SHERIFFDOM OF TAYSIDE, CENTRAL AND FIFE AT FALKIRK

[2023] SC FAL 4

FAI-AW58-17

JUDGMENT OF SHERIFF CHARLES LUGTON

in causa

FALKIRK COUNCIL, constituted under the Local Government etc (Scotland) Act 1994 and having its principal office at Abbotsford House, Davids Loan, Falkirk, FK2 7YZ

Applicant

against

D

Respondent

Act: Gillan, Falkirk Council
Alt: Morgan, Advocate

FALKIRK, 20 January 2023

The Sheriff, having resumed consideration of the cause, makes the following findings in fact:

1. The Adult, D, was born in 1997. He is 25 years old.

2. D has been subject to a guardianship order since 27 September 2017. D does not wish the guardianship to be renewed. D does not believe that the guardianship benefits him.

3. The main purposes of the guardianship are to provide D with structure to his day, to encourage him to eat and drink sufficiently, to help him to widen his social network and to improve his physical and mental wellbeing.

4. D has a diagnosis of Pervasive Developmental Disorder Autism Asperger's Syndrome ICD-10 – F84.5, possible Obsessive Compulsive Disorder and chronic low weight.

D's Asperger's Syndrome is an organic, neurodegenerative disorder, resulting from D's brain development since birth. It is permanent.

5. D has executive dysfunction. The effect of this is that he has problems with directed behaviour, planning, flexibility and responding to changing environments.

6. D has the capacity to understand, remember, weigh consequences and communicate in relation to simple matters, such as watching television. D does not have the capacity to understand and act in relation to complex matters. As a result of D's executive dysfunction he is not entirely in touch with reality; and he does not fully understand the dangers that sometimes accompany decisions that relate to complex matters. While D can describe risks and consequences, ultimately he does not properly understand them. D also struggles to act on decisions and to execute tasks. D is incapable of making decisions in connection with his care, diet, weight, health, participation in social activities, communications and correspondence with Falkirk Council, the Department of Works and Pensions, Banks, and other fiscal organisations and regarding plans to undertake travel.

7. D lives with his father, GM. GM has mental health difficulties. GM neglects his personal care and sometimes he does not eat properly. GM does not understand the complexity of D's needs and cannot provide him with consistent support. On one occasion GM advised D's social worker, CR, that D had become very unwell and had been unable to move for several days. GM said that he believed that D would die. GM had not sought medical assistance for D. In general, if D has a medical problem he and GM will not seek help, but D will report the problem to his support workers when they next attend.

8. GM tends to speak to visiting social workers and support workers about his own problems, which impedes their ability to work with D. When social workers and support workers attend the property, GM is reluctant to let them enter its communal areas.

9. D's mother died from cancer in 2016. D's twin sister, E, has autistic spectrum disorder. E requires a high level of support. GM was unable to care for E after her mother's death. E has been subject to a guardianship since 2017. E lives in residential accommodation.

10. The property in which GM and D live is dirty and cluttered. It is full of rubbish and contains a lot of electrical equipment. GM's possessions take up most of the space on the ground floor of the property. D spends most of his time in the upstairs of the property. D and GM barely communicate with each other. However, D likes living in the property and he does not wish to move. The state of the property is not sufficiently poor as to constitute a health hazard. The applicant has no present plan to seek to move D out of the property. If, in the future, the applicant considers that there is a need to move D because of the state of the property or because of his health, it will be open to the applicant to seek an order from the court at that time.

11. D is underweight relative to his height and age. He is on the third centile; and has been for his whole life. D has a poor diet. His calorie intake is low and his meals are often made up of small amounts of only one food-type. D receives treatment from a dietician, who he currently sees every six months. He has been prescribed build-up drinks, but he has stopped taking them. He has also been prescribed vitamin supplements, which he takes. In 2020 consideration was given to admitting D to hospital as a result of his low weight and poor diet. However, ultimately a decision was taken not to admit D to hospital. D's weight and diet require to be monitored.

12. During the period of the guardianship D's weight has remained broadly stable. At times D has put on weight but he has then lost it again. D has been supported to attend medical appointments and appointments with his dietician. As a result of the guardianship,

D's allocated social worker and support workers are able to monitor his diet, weight and health.

13. Throughout the period of the guardianship, D has generally taken up only a few of the allocated hours of support that have been available to him. D currently receives 2 one-hour sessions per week, although the sessions do not always last for the full hour that has been allocated.

14. D's interaction with the outside world is limited. He can go for several weeks and barely leave the house. He sometimes goes shopping, but can become anxious when doing so. During the 2021/22 academic year D attended a high school five or six times with Central Advocacy Partnership to speak to children with autism about transitioning to life after school.

15. During the period of the guardianship, D's social workers have arranged for D to visit his sister. He currently does this on a weekly basis without being supervised. He has also sometimes attended badminton sessions, although he only has the physical energy to play for short periods. The efforts made to encourage D to leave his home in order to participate in activities have been less successful than had been hoped. However, D's social workers and support workers continue to encourage his engagement with the outside world.

16. In April 2019 the guardianship order was varied to prohibit D from leaving the UK and to require him to surrender his passport to the applicant along with any travel documentation relating to a trip to Japan that D had been proposing to take with a friend. D had not appreciated the risks associated with international travel and of visiting a densely populated foreign country. He had not considered obtaining travel insurance. D will require support and assistance with any travel that he wishes to undertake.

17. D is unable to manage correspondence, including communicating with the local authority, the Department of Works and Pensions, Banks, and other fiscal organisations. There is a need for this to be attended to on his behalf under a guardianship order.

18. It is unlikely that D would engage with his social workers or accept support on a voluntary basis if the guardianship was not renewed. He would be at risk of missing medical appointments and appointments with his dietician. D's health, weight and diet would not be monitored. There would be a risk that any decline in D's health would not be identified and that he would not receive appropriate treatment. In the absence of the guardianship D would be at risk of becoming increasingly socially isolated. D might attempt to undertake travel without the oversight of his social workers. D does not have family members who would be able to manage his needs, monitor his health, provide him with the support that he receives under the guardianship and act as a safety net if the order were not in place.

Makes the following findings in fact and law:

1. That the respondent is incapable in relation to decisions about, and of acting to safeguard or promote his interests in his personal welfare and is likely to continue to be so incapable.

2. That no means by or under the Adults with Incapacity (Scotland) Act 2000 other than guardianship would be sufficient to enable the respondent's personal welfare to be safeguarded or promoted.

3. That the grounds for appointment of the applicant as guardian to the respondent continue to be fulfilled.

4. That a guardianship order will benefit the respondent and such benefit cannot reasonably be achieved without that intervention.

5. That a guardianship order in terms sought by the application in crave 1 (b), (c), (d), (e), (f) and (g) and crave 2 would be the least restrictive option in relation to the freedom of the respondent, consistent with the purpose of the intervention.

