having been renewed pending the outcome of this hearing).

Background

3. DY was the subject of care proceedings shortly after he was born, which culminated in a care order being granted on the basis of his returning home to live with his parents. By the time DY was about 10 years old he was demonstrating a variety of problems, which included sexualised behaviour and self-harming. He suffered from physical ill health and had a stoma bag fitted when he was a teenager.

4. By the time DY had reached his mid teens he was suffering from serious mental health problems, which included worsening self harm and suicide attempts. In 2016 he was detained under section 3 Mental Health Act and placed at a hospital unit. In 2017 he was determined to lack capacity to consent to his detention and treatment under the Mental Capacity Act. He was moved to a different placement which specialised in working with young people with sexually problematic behaviours. In 2017 DY pleaded guilty to two offences of sexual assault of a girl aged under 13, and received a 26 month Youth Rehabilitation Order. He was placed on the sex offender's Register for 5 years with a concurrent Sexual Harm Prevention Order (which expires in March 2023) with a residence requirement and curfew. He is prohibited from having contact with children under 16 save as is inadvertent and not reasonably avoidable in the course of daily life. He was referred to MAPPA and has been assessed as a category 1 offender requiring level 2 management. As of June 2021 he was still considered a high risk to children and known adults. To his mother he poses a risk of violence and sexual assault. To children he poses a risk of sexual assault.

5. DY was diagnosed with Autistic Spectrum Disorder in 2011, and also with Generalised Anxiety Disorder and Paedophilia. He moved to his current placement in 2019. He has continued to be assessed as lacking capacity to make decisions about accommodation and care. He is being deprived of his liberty pursuant to a standard authorisation pursuant to schedule A1 of the MCA. The most recent one is dated 24th June 2022.

He is always accompanied by male staff when he goes into the community, is checked four times a night due to his sexualised behaviour and self harm, and he is not allowed to enter bedrooms other than his own in his placement.

Proceedings

6. These proceedings were issued on 25th May 2021 pursuant to s21A MCA 2005, and challenges DY's deprivation of liberty at his placement. The grounds of the challenge to the standard authorisation are (a) that the mental capacity qualifying requirement in paragraph 15 Schedule A1 is not met; and (b) that the best interests requirement in paragraph 16 Schedule A1 is not met.

7. Dr. Christopher Ince, a Consultant Psychiatrist currently working in Forensic Learning Disability and Autism Services at Northgate Hospital in Northumberland was jointly instructed by the parties to prepare a report upon DY's capacity to conduct the proceedings and to make decisions on his residence, care, contact, sexual relations and access to social media. He produced a report dated 19th January 2022 and an addendum on 14th April 2022. He concluded that DY had capacity in relation to all the domains set out.

The hearing

8. I have read all the documents in the bundle provided to me and the very helpful skeleton arguments produced by Mr. O'Brien KC for the applicant and Mr Brownhill for the respondents.

9. I heard evidence from social worker employed by the first respondent City Council, the Best Interests Assessor, and the jointly instructed expert Dr. Ince followed by oral submissions from counsel.

The issues

10. Shortly before the hearing, the respondents conceded that DY does have capacity in relation to conducting these proceedings, contact, sexual relations and social media.

11. Subject to the court being satisfied that the primary focus of the care plan is to avoid harm to DY, I am left with one issue to decide, namely whether DY has capacity to consent to his care and support arrangements. If I determine that he lacks capacity then I am invited to remit the case to a Tier 1 or 2 judge to determine whether the best interests test is met.

12. On behalf of the applicant it is submitted DY does have capacity. On behalf of the respondents it is submitted that he does not.

The Legal Framework

13. Under s1 MCA 2005 a person must be assumed to have capacity unless it established that he lacks it (s1(2)), and is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success (s1(3)). He is not to be treated as unable to make a decision merely because he makes an unwise decision (s1(4)).

14. Section 2 MCA 2005 provides that

"(1) For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of the mind, or brain".

15. Section 3 provides that

"(1) For the purposes of section 2, a person is unable to make a decision for himself if he is unable –

(a) To understand the information relevant to the decision;
(b) To retain that information;
(c) To use or weigh that information as part of the process of making the decision; or
(d) To communicate his decision.

(4) The information relevant to a decision includes information about the reasonably foreseeable consequences of –
(a) deciding one way or another, or
(b) failing to make the decision.

16. Paragraph 16 Schedule A1 MCA sets out the best interests qualifying requirement;

"16(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.

17. Paragraph 15, Schedule A1 MCA provides that

"The mental capacity qualifying requirement
15. 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 purposes of being given the relevant care or treatment".

18. The burden of proof is upon the respondents in this case, and the standard of proof is the balance of probability.

The primary purpose of the care plan

19. It is the applicant's case, disputed by the respondents, that the primary purpose of the care plan is the protection of the public rather than to prevent harm to DY. Whilst such a motive would be understandable it is not permissible under the Act.

