Neutral Citation Number: [2023] EWCOP 9

Case No: COP 13825449

IN THE HIGH COURT OF JUSTICE
FAMILY DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 10/03/2023

Before :

MRS JUSTICE LIEVEN

- -

Between :

A LOCAL AUTHORITY

Applicant

and

PG
(by her litigation friend, the Official Solicitor)

First Respondent

and

EG

Second Respondent

and

AN NHS
INTEGRATED CARE BOARD

Third Respondent

- -
- -

Mr Mark Bradshaw (instructed by **the Local Authority**) for the **Applicant**
Ms Eleanor Keehan (instructed by **MJC Law**) for the **First Respondent**
Ms Sophie Allan (instructed by **Moore Tibbits**) for the **Second Respondent**
The Third Respondent did not attend and **was not represented**

Hearing dates: **2 February 2023**

- -

Approved Judgment

This judgment was handed down remotely at 10.30am on 10 March 2023 by circulation to the parties or their representatives by e-mail.

....

MRS JUSTICE LIEVEN

This judgment was handed down in private on 10 March 2023. It consists of 44 paragraphs. The judge gives leave for it to be reported in this anonymised form.

The judgment is being distributed on the strict understanding that in any report no person other than the advocates or the solicitors instructing them (and other persons identified by name in the judgment itself) may be identified by his or her true name or actual location.

Mrs Justice Lieven DBE :

1. This judgment concerns PG, a 34 year old woman. PG has diagnoses of an intellectual disability in the moderate range, and autism spectrum disorder. She has recently been diagnosed as having "trauma based mental illness with Emotionally Unstable Personality Disorder ("EUPD")" traits (impulsivity, suicidal thoughts and emotional instability), and mild learning disability.

2. In the hearing the Local Authority ("LA") was represented by Mr Bradshaw, PG was represented by Ms Keehan through the Official Solicitor, and EG was represented by Ms Allan. The Integrated Care Board ("ICB") was not in attendance.

3. The LA has social services responsibility for PG. The ICB has joint funding responsibilities under s.117 of the Mental Health Act 1983 ("MHA").

4. The issue before me relates to PG's capacity. The parties agree that PG lacks capacity in the following respects – to conduct these proceedings and to enter into an occupancy agreement. The parties agree that she has capacity to make decisions about where she lives. However, the parties disagree about whether PG has capacity in respect of decisions about her care, including when she is within the home, when in the community, and at times of heightened anxiety. They also disagree as to whether she has capacity as to contact with others, including at times of heightened anxiety.

5. PG currently resides at Placement 1, a supported living placement, where she has lived since August 2022. Prior to that she was living at home with her mother, EG, the Second Respondent. Due to a deterioration in her mental health, PG was admitted to a psychiatric unit under s.2 MHA between 14 November and 14 December 2022 and then returned to Placement 1. PG is currently in receipt of 2:1 support for 15 hours per day and 1:1 support for 9 hours at night.

6. In his Position Statement Mr Bradshaw helpfully produced a summary of incidents that raised the LA's concerns about PG, and which have relevance to her decision making capacity. They also illustrate why the LA is concerned about PG's safety, and feel the need to be able to intervene, on the basis that she does not have capacity to make the relevant decisions. I will not reproduce this in its entirety but will set out some parts that show the factual basis of the concerns.

7. In July 2020 EG raised concerns about PG spending time in the community, where she was becoming frequently intoxicated, and there was a suggestion of some drug use. PG made an allegation of rape, but this was subsequently withdrawn.

8. In August 2020 the Police brought PG in for a s.136 MHA assessment because she had been suicidal and running into the road. It was felt that her behaviours were due to being intoxicated. A similar incident occurred in early September 2020.

9. In February 2021 PG had a verbal altercation with a neighbour leading to a court appearance. She was absconding from home at night and coming home intoxicated.

10. At this time, she was living in a placement. The staff followed her to a local park where she approached a number of men and then got into one of their cars very early in the morning. The Police took her to a place of safety. There are a number of similar

incidents through 2021 when she approached strangers, asked them to kiss her, and at times walked into the road.