THEREFORE, under section 60(1) of the Adults with Incapacity (Scotland) Act 2000, GRANTS renewal of the guardianship order made on 27 September 2017 appointing the Chief Social Work Officer of Falkirk Council, Falkirk Council, Abbotsford House, Davids Loan, Falkirk, FK2 7YZ, for a further period of three years upon the issue to him by the Public Guardian of a certificate of continuation of the appointment in terms of Part 6 of the said Act with the following powers: [a] to require the respondent to have access to any community care staff or other carer and support worker which is considered necessary for his benefit and to determine and provide an appropriate care and support package; [b] to make any decision in respect of the respondent's health care, to make decisions and consent to and authorise medical, dental, optical or chiropody treatment and nursing care or treatment and to consent to any health care which is for his benefit and to refuse consent to any proposed health care where it is not for his benefit and does not accord with his known wishes and feelings all in terms of the powers contained in the said Act; and to arrange for the respondent to attend for any health care appointments and to arrange access to the respondent for the purposes of any health care; [c] to make decisions or arrangements regarding the respondent taking part in educative, vocational or social activities, holidays, travel and other pastimes including the nature, length and extent of the respondent's involvement or participation therein including as whether the respondent should work and

to what extent and on what terms and conditions; [d] to sign, complete and enable any deed or document immediately necessary to allow for the implementation of any decisions taken from powers granted in respect of this application; [e] to open, read, attend to and as appropriate reply to any mail or other communications addressed to or received by the respondent or on his behalf or to make arrangements to have such mail addressed to self as the respondent's representative and without prejudice to the foregoing generality to communicate either orally or in writing with Falkirk Council, the Department of Works and Pensions, Banks, and any other fiscal organisation on behalf of the respondent; and [f] to contact any person within any other public or private body to ensure that the respondent's care needs are met, that his care plan is properly determined and funded and that the appropriate officers and departments therein deal with any necessary review thereof; finds no expenses due to or by either of the parties to the application; and accordingly, repels the respondent's first plea in law, sustains the respondent's second plea in law, refuses crave 1(a) and grants craves 1(b), (c), (d), (e), (f) and (g) and crave 2 of the application; and Decerns.

NOTE

Introduction

[1] On 27 September 2017 the respondent, D, was made subject to a Guardianship Order in terms of section 60(1) of the Adults with Incapacity (Scotland) Act ("the 2000 Act"). The applicant seeks renewal of the order for a period of three years. D opposes this.

[2] I heard evidence on 24 October 2022 and submissions on 9 November 2022. In advance of the second day of proof, the parties helpfully lodged a joint bundle of authorities

together with detailed written submissions, to which I have referred throughout this opinion. I am grateful to agents and counsel for all of their assistance.

The Statutory Framework

[3] In these proceedings the applicant seeks renewal of an existing order in terms of section 60 of the 2000 Act, under which a guardianship order may be renewed for a period of five years or for such other period (including an indefinite period) as the court may determine, on cause shown.

[4] Sections 57 to 61 within Part 6 of the 2000 Act make provision for applications for and the renewal of guardianship orders. Section 58(1) provides that before a guardianship order may be renewed, the court must be satisfied that:

> "(a) the adult is incapable in relation to decisions about, or of acting to safeguard or promote his interests in, his property, financial affairs or personal welfare, and is likely to continue to be so incapable; and
>
> (b) no other means provided by or under this Act would be sufficient to enable the adult's interests in his property, financial affairs or personal welfare to be safeguarded or promoted."

[5] For the purposes of the 2000 Act "incapacity" is defined in section 1(6) as being incapable of:

> "(a) acting; or
> (b) making decisions; or
> (c) communicating decisions; or
> (d) understanding decisions; or
> (e) retaining the memory of decisions,
> as mentioned in any provision of this Act, by reason of mental disorder or of inability to communicate because of physical disability; but a person shall not fall within this definition by reason only of a lack or deficiency in a faculty of communication if that lack or deficiency can be made good by human or mechanical aid (whether of an interpretative nature or otherwise)"

[6] As the renewal of the order would be an intervention into D's affairs in pursuance of the 2000 Act, the court must apply the principles set out in section 1(2) to 1(4) of the 2000 Act, as per section 1(1). These are as follows:

> "(2) There shall be no intervention in the affairs of an adult unless the person responsible for authorising or effecting the intervention is satisfied that the intervention will benefit the adult and that such benefit cannot reasonably be achieved without the intervention.
>
> (3) Where it is determined that an intervention as mentioned in subsection (1) is to be made, such intervention shall be the least restrictive option in relation to the freedom of the adult, consistent with the purpose of the intervention.
>
> (4) In determining if an intervention is to be made and, if so, what intervention is to be made, account shall be taken of—
>
> > (a) the present and past wishes and feelings of the adult so far as they can be ascertained by any means of communication, whether human or by mechanical aid (whether of an interpretative nature or otherwise) appropriate to the adult;
> >
> > (b) the views of the nearest relative and the primary carer of the adult, in so far as it is reasonable and practicable to do so;
> >
> > (c) the views of—
> >
> > > (i) any guardian, continuing attorney or welfare attorney of the adult who has powers relating to the proposed intervention; and
> > >
> > > (ii) any person whom the sheriff has directed to be consulted,
> > > in so far as it is reasonable and practicable to do so; and
> >
> > (d) the views of any other person appearing to the person responsible for authorising or effecting the intervention to have an interest in the welfare of the adult or in the proposed intervention, where these views have been made known to the person responsible, in so far as it is reasonable and practicable to do so."

[7] The powers of the sheriff in any application under the 2000 Act are set out in section 3(1) and (2) in the following terms:

> "(1) In an application or any other proceedings under this Act, the sheriff may make such consequential or ancillary order, provision or direction as he considers appropriate.

(2) Without prejudice to the generality of subsection (1) or to any other powers conferred by this Act, the sheriff may—

(a) make any order granted by him subject to such conditions and restrictions as appear to him to be appropriate;

(b) order that any reports relating to the person who is the subject of the application or proceedings be lodged with the court or that the person be assessed or interviewed and that a report of such assessment or interview be lodged;

(c) make such further inquiry or call for such further information as appears to him to be appropriate;

(d) make such interim order as appears to him to be appropriate pending the disposal of the application or proceedings."

[8] The agent for the applicant and counsel for the respondent made careful submissions regarding the interpretation of these provisions, which I have found to be of considerable assistance. It is convenient to deal with these at this stage.

[9] Firstly, both parties submitted that the correct approach to the legislation is to begin by asking whether the adult lacks capacity, as per section 58(1)(a); and then, if the answer is in the affirmative, to proceed to apply the general principles set out in sections 1(2) to 1(4). I agree with parties that a two-stage approach falls to be applied, subject to two observations.

[10] The first of these relates to section 58, which should be read as a whole. In addition to the requirement of incapacity set down in section 58(1)(a), the court must also be satisfied that no other means provided under the 2000 Act would be sufficient to enable the adult's interests to be safeguarded or promoted, as per section 58(1)(b). In practice the court would have to address this question at the point of applying the general principle that the least restrictive intervention should be imposed, as per section 1(3) ("the least restrictive principle"). But for completeness I notice that the consideration of the issue is also a specific requirement under section 58(1)(b).

[11] The second point is that if there are two stages to the application of the legislation, it follows that at the stage of assessing capacity the court has not reached the point of applying the general principles set out in sections 1(2) to (4). These are two discrete exercises which should not be conflated. This may seem self-evident, but it arose as an issue in this case, as I shall come on to.

[12] Secondly, insofar as the general principles set out in sections 1(2) - (4) are concerned, counsel for the respondent explained that the term "benefit" in section 1(2) was chosen by the Parliament in preference to the phrase "best interests" as the latter was deemed to be paternalistic. This terminology was intended to be consistent with the idea that the adult's views should be taken account of, as expressly provided for by section 1(4). I accept counsel's submission on this point and I have endeavoured to apply section 1(4) to the facts of this case consistently with it.