20. Having heard and read the evidence and submissions on this point, I have come to the conclusion that the primary purpose of the care plan is to avoid harm to DY. There is no doubt that he poses a risk to the public, but it is also clear that it would be very harmful to DY himself were he to commit further offences. DY is a young person who is vulnerable and has engaged in self harming behaviour (albeit not recently). The social worker stated in her evidence that when DY becomes stressed and anxious that this leads to him ruminating and in turn puts him at risk of self harm. If he were to reoffend he would be very distressed, and engage in self loathing. There would also be the risk of retribution from the public. I agree with Lieven J in *Birmingham City Council v SR; Lancashire County Council v JTA* [2019] EWCOP 28 that it is a false dichotomy to conclude that the protection of P cannot also include protecting him from harming members of the public. As in that case, it is strongly in DY's best interests not to commit further offences, or place himself at risk of further criminal sanctions. In my judgment this falls squarely within the meaning of the qualifying requirement in paragraph 16 schedule A1, 'to prevent harm to the relevant person'. That this harm would come about by his harming others does not detract from this.

21. The rest of the conditions in paragraph 16 would be met also, subject to my conclusions on capacity, below.

Capacity

22. The matter in question which then fall for determination is whether DY has capacity to make decisions about his care and support arrangements. It is accepted by the respondents that he is able to understand and weigh the information relevant to the decision and that he can communicate it.

What they argue is that DY is not capable of using or weighing the information as part of the process of making a decision.

23. In the Statement of Facts and Grounds dated 25th May 2021, the Best Interests Assessor (BIA) stated that despite DYdisplaying some insight into his care and support needs he was unable to weigh the consequences of not receiving full support.

24. In her written and oral evidence the BIA stated that she found DY to be contradictory in his responses to questions about his support needs. She believed that he was inclined to say things which he thought the person in front of him wanted to hear. One minute he would say he wanted to live his life without restrictions and another he would then say he had to have support. Then he would say he has learned ways to cope over the years, and follow this by saying that it was staff who kept him safe. These contradictions in his answers was a factor in her conclusions that whilst understanding and retaining relevant information he could not use or weigh it. She said that she believed that not having help with budgeting or managing his medication would raise his anxiety levels and have a negative effect on other aspects of his life.

25. In her statement and oral evidence, the social worker responsible for DY's care stated that he was not able to think through the consequences if he was to go into the community unaccompanied. She described him as being 'able to talk the talk, but not walk the walk'. As an example she said that when discussing how he might control his urges to sexually assault a child if he was out in the community alone he suggested using distraction techniques of drinking a hot drink or eating chilli or spicy food without considering how realistic or practical this was. When challenged about this he acknowledged that that it was not. When DY went out into the community with the social worker he did not take a hot drink with him, nor did he appear to think about this at all. In further discussions he was unable to say how things would be if he was in the community without staff to support him. In her view, he uses professional jargon that he has picked up but is not able to explain what it means – one example being the term 'intrusive thoughts'.

26. The social worker further referred to an incident where DY had tried to restrain a resident in the care home and had scratched him. He had put himself into a situation of risk without understanding that it was there. In her oral evidence she stated that he thought these proceedings were related to MAPPA and the police.

The evidence of Dr. Ince

27. Dr. Ince is an extremely experienced expert in his field who has prepared many reports for proceedings such as this. He has very significant expertise both in relation to autism and the assessment and treatment of sexual offenders. The reports he prepared for this case are detailed and thorough.

28. Following his examination of DY, Dr. Ince confirmed the diagnosis of Autism Spectrum Disorder. He did not consider that he presents with any acute or enduring mental illness. In his addendum report and in his oral evidence he stated that he did not consider that DY's paraphilic disorder could be relied upon by itself as a global impairment or disturbance of the functioning of the mind or brain, or that it created the relevant causative nexus to the majority of the subject specific decisions that he was reviewing. For DY, it is the ASD which is the relevant condition, which includes anxiety.

29. In order to assess DY's capacity across the relevant domains which were in issue at the start of these proceedings, as well as considering the reports DY's medical records, Dr. Ince conducted an in person interview with him at his current home. Within the body of the report, he set out at some length the answers given by DY to a variety of questions, a process that I found to be extremely helpful and illuminating because it enables the reader to understand why Dr. Ince came to the conclusions he did, namely that DY has capacity across the domains. Focussing on the area which remains in dispute, I note that DY told Dr Ince that if the DOLS was removed 'i*t would mean I am able to meet people in the community….make friends….maybe have a relationship with a woman….my ultimate goal is to live my life peacefully…….I don't know about making relationships….I've never made any friends in the community for the last ten years….wouldn't know how to do it…..I'm a bit rusty….obviously you'll meet them and taken them to a restaurant, maybe have a drink or a meal…discuss hobbies and interests'* and then '*I don't want the DOLS completely removed..I want something like the DOLS… something that is similar to the DOLS but is less restrictive…to regain the life skills I need…I'd like to be happy and with having support…having support in the community on a one to one basis'*. When asked about the prospect of being unescorted in the community, DY stated '*to be honest with you I don't…I don't want staff in the community but I'd say it is because I have been told…I know I am high risk but there has to be a point where things change…constantly having staff coming out with you…at the moment if there are no staff I don't go out and it's frustrating…my preference is to not have staff with me but I know that*

*people will be worried about the risks…and I've never done it before…the risk of reoffending would be the number one risk..from my understanding reoffending is the only one I can think of…I know how to be civil with people in the community..I know if I broke the SHPO I'd go to prison…one way ticket to prison…I know I'd have to register my address if I moved house…I'd be terrified about going to prison…people with my convictions in prison they get killed or severely beaten up or killed'*.