11. In November 2021 she was being transported by care staff in a taxi and tried to get out whilst the taxi was moving. The staff then started to use child locks to prevent her leaving a moving vehicle.

12. There are a number of incidents of self-harm and suicidal ideation.

13. In April 2022 there was an incident when PG met some boys who were smoking drugs. She seems to have smoked the stubs and was brought home by one of the boys and became semi-unconscious. She then went out again but was brought home by a neighbour.

14. On 26 April 2022 PG went out and met a boy at the shops. She gave this boy her phone number, and he then started calling her daily. There was then an incident two days later where she got into an altercation with some boys over a beer. There are a series of records during April of her going out and approaching boys/young men. At times she seems to have been intoxicated. On one of these occasions the staff tried to persuade her to leave, but she refused and became increasingly agitated and abusive to staff. The staff called EG and she eventually persuaded PG to go home. On another occasion she called a young man a murderer and staff had to intervene to keep her safe. One time PG approached a young man and asked him to be her boyfriend, the staff had to call the Police to de-escalate the situation and keep PG safe and deter the male from further communications with her.

15. There are a number of incidents when PG seems to have been drinking and possibly taking drugs with young men and then became highly confused, and either the Police or an ambulance had to be called.

16. PG’s current social worker, filed a statement setting out recent incidents of verbal abuse in the community, creating a risk to PG, both directly from others and from possible legal repercussions from her actions. When PG becomes heightened in her placement, PG can become verbally and physically abusive to staff and damage property. PG can refuse the support of staff and leave the property on her own.

17. PG’s previous social worker, set out a list of potential triggers of PG’s challenging behaviour, which includes sirens; increased alcohol consumption above her three a day allowance; stress around Court hearings or discussions; her menstrual cycle; changes of residence; Police involvement.

18. Dr Jordan King, Highly Specialist Clinical Psychologist at the Intensive Support Team of the Adult Neurodevelopmental Services for the relevant NHS Trust, was involved in PG’s care between 2018 and the middle of 2022. He prepared a report for s.49 Mental Capacity Act 2005 (“MCA”) purposes. Dr King then produced two further supplementary reports. Dr King has now left the Trust and his report is almost a year old. However, he knew PG well over a period of time, and as such he remained an appropriate witness to consider her capacity.

19. Dr King gave oral evidence to the Court and was cross examined. It was clear from his evidence that this is a complex case in respect of PG’s capacity and that the law’s

desire for clear lines as to both what decisions she does and does not have capacity to make, and in what circumstances she loses capacity, does not fit with the reality of PG's presentation. It might be said there was a lack of clarity in Dr King's reports, and perhaps shifts in his oral evidence. However, in my view that was not because of any lack of expertise or careful consideration by Dr King, but rather because of the complex interactions in PG's presentation and behaviours. It is important to note that Dr King had seen PG at times when she was in a heightened state, after some of the incidents referred to above. Therefore, his evidence was more based on actual observations of PG at critical moments, than is often the case with experts in these cases.

20. In her Position Statement for the hearing on 23 January 2023, Ms Keehan produced a summary of apparent inconsistencies in Dr King's report. Given that Dr King knew PG well, and the obvious complexity of her case, I decided that he should give oral evidence, rather than instruct another expert to produce a fresh report.

21. In his report dated 11 March 2022 Dr King said in respect of PG's capacity to make decisions as to contact with others:

> *"[PG] is a vulnerable adult, and her Autism and Intellectual Disability undoubtedly impact on her perception / experience of interpersonal relationships and her interactions within these. However at the time of my assessment [PG] was able to understand, retain, weigh the relevant information, and communicate a decision with respect to contact with others in the community."*

22. In respect of decisions as to her care, Dr King said:

> *"[B]ased on my previous assessment in March 2022, it is my opinion that [PG] does not lack capacity in every element of her care and support needs. There are more daily elements she had capacity to engage in at the time of the assessment…although [PG's] propensity to become emotionally dysregulated as a consequence of her neurodevelopmental disorders may impact her decision-making ability in situations where she becomes highly anxious… However, she lacks capacity at all times to make decisions about the support she requires to maintain her safety (and that of others) in the community around traffic because of attentional deficits and/or heightened anxiety attributed to her Intellectual Disability and Autism."*