[13] Thirdly, counsel also made submissions regarding the role of the least restrictive principle, provided for by section 1(3), within the statutory scheme. The starting point was that the effect of any intervention under the 2000 Act would be to deprive the adult of his or her right to self-determination. The least restrictive principle should operate to limit the effects of this. It followed that the purpose of the 2000 Act was not to allow intervention on an *anticipatory* basis: there must be a real need for intervention in an adult's life; and the court should take account of the potential availability of other orders should a future crisis arise, such as a Compulsory Treatment Order or an Emergency Order under sections 72 and 26 of the Mental Health (Care and Treatment) (Scotland) Act 2003, respectively.

[14] I accept counsel's submission as regards the rationale for section 1(3). However, it does not seem to me that the remainder of her submission follows logically on from this. Section 1(3) provides that at the point of applying the least restrictive principle the court

must already have "determined that an intervention as mentioned in subsection (1) is to be made." In other words, the least restrictive principle only falls to be applied *after* it has been decided that an intervention is required. If the view were taken that an intervention was not required at present but that in the future orders could be sought under the 2003 Act should the need arise, this would be consistent with the conclusion that the proposed intervention would not benefit the adult in a way that could not otherwise be achieved, as per section 1(2). On this scenario, there would be no need for the least restrictive principle to be applied, as the application would have failed at an earlier stage.

[15] More generally, I treat the proposition that an intervention should not be made on an *anticipatory* basis with caution, as it seems to me that the weighing up of risk and probability, together with the assessment of whether a proposed intervention will be beneficial, are inherently fact-sensitive exercises and much must depend on the circumstances of the individual case.

[16] Fourthly, insofar as section 1(4) was concerned, counsel for the respondent submitted that the requirement to take account of the adult's past and present views is absolute. I accept this submission. Indeed I notice that whereas in all other parts of the sub-section, which are concerned with taking views from other persons, the words "insofar as reasonably practicable" appear, there is no such qualification in relation to the duty to take the adult's views. This suggests that the duty is absolute, as counsel submitted.

[17] Fifthly, turning to the sheriff's powers under sections 3(1) and (2), both parties submitted that the court should not call for any further inquiries or investigations. Counsel for D submitted that it would be contrary to D's welfare to undergo further assessment. In the event, I found it unnecessary to do so.

The Terms of the order sought

[18] The specific terms of the order that the applicant craves are as follows:

1. To make an Order under Section 60(1) of the Adults with Incapacity (Scotland) Act 2000 renewing the Order made on 27 September 2017 at Falkirk Sheriff Court appointing the Chief Social Work Officer of Falkirk Council as guardian for D, with the powers to:-

[a] determine where the Adult resides on a permanent or temporary basis and to return him there in the event of him leaving, and to transport him there as necessary;

[b] require the Adult to have access to any community care staff or other carer and support worker which is considered necessary for his benefit and to determine and provide an appropriate care and support package;

[c] make any decision in respect of the Adult's health care, to make decisions and consent to and authorise medical, dental, optical or chiropody treatment and nursing care or treatment and to consent to any health care which is for his benefit and to refuse consent to any proposed health care where it is not for his benefit and does not accord with his known wishes and feelings, all in terms of the powers contained in the said Act; and to arrange for the Adult to attend for any health care appointments and to arrange access to the Adult for the purposes of any health care;

[d] make decisions or arrangements regarding the Adult taking part in educative, vocational or social activities, holidays, travel and other pastimes including the nature, length and extent of the Adult's involvement or participation therein including as whether the Adult should work and to what extent and on what terms and conditions;

[e] sign, complete and enable any deed or document immediately necessary to allow for the implementation of any decisions taken from powers granted in respect of this application;

[f] open, read, attend to and as appropriate reply to any mail or other communications addressed to or received by the Adult or on his behalf or to make arrangements to have such mail addressed to self as the Adult's representative and without prejudice to the foregoing generality to communicate either orally or in writing with Falkirk Council, the Department of Works and Pensions, Banks, and any other fiscal organisation on behalf of the Adult;

[g] contact any person within any other public or private body to ensure that the Adult's care needs are met, that his care plan is properly determined and funded and that the appropriate officers and departments therein deal with any necessary review thereof.

2 To renew the order for a period of 3 years."

The Evidence

D

[19] D is 25 years old, having been born in 1997. He confirmed that he understood that the hearing was about the proposed renewal of the guardianship order to which he is subject. He said that he was opposed to this, explaining that he did not consider that it brought any benefit to him. D rejected the suggestion that he would stop engaging with social services if he was not subject to guardianship. He said that he was happy to engage with his support worker, G, with his social worker, who had been CR until recently, and with his new social worker, C. He said that he would also continue to engage with his dietician on a voluntary basis. He was very happy with the current level of support that he received and he would not want this to be increased.

[20] D said that he understands that he has low weight for his age and height. He said that he has had a BMI of under 16 for his whole life.

[21] D said that he receives ESSA and PIP via direct debit. He has a bank account, which he manages. When he goes shopping he pays for items with his bank card. He said that he visits his twin sister every week. He goes to see her on foot and the walk takes around five minutes. He confirmed that before the summer he attended a high school five or six times with Central Advocacy Partnership to speak to autistic pupils about transitioning to life after school. D said that he also plays badminton at the sports complex in his town.

[22] In cross-examination D was asked about his home. He said that it is very cluttered, but it is his favourite place to be. He was asked if there had been issues with vermin in his home. He said that he had once thought he had seen a rat, but it turned out just to be a mouse. He was asked about an occasion when he had planned to go to Japan; and about

how he would have coped in the airport and in a foreign country. He replied that his main focus had been to be with his friend.

[23] At the start of the proof I was told that D was unlikely to give evidence, but in the late afternoon counsel advised me that he would do so, in an apparent change of course. This clearly took real courage on D's part and at times he was visibly distressed while in the witness box. He did, however, manage to engage effectively with the court, giving clear and cogent answers throughout his evidence.

[24] I considered D to be a straightforward witness, but ultimately I am not satisfied that I can rely on his evidence that he would continue to engage with his current supports if the guardianship were not to be renewed. At another point in his evidence he said that he did not consider the guardianship to be beneficial to him, which is difficult to reconcile with the idea that he would engage voluntarily in its absence. According to D's social worker, CR, D said the same thing to her; and he also told her that he wished to get rid of the guardianship so that he could choose how little or much help to accept. In a similar vein, D's mental health officer, AN, said that D is currently trying hard to engage, albeit he is still struggling to do so, because he is aware of these proceedings, but that his level of engagement would be likely to taper off in the absence of an order. Also relevant is the fact that throughout the term of the guardianship D has not taken up all of the support that he has been offered. While I do not believe that D was seeking to mislead the court when he said he would engage voluntarily, I think that in reality he would be unable to engage with his support package on a voluntary basis. Accordingly, I reject D's evidence on this issue.

[25] More generally, I consider how D's evidence is to be interpreted and what its implications are in my discussion of capacity and the general principles, below.

AN, Mental Health Officer

[26] AN was a mental health officer, based at Woodlands Resource Centre, Falkirk Community Hospital, Falkirk. He had qualified as a social worker in 1986 and as a mental health officer in 1997. AN said that he was involved in the introduction of the 2000 Act when it came into force; and that he had trained other staff members in relation to the legislation. In this case he provided an AWI [3] report, dated 25 September 2020. He swore an affidavit, dated 4 August 2022.

[27] By way of background, AN explained that D was diagnosed with autistic spectrum disorder (ASD) in 2014. His twin sister, E, had been diagnosed with ASD as a young child. After their mother's death from cancer in 2016, D and E were cared for by their father, GM. In 2017 it became clear that GM was unable to care for E, who has a high level of need. The condition of the family home had deteriorated. A guardianship order was obtained in respect of E and she was moved to residential accommodation.