30. Assessing DY's capacity to make decisions about his care arrangements with respect to the list of factors set out by Theis J in *LBX v K,L,M* [2013] EWHC 3230 , Dr Ince stated that DY was able to articulate at length his relevant strengths and weaknesses and that it was clear he has an understanding of his care needs, the views of others, and acknowledges a discrepancy between the two. He was also aware of the consequences of refusal or withdrawal of care and that care can currently be enforced as a component of the Standard Authorisation and DOL. Perhaps most importantly, he was able to set out a level of care that he believed would be both sufficient, beneficial and would balance his own wishes for a greater degree of autonomy and independence with an umbrella of oversight and protection. Dr. Ince acknowledged that there is a relevant issue as to the degree to which DY's decisions as to his care needs and supervision are impaired at times of sexual pre-occupation and whether this would constitute a fluctuating picture of capacity and lack of it, but by reference to Finklehor's model he concluded that the fact that DY can make impulsive decisions regarding further offending does not lead him to make what he describes as an intuitive leap that these are due to an absence of capacity.

31. Dr. Ince concludes that reaching such a conclusion confirms that any further offending should be viewed as the remit of the Criminal Justice System and that this is consistent with the current SHPO.

32. Following his initial report, Dr Ince was asked a number of searching written questions in relation to this particular area of his report; and he also gave oral evidence. He was cross examined by Mr Brownhill for the respondents but did not shift in his opinion which was clear, cogent and firm. He emphasized that DY has an understanding of his offending, his victim profile and consequences of offending and that there is no suggestion he would be unable to plead in a criminal trial. He concluded that DY's understanding was relatively sophisticated, that it was consistent with his cognitive functioning, and that it was not mere repetition.

Discussion and conclusions

33. Having considered all the evidence and submissions, I have come to the conclusion on the balance of probability that DY has capacity to make decisions as to his care and support. I accept Dr. Ince's evidence. In arguing otherwise, it seems to me that the respondents are setting the bar of capacity at too high a level. In the final analysis, their arguments relied heavily on the fact that DY makes contradictory statements about his need for care and supervision, that he was inclined not to think things through and that fact that he can overestimate his abilities. In doing these things, DY is no different from many people who do have capacity. People with capacity can make unwise decisions and act on impulse.

34. When interviewed by Dr. Ince DY was honest about the risks he posed, and was able to express his fear of what would happen to him if he committed another offence. I agree with his conclusions that DY was not merely repeating what he had been told or saying what the interviewer wished to hear. I do not accept the respondents' submissions that Dr. Ince asked himself the wrong questions or relied too heavily on DY being able to describe the risk factors rather than being able to show what benefit his care and support offers him. It is very difficult for DY to demonstrate the benefit to him in circumstances where he has not experienced being without it (a situation he himself recognises). I reject the submission that Dr. Ince did not appear to consider the impact of the interplay between DY's paedophilic or paraphilic disorder, his anxiety and his autism, for he discussed and explained this at length in his evidence. DY has an impairment/disturbance of the mind or brain by reason of his ASD and accompanying anxiety, but Dr Ince does not accept the additional diagnosis of paraphilia is relevant in this context or that the fact that DY can make impulsive decisions regarding further offending is due to lack of capacity.

35. I entirely appreciate why the respondents in this case are so concerned, because there is a high risk that DY will reoffend if he is given the opportunity to do so. If he is allowed to make decisions for himself he could go out alone, and in doing so he could put others and himself at risk by acting impulsively and committing a sexual assault. Those responsible for his care are undoubtedly very worried about the effect upon him (and of course others too) were he to do this. Anyone responsible would be concerned about this, as I am myself. But Dr. Ince is right that any further offending is a matter for the Criminal Justice System. The current SHPO is an example of such risk management. The truth is that most sexual offenders and risky adults have capacity, and,

like DY are not to be managed by a Deprivation of Liberty within the provisions of the Mental Capacity Act 2005.

Conclusion

36. This finding inevitably leads to the Standard Authorisation being terminated in accordance with paragraphs 15 and 16 of Schedule A1 MCA. This means that DY will no longer be subject to a Deprivation of Liberty Authorisation. He will, however, continue to be offered the same care package he now has (including help with his daily living and medication), and he will be strongly encouraged to continue to be accompanied by at least one care worker whenever he goes out. What this decision changes is that DY will no longer be compelled to accept what is on offer, but I sincerely hope that he does.

37. The SHPO will remain in force for a few more months, and DY will remain on the sex offender's register. It is vital that DY is offered the psychological help and therapy that he so clearly needs as a matter of urgency for his own benefit and of course the protection of the public.