23. In his oral evidence Dr King said that PG would struggle to weigh and understand information when she became dysregulated, but when she is calm she can assess and weigh up risks. This causes an obvious problem for any capacity assessor, because when they are doing the assessment PG may well be calm and capacitous, but that is much less likely to be the case at the actual point of decision making at difficult moments in the community when her safety is at risk.

24. Dr King's evidence that she lacked capacity in relation to her care when in the community was clearer than his position in relation to her capacity to make decisions as to contact with others.

25. Dr King explained that there are a number of triggers for PG in the community, such as emergency sirens, which make her anxious that someone is coming to take her away. Even in her placement there have been times when she has become very agitated and caused damage and been violent to staff, and in Dr King's view she lacked capacity at those times. He thought that when in risky situations, such as around roads, she lost the ability to weigh and understand information and therefore to keep herself safe. Ultimately Dr King concluded that she did not have capacity in relation to her care at all times in relation to access to the community.

26. In relation to incidents in the community associated with contact with others, Dr King said he thought many of these related to alcohol, although it was hard to disentangle the influence of alcohol from issues concerning mental capacity. He said that whether PG had capacity during these interactions depended in large part on the degree to which she was heightened. Sometimes her decisions were capacitous but unwise, and at other times she had lost the ability to weigh up the information and the risks. It would only be possible to differentiate if someone spoke to PG at those instances. Dr King said:

> *"I find it hard to come down one side or the other because it varies on the environment, intoxication, moments leading up to it and the people around her. I am finding it very difficult to confidently assert when she is in a heightened state as if it was a static factor, in those heightened moments there are nuance variables."*

27. He thought it unlikely her capacity had altered since he assessed her given the lack of capacity related to her mental functioning, and there was no evidence that she had received care that effectively focused on building her decision making skills.

The Mental Capacity Act 2005

28. Sections 1-3 and s.4(3) MCA state as follows:

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

2 People who lack capacity

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

(2) It does not matter whether the impairment or disturbance is permanent or temporary.

(3) A lack of capacity cannot be established merely by reference to—

(a) a person's age or appearance, or

(b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about his capacity.

(4) In proceedings under this Act or any other enactment, any question whether a person lacks capacity within the meaning of this Act must be decided on the balance of probabilities.

…

3 Inability to make decisions

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

(a) to understand the information relevant to the decision,

(b) to retain that information,

(c) to use or weigh that information as part of the process of making the decision, or

(d) to communicate his decision (whether by talking, using sign language or any other means).

(2) A person is not to be regarded as unable to understand the information relevant to a decision if he is able to understand an explanation of it given to him in a way that is appropriate to his circumstances (using simple language, visual aids or any other means).

(3) The fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him from being regarded as able to make the decision.

(4) The information relevant to a decision includes information about the reasonably foreseeable consequences of—

(a) deciding one way or another, or

(b) failing to make the decision.

…

4 Best interests

(2) He must consider—

(a) whether it is likely that the person will at some time have capacity in relation to the matter in question, and

(b) if it appears likely that he will, when that is likely to be.

29. PG's case poses a number of challenges in trying to determine whether she has capacity in respect of the decisions in issue. Firstly, the evidence suggests that she does at times have capacity within the terms of s.3, but at other times she probably does not. Secondly, there is a close correlation between times when she may not have capacity and the making of what would plainly be considered unwise decisions. Thirdly, there is also some correlation between her making of unwise decisions and her being intoxicated.