[28] D continues to live with GM in the family home. AN said that the house remains in poor condition: it contains a lot of electrical equipment, is full of rubbish and is very dirty. D and GM barely communicate and D spends most of his time upstairs. AN said that GM has mental health difficulties. He has said that he has not washed for several years. His income is very limited and he is sometimes unable to buy food, at times resorting to living off raisins.

[29] AN said that at a multi-disciplinary meeting in May 2021 it was noted that D's BMI remained very low but had been more or less stable for the last two years. There had been serious concerns about his low weight since 2013, but these had escalated following his mother's death. The purpose of the guardianship order had been to provide D and his father with support in order to enable him to eat a sufficient diet to reduce the risk of

starvation and death. He had been provided with support workers who specialised in autism, in attempts to assist him with eating and with leaving the house to participate in social activities. D had been prescribed diet supplements by his doctor. LB, Dietician, had also been involved, in order to assist him in gaining weight.

[30] AN said that despite these interventions, D's weight had not improved and there remained a significant risk that he might die. He had spoken to the social workers, the support workers, the dietician and Dr M, all of whom had expressed a high level of concern regarding D's welfare.

[31] AN explained that the efforts of those involved are being hindered because D lives with his father. Because of this and in view of the state of the home, in 2021 an intervention order was sought in order to move D to alternative accommodation. Ultimately this was not insisted on because concerns about the potential psychological and financial effects of D's removal on his father; and because D was only accepting two hours of support per week, which would be insufficient were he to move to new accommodation. The view was also taken that the level of dirt in the house did not amount to a health hazard. GM said that they had applied the minimum intervention principle when taking the decision to drop the proposed intervention order.

[32] AN said that D has never been in favour of the guardianship order, which he does not consider to be beneficial to him. He does not accept that his weight is dangerously low and he believes that if he maintains his current weight he will avoid hospitalisation. He does not recognise that his low weight diminishes his energy levels, thus preventing him from going out and engaging in activities.

[33] AN explained that D will talk positively about things in his life, but this does not reflect the reality. For example, he has spoken of playing badminton but it transpires that

when he went to play, he was only able to do so for a few minutes because of his low energy levels. He does not seem to appreciate the reality or to understand the link between his inability to play a full badminton session and his poor diet. Similarly, he has spoken of leaving the house regularly, but when quizzed about this it has emerged that he has not been out for two or three weeks.

[34] D is aware of the proof diet and is currently trying particularly hard to engage with his care package - but he is still struggling to do so. AN suggested that if the order were to be removed, D would not take support at anywhere near the existing level. He would be likely to engage for a time, but this would taper off. He would not get to medical appointments and appointments with the dietitian, his diet would deteriorate, his weight would drop and he would become more socially isolated. AN's view was that renewal of the guardianship order was necessary for D's protection. There was no other way of achieving this and it was the least restrictive option.

[35] It was suggested to AN in cross-examination that D should be given the opportunity to try to engage with services voluntarily, but he responded that to do so would be to play dice with D's life as the risk was so substantial. He acknowledged that he was not a medical practitioner, but said that he was told that there was a risk of damage to D's internal organs. A strategy of prevention was better than responding after the event. When it was put to AN said that D had not required hospitalisation he replied that this had been considered in 2020. Ultimately, it was deemed better to try to support D in the community. Hospital admission for people with low weight was not a magic wand and account had also been taken of the fact that D has an aversion to hospitals. This had been a medical decision rather than one made by him.

[36] AN confirmed that Dr M's assessment of D's capacity was consistent with AN's experience of dealing with D. In cross-examination, two letters written by Dr B, consultant psychiatrist, dated 24 December 2021 and 12 January 2022, were put to AN. In the first letter Dr B reported the outcome of a professionals meeting at which AN and CR were present together with D's occupational therapist and a solicitor for the local authority. Dr B wrote that there was a difference of professional opinion over whether the guardianship was still required - AN and CR were of the view that D was unlikely to engage with services and might deteriorate if he was not subject to the guardianship, whereas Dr B considered that D should be "tested out" - i.e. the guardianship should not be renewed and if his health and welfare were to deteriorate a fresh application could then be made. In the second letter Dr B reported that he had reviewed D on 11 January 2022 and confirmed that he did not support renewal of the guardianship order. When AN was asked about these letters he confirmed that he disagreed with Dr B about the proposed renewal of the order, which he supported.

[37] AN is a very experienced social worker and mental health officer. He struck me as a credible and reliable witness, who gave careful and measured answers. His descriptions of aspects of D's behaviour were detailed and convincing - e.g. his account of the gap between what D will say about activities such as playing badminton and leaving the house. AN's concerns about D's attitude to his care package and the likelihood that he will disengage if he is not subject to a guardianship order seemed to me to be considered and well founded.

[38] Counsel for D made a number of criticisms of AN. Firstly, she criticised him for refusing to accept Dr B's position on renewal of the order, despite not being medically qualified. I reject this criticism because in an application of this kind a mental health officer is required to interview and assess the adult and express a view on the appropriateness of continuing the guardianship in terms of section 60(3)(b)(i) of the 2000 Act. It follows that the

mental health officer must form an independent view on whether the order should be renewed. In any case, while Dr B and AN were divided over the merits of renewal, another consultant psychiatrist, Dr M, supports the application.

[39] Secondly, counsel pointed to the fact that AN had not seen D since April 2021. In my view this does not diminish the value of AN's evidence: AN's assessment was consistent with the evidence of D's social worker, CR, who has had more recent and regular contact with D. AN made clear that he had formed a view not solely on the basis of his own interview with D, but also as a result of speaking to other professionals who see D more frequently than he does. In my opinion, one would expect a mental health officer's assessment of an adult for the purposes of section 60(3)(b)(i) to involve making inquiries of this kind with professionals who are involved with the adult on a regular basis. It is also worth observing that AN did have prior direct knowledge of D - he had been his mental health officer since the start of 2020 and in his AWI[3] report, he wrote "I have known D for almost a year and he has consistently expressed the view that he does not support any guardianship order or this application."

[40] Thirdly, counsel for the respondent criticised AN for commenting on areas that lay outside of his expertise and exaggerating the risks when he said that D's organs might close down and that he might die. But as I have it noted AN made no attempt to express a view of his own on these medical questions and said repeatedly that he had been told by D's dietitian and the treating doctors that these were the risks.

[41] Ultimately, I was unconvinced by the criticisms that were levelled at AN and I was not diverted from the conclusion that he was an impressive witness.

CR

[42] CR is an acting senior social worker, based within the East Locality Team at Meadowbank Health Centre. She qualified as a social worker in 2005. CR was the allocated social worker for D between February 2018 and May 2022. CR swore an affidavit, dated 21 July 2022, and gave parole evidence at the proof.

[43] CR gave similar evidence to AN as regards D's ASP diagnosis, low weight, level of understanding, domestic circumstances, social isolation and limited engagement with his support package.

[44] CR noted that social work records recorded concerns about D's low weight dating back to 2013. These concerns had remained live when D had been transferred to Adult Mental Health Services in August 2016. Dr B, consultant psychiatrist, had provided an opinion that D did not have capacity to make decisions regarding his care and welfare needs. Ultimately, a decision had been taken to apply for the guardianship order that was granted on 27 September 2017.

[45] In April 2019 the order was varied to prohibit D from leaving the UK and to require him to surrender his passport to the applicant along with any travel documentation relating to a trip to Japan that D had been proposing to take. D had been intending to travel to Japan with a friend. CR explained that this raised concerns because he was liable to become anxious when leaving the family home - e.g. to go to the supermarket. It was unclear how he would cope with travelling through airports, on board a plane, and ultimately within a foreign country. Air travel gave rise to the risk that he might catch a virus. If he became unwell for this or any other reason it was not obvious how he would manage to obtain medical assistance in Japan. There was a real risk that his needs would not be met there. D had not considered obtaining travel insurance. D was not prepared to identify the friend

with whom he was proposing to travel, or tell CR anything about him. He appeared not to have appreciated the risks posed by his proposed trip.

[46] CR described the support that has been made available to D in recent years. Its purpose was to provide him with structure to his day, to establish a regular routine that included supporting him to shop for food and make meals, and to encourage him to eat and drink sufficiently. The support offered was also intended to help D to widen his social network and to improve his physical and mental wellbeing. It was also hoped that D would accept prompting to attend to his personal care needs along with doing laundry and completing cleaning tasks in his home.

[47] Prior to the pandemic he received nine hours of support per week via Scottish Autism, though he rarely accepted the full amount of hours for each session. This ceased in March 2020 due to the introduction of the first lockdown. Since around September 2020, Dalriada Home Care has provided D with support. D initially only been received 2 hours per week due to his reluctance to go out during the pandemic. Up to 30 hours per week of support would be available if D had his own accommodation, but he is opposed to moving out of his father's home. At one stage after Dalriada became involved he was receiving 6 hours, but his engagement was variable and he rarely accepted all 6 hours. He currently receives 2 one-hour sessions per week, although the sessions do not always last for the full hour that has been allocated.

[48] D has told CR that he does not want any additional support. CR noted that D had spoken to Dr B in positive terms about the support with which she, Dalirada and the dietician provided him, but she said that she did not believe that he has changed his mind about his care package. D has told her that he has heard from others that the only way to avoid being on an order is to accept what social services have put in place, so that it can be

argued that the order is unnecessary. Once the order is removed he can choose what support he accepts.

[49] CR said that D's weight has largely remained the same since 2020. Despite the dietician's involvement he often gains weight only to lose it again. It was CR's understanding that he is significantly underweight for his age and height. His calorie intake remains low and he is no longer willing to take the build-up drinks that he has been prescribed, but he does take a daily vitamin supplement. His meals often consist of a very small portion of one food-type. CR said that if the order were removed she would be concerned that D's weight would drop and that he would become more socially isolated.

[50] CR said that the support package has been a limited success. It has not been more successful in part because D resides with his father. GM tends to speak to visiting social workers and support workers about his own problems, which impedes their ability to work with D. The poor condition of the property also makes it difficult to provide D with support within the home, as does the fact that GM is reluctant to let staff into the communal areas of the property. CR gave similar evidence to AN about the proposal to move D to alternative accommodation that was ultimately not insisted on. CR suggested that GM does not understand the complexity of D's needs and cannot provide him with consistent support due to his own lifestyle. GM himself has a poor relationship with food and neglects his own personal care.

[51] CR described an occasion when D had been very unwell and barely able to move for several days. GM told CR that D had nearly died, but he confirmed that despite this he had not sought medical assistance. CR said that she has found that in general if there is a medical problem D will not seek help, nor will his father assist. Instead, he often waits until he sees her or his support workers.

[52] CR reported historical problems with the fire alarm in the property. On one occasion she had arrived to find that the alarm was beeping, indicating that the battery needed to be changed. On an earlier date the alarm had again been sounding with the result that the Fire Brigade had attended. The Fire Brigade had raised concerns about the electrical sockets being overloaded within the property. GM had refused to allow access to the loft space for checks to be made, despite the fact that a number of sockets were understood to be located there.

[53] CR identified the current risks to D as being poor physical health due to limited dietary intake, a very high risk of social isolation, a high risk of poor mental health due to boredom and a lack of purpose, and risks created by his father's poor mental health. She suggested that renewal of the existing order was necessary and constituted the least restrictive means of reducing these risks.

[54] I regarded CR as a credible and reliable witness. She gave detailed evidence of the attempts to support and manage D over the past few years. While counsel for the respondent suggested that much of what CR said related to the condition of D's home and to D's father's mental health difficulties, her evidence ranged more widely than this, as I have summarized above. Counsel also challenged CR's credibility and reliability on the basis that CR and Dr M gave conflicting evidence over whether she had advised him that the application for guardianship was contested. I will return to this when I come on to Dr M's evidence, but at this stage I observe that this is not an issue to which I attribute great significance. It does not cause me to doubt the credibility and reliability of CR's full and helpful evidence of her involvement with D, which I found convincing on the basis of its content.

Dr M

[55] Dr M, Consultant Psychiatrist, gave evidence via webex. He was employed until recently as a locum Consultant Psychiatrist at Falkirk Integrated Mental Health Service. He had been a member of the Royal College of Psychiatrists since 2008. He had been providing reports for court proceedings for over 20 years. Dr M said that half of his professional experience related to adults with learning disabilities and autistic disorders. He had been dealing with patients with such disorders since 1988 and he had read most of the relevant published materials including books, journals and articles relating to autistic disorders.

[56] Dr M examined D on 11 May 2022 and provided a letter following the appointment, dated 16 May 2022. He completed an AWI [1] Form on 17 August 2022. Dr M swore an affidavit on 1 September 2022 and he gave parole evidence at the hearing. Dr M acknowledged that one meeting was a "snapshot" and was insufficient to assess D's condition. But Dr M had been through D's mental health records, reviewed the opinions of previous consultant psychiatrists and spoken to the social workers.

[57] Dr M diagnosed D with Pervasive Developmental Disorder Autism Asperger's Syndrome ICD-10 - F84.5, possible Obsessive Compulsive Disorder and chronic low weight. He confirmed that the first of these conditions was a mental disorder. He explained that Asperger's Syndrome is a milder form of Autistic Spectrum Disorder. He categorised it as an organic, neurodegenerative disorder, resulting from D's brain development since birth. Some practitioners prescribe therapies in an attempt to reduce the symptoms, but there is no cure.

[58] Dr M said that he had been impressed with D, who was articulate and had maintained a good rapport with him. Dr M opined that D has the capacity to understand, remember, weigh consequences and communicate in relation to simple tasks. But complex

tasks are beyond his reach. He is incapable of making decisions about complex matters such as money, property and health needs. Dr M referred to this as complex mental incapacity. What underlies this is that D suffers from executive dysfunction, which means that he has problems with directed behaviour, planning, flexibility and responding to changing environments. A feature of D's executive dysfunction is that he is not entirely in touch with reality, nor is he fully aware of the dangers that sometimes accompany decisions. He also has difficulty in acting on decisions: he can express himself but when it comes to the execution of tasks he cannot complete them. This is typified by D's approach to eating - he can articulate the risks of not eating, but he is still unconvinced that he should eat. This means that he might manage to put on weight for a time but he remains prone to lapses.

[59] Dr M said that as D's disorder is permanent he will be permanently incapable. He did, however accept that D might be assessed as being capable in the future. This was because there is no objective test for capacity. He was asked about an opinion given by an earlier treating psychiatrist who had been involved with D's care, Dr B, that D has capacity. He explained that psychiatry is a subjective practice and that different psychiatrists will give different opinions. It followed that he could not rule out the possibility that a psychiatrist might assess D as being capable in the future, just as Dr B had done previously.

[60] Dr M said that D needs support in all walks of life and suggested that guardianship was a suitable form of legal order for him.