30. The Court of Protection has frequently had to consider the position of a person who has "fluctuating capacity" and such cases have been treated somewhat differently. In Cheshire West v PWK [2019] EWCOP 57, Sir Mark Hedley was dealing with a case where P at times became overwhelmed by anxiety and made decisions he regretted [25]. At those times he lost capacity. Sir Mark analysed the case by taking a "longitudinal view". He said:

"17. I take the liberty, if I may, of adopting the position that I sought to set out in my judgment in A,B & C v X, Y & Z [2012] EWHC 2400 (COP) . There I was dealing with a person with some fluctuating capacity. I sought to draw a distinction between isolated decisions, for example, making a will or power of attorney, and cases where decisions may regularly have to be taken sometimes at short notice, as for example, in managing one's own affairs.

18. In paragraph 41 of the judgment I expressed myself as follows:

'In the light of Dr Posser's evidence, I am satisfied on balance that he lacks capacity to manage his own affairs. In so finding I acknowledge, as I have done in relation to the other matters, that there would be times when a snapshot of his condition would reveal an ability to manage his affairs. But the general concept of managing affairs is an ongoing act and, therefore, quite unlike the specific act of making a will or making an enduring power of attorney. The management of affairs relates to a continuous state of affairs whose demands may be unpredictable and may occasionally be urgent. In the context of the evidence that I have, I am not satisfied that he has capacity to manage his affairs.'

> *19. Some have referred to this as taking a longitudinal view. In my view, this approach has the value of clarity. It establishes that the starting point is incapacity. ...*
>
> *20. It seems to me that the closer the protected person is at the moment of actual decision to capacity, the greater the weight that his views must carry and of course, any decision made must take in to account that he may acquire capacity and, therefore, it must not be beyond change.*
>
> *21. In PWK's case all the relevant decision-making with which I am concerned lies in the field of repeat rather than isolated decisions. Dr Rippon's view, which was not really the subject of challenge, was that where a longitudinal perspective was adopted then PWK lacked capacity in all relevant areas."*

31. In Greenwich v CDM [2019] EWCOP 32, Newton J considered a case of potentially fluctuating capacity. He analysed the case in terms of whether the decision was one involving a "macro" decision or a series of "micro" decisions and said at [47] and [48]:

> *"47. I do not think it is necessary or helpful to draw inferences or parallels on examples of other conditions or other classes of individuals, since the interrelationship between the micro and macro-decisions still needs to be decided, having regard to a particular individual in particular circumstances, and having regard to their particular condition. No two people self-evidently are ever the same, their condition the same condition, or the circumstances the same. The elements in relation to CDM's own particular conditions are unique to her. CDM has diabetes which is not unique to her, being shared with many other millions of people in the United Kingdom, but as an individual the factors are unique.*
>
> *48. I have reached very clear conclusions, both on the evidence and on the law, on the powerful experts' analysis, which I adopt:*
>
> *a) on the assessment of capacity to make decisions about diabetes management, in all its health consequences, the matter is a global decision, arising from the inter dependence of diet; testing her blood glucose and ketone levels; administration of insulin; and, admission to hospital when necessary in the light of blood glucose levels. And*
>
> *b) that CDM lacks the capacity to make those decisions, and having regard to the enduring nature of her personality disorder which is lifelong and therefore unlikely to change."*

32. Ms Keehan submits that these cases do not apply to PG's case in the light of Dr King's view that PG has capacity in relation to contact with others and has capacity in relation to her care, save to a limited extent when in the community. She therefore refers to the decision of Cobb J in Wakefield MDC v DN and MN [2019] EWHC 2306 (Fam), particularly at [51]. In that case DN had a severe form of Autistic Spectrum disorder and a general anxiety disorder. The evidence was that he generally had the

relevant capacity, but at times he had "meltdowns", when he became highly dysregulated and lost capacity, see [8]. The LA sought anticipatory declarations in respect of when DN had meltdowns:

> *"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.*
>
> *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."*

33. Ms Keehan submits that the present case is analogous to DN, and therefore an anticipatory declaration is appropriate.