[61] I was impressed with Dr M's evidence and I accepted his opinion on the issue of D's capacity, in preference to that of the respondent's expert, Dr L, whose evidence I shall come on to shortly. I consider this in detail below, in the course of my discussion of capacity; but at this stage I will address a number of challenges to Dr M's credibility and reliability that were advanced by counsel.

[62] Firstly, counsel suggested that Dr M's answers tended to be rambling rather than clear. It is true that he gave a number of rather long answers but I attribute this to the fact that he was giving evidence virtually. Often evidence is taken from witnesses via webex without difficulty, but this was not one such occasion - through no fault on anyone's part, the parties' representatives struggled to establish a rapport with Dr M and the result was that he sometimes gave lengthy answers that went undirected by interjections from those appearing. I suspect that the exchange would have proved easier and more fluent had Dr M given evidence in the flesh. Despite this Dr M's evidence was intelligible and covered all of the crucial points.

[63] Secondly, counsel questioned Dr M's credibility and reliability because he said in cross-examination that he had not known that he was being asked for an opinion on D's capacity in the context of a contested litigation. Dr M said that had he known this he would have provided a more detailed report. As I mentioned earlier, Dr M's evidence was in conflict with the evidence of CR, who said that she had told Dr M that the application was contested. Both CR and Dr M seemed to me to be responsible and conscientious witnesses who were doing their best to assist the court. In my view it is inconceivable that either of them was being deliberately untruthful. This leaves open the possibilities either that one of them misremembered the detail of their discussions or that they were at cross purposes and a misunderstanding arose. Whatever the explanation, this issue seems to me to be collateral to Dr M's evidence regarding D's capacity and it does not cause me to doubt the credibility and reliability of his evidence on this central question. Counsel made the related criticism that Dr M's report was brief in its terms, but I consider that his report, affidavit and parole evidence in combination form a suitably full and detailed explanation of his opinion.

[64] Thirdly, counsel identified two purported inconsistencies between Dr M's report and an earlier letter that he had written shortly after seeing D, dated 16 May 2022. The first of these was that on page 2 of the letter of 16 May, Dr M had written that "D has limited Mental Capacity and poor Welfare Capacity whereas at page 4 of his report he wrote "Mr McLaren lacks Welfare Capacity." While these two statements may appear inconsistent when removed from their contexts, it is worth reading the relevant passage from the report in full. Dr M writes:

> "Dr McLaren lacks welfare capacity as he is not *fully* capable to make decisions regarding money, property and health needs simple or complicated and thus cannot convey consent regarding his welfare" (my italics).

I do not regard the two forms of wording as being irreconcilable, as the distinction between having poor capacity and not being fully capable appears semantic rather than substantial. On my interpretation of these documents, in both the report and letter Dr M expresses the consistent view that D's level of understanding is not sufficient to render him capable in relation to the matters under consideration.

[65] The second purported inconsistency concerned what Dr M had written about D's use of money. Counsel quoted Dr M as that D "uses his money sensibly" and "is now using his bank card" in the letter of 16 May, and suggested that this was difficult to reconcile with Dr M's statement in his report that D "is not fully capable to make decisions regarding money." In fact, the letter and the later report are entirely consistent on the issue of money: the phrases to which counsel referred are not representative of Dr M's opinion, but are taken from his summary of what D told him. Later in the letter Dr M concludes that D "does not have capacity for complicated tasks like managing money" which corresponds exactly to what he says in his subsequent report.

[66] While I have dealt with these two supposed inconsistencies in deference to counsel's submissions, I doubt that there is much to be gained from undertaking a close textual analysis of Dr M's report. It is a somewhat telescoped document and Dr M went on to provide a much fuller exposition of D's capacity in his affidavit and his parole evidence.

[67] The final point that counsel made was that while Dr M raised the possibility of fixing a follow up appointment with D in his letter of 16 May 2022, no date was set. When Dr M was asked about this in cross-examination he responded that there was no psychiatric emergency that would necessitate a further appointment. This seems to me to be a perfectly reasonable explanation and the question of a possible follow up appointment has no obvious bearing on Dr M's credibility and reliability or on the opinion that he provided regarding D's capacity.

Dr L

[68] Dr L became a consultant psychiatrist in learning disability in 2009. He is currently based at the Low Secure Ward in Lynebank Hospital, Dunfermline. He has also owned the company Independent Psychiatry since 2017/2018. Dr L's specialism is forensic psychiatry and psychiatry in learning disabilities. He deals with patients with mental disorders who pose a danger to the public. Dr L said that autism spectrum disorder is a very common disorder and that he has been diagnosing and working with patients with autism for many years. He confirmed that he is qualified to provide reports in relation to guardianship and said that he has provided hundreds of such reports, or perhaps over a thousand.

[69] Dr L had prepared two reports regarding D, dated 12 April 2021 and 18 August 2021, which he adopted as his evidence. Dr L spoke to D's dietician and to his advocacy worker before preparing his first report. At that stage, part of the context was that consideration

was being given to removing D from his home. Dr L wrote that he was opposed to this, offering the view that to do so would run contrary to the principles set out in section 1 of the 2000 Act. He went on to address the issue of capacity at paragraph 58, which is worth reproducing in full:

> "D is able to make, understand, as well as retain the memory of decisions. He does have some deficits in his ability to act on decisions; however, can be supported in this regard. I am aware as the risks increase the bar to decision making ability can be increased, and in such a situation his deficit to act may fall within the realms of incapacity but this threshold in my opinion has not currently been reached. He has gained weight and his condition is stable. The professionals involved in his care should continue to work in partnership with him and he can be offered support at home to try and enhance his quality of life as well as to help him maintain or make some very gradual but realistic small gains. I therefore do not think that there is sufficient evidence that he currently lacks capacity and would not support his forced removal from his home."

In his second report Dr L confirmed that his opinion on capacity remained unchanged.

[70] In his parole evidence Dr L opined that D can make, understand, communicate and act on decisions. He rejected the suggestion that D has executive dysfunction, explaining that executive dysfunction is to do with the frontal part of the brain and with high order functions, such as problem solving, judgment and inhibiting unwanted forms of behaviour; and causes people to struggle with day-to-day tasks. Dr L suggested that instead of suffering from this, D has compulsive-type behaviour, associated with autism.

[71] Dr L explained that D knows that he is underweight and knows what his BMI is. He appreciates the implications of this for his health, in particular that he is more prone to infections. He does not see his weight as much of an issue but he understands what the professionals are saying to him. According to Dr L, D has been hearing that he is going to die for as long as the present application has been ongoing, but in reality the risk is not as great as is being suggested. D is on the third centile and has been for his whole life. His weight has been quite stable, he is working with services and he should be given the chance

to make decisions by himself. Dr L said that if D's weight falls below the third centile services should be involved and the application of the legislative framework should be considered.

[72] Dr L said the assessment of a person's capacity can change depending on the circumstances. Changes in brain functioning can alter a person's ability to make decisions. Alternatively, the risks that the person is subject to can change - and this in turn can raise the bar for capacity. Dr L suggested that the Code of Practice makes provision for this. In cross-examination Dr L added to this that in the course of assessing capacity it was necessary to apply the principles set out in section 1 of the 2000 Act.

[73] Dr L conceded that he had not spoken to D's mental health officer or to the social workers who were involved with him. It was put to Dr L that the assessment of risk in the context of D's management is a matter for the social workers. He rejected this, suggesting that the risks relate to D's physical and mental health and that medics are therefore involved in assessing them.