Conclusion

34. This is a complex case because of the nature of PG's presentation. In respect of both care and contact with others there are times when the evidence suggests that she does have capacity to make decisions and others when she does not, therefore this is undoubtedly a case of fluctuating capacity. The fluctuations appear to depend on the level of PG's anxiety and whether she feels under stress. The situation is made even more complicated by the fact that when PG is in the community, her decision making may also be influenced by the consumption of alcohol. This is, of course, not a ground for finding a lack of capacity under the MCA. However, her consumption of alcohol may itself be influenced by the degree to which she feels anxious and under pressure.

35. In respect of decisions about both her care and contact with the others, the issue about loss of capacity largely, if not solely, arises when she becomes highly anxious. In relation to contact with others, this will probably only arise when she is in the community because that is when such situations arise. However, in relation to decisions around her care, Dr King's evidence is that loss of capacity may also be an issue when she is at home if she becomes agitated and anxious.

36. I am really faced with a choice between making orders that follow the line of Sir Mark Hedley in *PWK*, and thus taking a "longitudinal view" of PG's presentation, and which closely relates to Newton J's "macro" decisions; or that of Cobb J in *DN* and making anticipatory declarations in respect of when PG has the equivalent of a "meltdown". Having analysed the facts of those cases, and considered those of PG, I do not think that one or other is the correct or indeed better approach. How an individual P's capacity is analysed will turn on their presentation, and how the loss of capacity arises and manifests itself. Both the decisions in issue here are ones that arise on a regular basis and often not in planned or controlled situations. That will influence how decisions about capacity are approached.

37. In deciding this issue I must have regard to the importance of making orders that are workable and reflect the reality of PG's "lived experience", both for the sake of PG and those caring for her. This can be analysed in various difference ways. It is a fundamental principle of the European Convention on Human Rights and the Strasbourg jurisprudence that the Rights should be interpreted in a way which makes them real and practical, not theoretical and illusory. It is a principle of statutory construction that the Court must have regard to the "mischief" of the statute. One of the mischiefs of the MCA is to seek to preserve an individual's autonomy, but in a way that ensures that when they do not have capacity, their best interests are protected.

38. My concern about making an anticipatory declaration in a case such as this, is that it would in practice be unworkable for those caring for PG. Unlike DN, PG does not have capacity in relation to decisions around her care, both when at home and in the community. Although when calm, she does at times make capacitous decisions within the meaning of section 3(1), I accept Dr King's evidence that even when at home, when she becomes anxious and emotionally dysregulated, she loses capacity. This

seems to me to be a more fundamental part of her general presentation than was the case with DN.

39. The issue is even more pronounced in the community and around contact with others. The records suggest that she often makes very unwise decisions about contact with others when in the community. That fact alone naturally does not mean that she does not have capacity, see s.1(4). But the frequent reference to her approaching strange men, and sometimes trying to get into their cars, strongly indicates that she cannot understand or weigh information about those decisions.

40. It may well be that there are times when her decision making is impacted by alcohol consumption. However, the evidence is clear that her decision making is impacted by her mental impairment under s.2(1) and not simply by consuming excessive alcohol.

41. It is not possible to disentangle the influence of alcohol from the impact of her mental impairment. If the evidence was that PG only lacked capacity at times when she is intoxicated then the position would be different, but that is not the evidence. No party argued that the mental impairment has to be the sole cause for the person being unable to make a decision within the meaning of s.3(1).

42. On the basis of Dr King's evidence, I conclude that the primary, though quite possibly not only reason, for PG not having capacity in relation to decisions about contact with others is her mental impairment.

43. In the light of these findings, I consider that the appropriate approach is to take the "longitudinal view". An anticipatory order would in practice be close to impossible for care workers to operate and would relate poorly to how her capacity fluctuates. The care workers would have to exercise a complicated decision making process in order to decide whether at any individual moment PG did or did not have capacity. This might well vary depending on the individual care worker, and how much of the particular episode they had witnessed or not. The result would fail to protect her, probably have minimal benefit in protecting her autonomy and in practice make the law unworkable.

44. In my view, the more practical and realistic approach is to make a declaration that PG lacks capacity in the two key respects, but also make clear that when being helped by the care workers they should so far as possible protect her autonomy and interfere to the minimum degree necessary to keep her safe.