[74] In my view Dr L was a straightforward witness who was doing his best to assist the court. Regrettably, I think that he adopted a flawed and confused approach to the assessment of D's capacity. I elaborate on this below in the course of my discussion of D's capacity.

Section 58(1)(a): Capacity

[75] I turn now to the question of whether D lacks capacity, for the purposes of the matters to which the proposed guardianship order relates, as required by section 58(1)(a) of the 2000 Act. In terms of section 1(6), the petitioner must establish that D is incapable by

reason of a mental disorder. It is convenient to start by considering whether D has a mental disorder and then, if so, to determine whether this renders him incapable.

Does D have a mental disorder?

[76] Does D's Asperger's syndrome constitute a mental disorder for the purposes of section 1(6)? The psychiatrists both appeared to accept this. Dr M stated explicitly that D has a mental disorder. Dr L did not address the point directly, but it was apparent from his analysis that D's Asperger's syndrome might render D incapable in terms of section 1(6) in certain circumstances, which implies his acceptance that Asperger's syndrome would fall within the definition of a mental disorder for the purposes of the legislation.

[77] Having said that, the psychiatrists gave differing explanations of the nature of D's Asperger's syndrome, which Dr M described as an organic neurodegenerative disorder that causes D to have executive dysfunction. Conversely, Dr L rejected both the categorisation of Asperger's syndrome as a neurodegenerative disorder and the notion that D has executive dysfunction, instead suggesting that he exhibits compulsive-type behaviour, associated with autism.

[78] The reasons for this difference of views were not explored in any detail at the proof; and neither Dr M nor Dr L made reference to any academic literature as a basis for their opinion. In her submissions, the agent for the applicant referred me to the case of *The City of Edinburgh Council* v *D* 2011 S.L.T. (Sh Ct) 15, which concerned a guardianship application made in respect of an adult who had Asperger's syndrome, in which Dr Alan Carson, neuro-psychiatrist, gave evidence. Dr Carson described the adult's condition in similar terms to Dr M's description of D's disorder - i.e. as a neurodegenerative disorder that had caused executive dysfunction. Dr Carson is well known to the Scottish courts, having

provided opinions in numerous cases over many years. But it would be inappropriate to take account of evidence that he gave in relation to a different adult in another case, as to do so would be to misuse authority as a source of evidence rather than of law.

[79] Ultimately, I have come to the conclusion that I should prefer Dr M's categorisation of D's Asperger's syndrome as a neurodegenerative condition, causing executive dysfunction. This is because I consider his evidence to be a better fit with the evidence of D's behaviour, in particular D's lack of touch with reality and his limited insight into risks to his welfare, as I discuss below. But in any case, the dispute over this issue carries less significance than it might have done because, as I have said, both experts accepted that D's Asperger' syndrome could, in principle, render him incapable for the purposes of the legislation.

[80] Before leaving this issue I must deal with a submission advanced on D's behalf. Counsel for D referred me to *Scottish Borders Council* v *AB* 2020 SLT (Sh Ct.) 41, in which Sheriff Scott QC said:

"(a) person is not suffering from mental disorder by reason only that she acts as no prudent person would act" (paragraph 10).

Counsel proceeded to submit that the way in which a person self-determines how to live their life is not a basis for intervention; and that while the applicant might prefer D to make different choices, he understands those choices and their associated risks. In my opinion, this submission elided the two separate questions of (i) whether D has a mental disorder; and (ii) if so, whether his mental disorder renders him incapable. As I have just explained, it is not in dispute that D has a diagnosis of Asperger's Syndrome and both psychiatrists appeared to accept that this constitutes a mental disorder for the purposes of the legislation.

It follows that Sheriff Scott's observation, although undoubtedly correct, has no application to the facts of this case.

[81] I turn next to the question that follows on from this: whether D is incapable as a result of his Asperger's syndrome diagnosis.

Capacity

[82] The consultant psychiatrists provided competing opinions as to whether and to what extent D is capable of understanding, making and acting on decisions, which I have summarised above. As I have already indicated, I preferred the evidence of Dr M to that of Dr L. I now propose to explain why.

Dr M

[83] Earlier in this opinion I dealt with various criticisms that were made of Dr M, which were said to touch on his credibility and reliability. None of these really engaged with the substance of Dr M's opinion and it is to this that I turn now. I was impressed with the cogency of Dr M's evidence. In my view he provided a nuanced assessment of D's capacity, in which he distinguished between simple tasks in relation to which D has capacity, and complex tasks as regards which he does not. As I understood it, Dr M's opinion was that D's incapacity flows from his inability to (i) understand decisions regarding complex matters; and (ii) act on them. As to D's understanding, Dr M explained that D recognises that he is underweight and is able to discuss his eating habits; but while D can articulate the problem and the risks, he is still not convinced that he should eat. Dr M suggested that D is therefore not fully aware of the risks of failing to eat. He characterised this as a lack of touch with reality. On this subtle analysis, although D is able to describe risks and consequences,

ultimately he does not properly understand them. As regards inability to act, Dr M said that D can express himself but that he is unable to execute complex tasks. D's limitations were indicative of executive dysfunction, caused by Asperger's syndrome.

[84] On the face of it, this seemed to me to be a logical and coherent analysis. Dr M properly acknowledged that his consultation with D represented a "snapshot", explaining that one would ideally assess a person's capacity after observing them within the community for a period. It is not difficult to understand why this might be so, given that capacity cannot be tested objectively, as Dr M said at another point in his evidence. But Dr M suggested that his opinion was consistent with previous assessments, as documented in D's medical records.

[85] It also seemed to me that Dr M's assessment of D's capacity corresponded with the evidence that I heard from other witnesses of the realities of D's life. AN, while recognising that the assessment of capacity is a matter for a psychiatrist, confirmed that Dr M's opinion tied in with his own experience of D. This was borne out by AN's account of D's "participation" in badminton, i.e. of the gap between what D says about his badminton sessions and the reality that he only manages to play minimal badminton due to lack of energy, together with his failure to understand the relationship between his low energy and his poor diet. It was also consistent with AN's evidence of the disparity between D's descriptions of leaving the house regularly and the true position, which is that he can go for several weeks without doing so. Similarly, CR gave evidence of D's abortive trip to Japan: as she explained, such a journey posed obvious risks to D's welfare, in relation to which D seemed to have no insight. Finally, AN and CR both gave evidence of D's failure to maintain an adequate diet, notwithstanding the risks that his low weight gives rise to.

[86] In light of Dr M's evidence, I also find that D does not have capacity to communicate and correspond with Falkirk Council, the Department of Work and Pensions, banks and other fiscal organisations. I recognise that D gave evidence that he can use a bank card and I note that he was able to identify the benefits that he receives, but it does not necessarily follow that he is capable of managing correspondence of the kind regarding which the applicant seeks powers. While D said that he manages his bank account, he did not say what this involves in practice - e.g. checking the balance, managing the overdraft (if he has one), or paying regular bills. Having accepted Dr M's evidence that D is unable to perform complex tasks, I think it is unlikely that D would be capable of performing tasks such as these, which can fairly described as being complex. Similarly, I do not consider that D has the capacity to manage his correspondence with organisations of the kind that the applicants identify.

[87] In her submissions counsel characterised D as being a person who has capacity, who might make what the applicant considers to be poor decisions, but who understands those decisions and their associated risks. But I prefer Dr M's analysis that as a result of D's Asperger's syndrome he has executive dysfunction, leaving him detached from reality and with an inability to properly understand risks or act on decisions. This conclusion seems to me to be supported by the evidence.

Dr L

[88] Turning to Dr L, the opinion that he offered on capacity was vitiated by his flawed approach to the issue. As I have narrated above, Dr L suggested that what he called "the bar for capacity" could be raised, depending on the seriousness of the risk posed to an adult. He referred to the Code of Practice as the basis for this approach. Having spoken to the

dietician responsible for treating D, Dr L concluded that those responsible for caring for D had overstated the risks that D's low weight give rise to. Dr L also suggested that making an assessment of D's capacity involved the application of the general principles set out in sections 1(2) to 1(4) of the 2000 Act. Dr L's conclusion was that standing D's level of understanding and the extent of the risks, D ought to be given the chance to attempt to engage with his care package in the absence of a guardianship order.

[89] This evidence betrayed a misunderstanding on Dr L's part of his role in these proceedings, which was to provide the court with the necessary evidence to determine whether D lacks capacity for the purposes of section 58(1)(a) of the 2000 Act, as defined by section 1(6). Psychiatric evidence given in this context ought to focus on the statutory test for capacity - i.e. does the adult have a mental disorder (or an inability to communicate because of physical disability) which prevents him from making, communicating, understanding, acting on or retaining the memory of decisions; and on the question of whether the adult will continue to be incapable, as per section 58(1)(a).

[90] In order to provide evidence on these questions, the psychiatrist will need to understand the background circumstances. Context matters because an assessment of capacity is issue-specific and must be made as regards the particular matters about which decisions or actions are required. Thus, in this case the applicant seeks powers to take various steps in relation to inter alia D's low weight, poor diet and risk of social isolation. But while the psychiatrist needs to understand the context it does not follow that his or her assessment of capacity should involve judging the gravity of any risks that are apparent from the circumstances, as this would involve deviating from the terms of the statutory test for capacity. The question of whether an adult can understand or act on particular decisions cannot be answered by measuring the risks that might materialise if he proves unable to do

so. The issue of risk may be relevant to the consideration of the general principles set out in sections 1(2) to (4), which the court must proceed to apply if the adult lacks capacity. But their application is a distinct exercise from the preliminary question of capacity.

[91] Dr L appeared to conflate the two stages of the process. He fell into error by taking it upon himself to assess the gravity of the risks posed by D's low weight and allowing this to influence his assessment of capacity. Even if such an assessment had been relevant to the test laid down in section 1(6), Dr L would not have been qualified to undertake it, as the possible health consequences of D's weight and diet are matters that lie outside of Dr L's expertise.

[92] Dr L's reliance on the Code of Practice was also misconceived: the Code to which Dr L referred was prepared in terms of section 13(1)(h) of the 2000 Act and is directed to practitioners who are authorised to act under Part 5 of the Act, as is apparent from its full title: "Code of Practice 3rd Edition for Practitioners Authorised to Carry out Medical Treatment or Research under Part 5 of the Adults with Incapacity (Scotland) Act 2000." It has no direct bearing on a renewal of guardianship application under Part 6 of the Act, with which these proceedings are concerned. Its role is not to provide a gloss on the statutory test for capacity which the court is tasked with applying in such an application. In any case, the parts of the Code that refer to the assessment of capacity do not appear to lay down the approach that Dr L adopted as they make no provision for the bar for capacity to be varied depending on the gravity of the risks.

[93] Given these fundamental problems with Dr L's approach to capacity, I do not think that I can rely on his conclusions. But for completeness I note Dr L's evidence in relation specifically to D's level of understanding and ability to act. Dr L noted that D can describe and understand what the professionals involved in his care have been saying to him about

the risks of failing to adopt a healthy diet, on the basis of which Dr L concluded that D has capacity. Dr L also appeared to accept that D would be willing and able to engage with services on a voluntary basis. For the reasons given above I prefer Dr M's opinion on the question of D's ability to understand, which is that while D is able to articulate the risks, he does not properly appreciate them and that he suffers from a detachment from reality as a result of having executive dysfunction. As I observed earlier, this conclusion seems to me to be consistent with the evidence given by those who are familiar with the realities of D's life.

Will D continue to be incapable?

[94] It is a requirement of section 58(1)(a) that the adult is likely to continue to be incapable. Dr M's evidence was that as D's disorder is permanent, so is his capacity. As I have accepted Dr M's diagnosis of D's disorder and his assessment of D's capacity, I think that I must also accept his conclusion that D will be permanently incapable. Similarly, as I have rejected Dr L's approach to capacity, I also reject his suggestion that D's state of capacity may change.

[95] As I have explained above, Dr M accepted that a contrary conclusion might be reached in relation to D's capacity in future, given that the assessment is subjective. In my view this does not prevent me from finding that D is likely to continue to be incapable for the purposes of section 58(1)(a): I am entitled to do so on the basis of Dr M's assessment that D's incapacity is permanent, irrespective of the speculative question of what the outcome of a future assessment might be. I do however take account of the possibility that D might be found to have capacity in the future at the point of assessing the appropriate period for the guardianship to be in force, as I discuss below (see paragraphs [130] - [132]).

Summary on Capacity

[96] In summary, I prefer the evidence of Dr M in relation to the issue of capacity. I find that D lacks capacity in relation to complex matters, including care, diet, weight, health, participation in social activities, communication and correspondence and regarding plans to undertake travel. I find that he is likely to continue to be incapable.

The Requirements of Section 58(1)(b)

[97] In terms of section 58(1)(b) I must be satisfied that no other means provided by or under the 2000 Act would be sufficient to enable D's interests to be safeguarded or promoted.

[98] I discuss this issue in detail below, in the context of the least restrictive principle, as per section 1(3). Briefly put, I consider that the 2000 Act provides no other means that would be sufficient for this purpose because D needs a continuing regime of monitoring and management that can only be achieved via guardianship.

The Requirements of Section 1(2), (3) and (4): the General Principles

[99] I turn next to the general principles set out in section 1(2), (3) and (4). It is appropriate to consider their application to the various powers sought by the applicant under a number of headings.

D's Health and Low Weight

[100] Much of the evidence concerned D's health, in particular his poor diet and low weight. I must first consider whether D would benefit from the proposed intervention in

relation to these matters and whether no such benefit could reasonably be achieved without the intervention, as per section 1(2). In my opinion these requirements are satisfied.

[101] Many of the relevant facts are undisputed: D is on the third centile, which means that he is underweight relative to his age and height. AN gave unchallenged evidence that consideration was given to admitting D to hospital in 2020 as a result of his low weight, although ultimately a decision was taken not to hospitalise him. D receives treatment from a dietitian, who he currently sees every six months. He has been prescribed build up drinks, but he has stopped taking these, although he does take vitamin supplements. D's diet remains poor. D's weight has remained broadly stable for the duration of the guardianship order.

[102] One area of dispute is whether D's weight places him at an imminent risk of organ failure and death. AN gave evidence to this effect, but counsel for the respondent invited me to reject his evidence on the ground that he is not medically qualified. I accept this submission, although as I have mentioned above, there is no criticism to be made of AN, as he made clear that he was relaying what he had been told by the medical practitioners, instead of providing his personal opinion regarding what he acknowledged to be medical questions. On a related point, as I referred to earlier, Dr L gave evidence that the risks posed by D's low weight are not as great as those responsible for his care have suggested to him - in particular, the notion that D is at risk of dying is overstated. Dr L is medically qualified but as he is a psychiatrist the effect of D's weight on his physical health is not a matter that lies within his expertise. Accordingly, I attribute little weight to Dr L's evidence on this point.

[103] In any case, I think that it is unnecessary to reach a conclusion on this issue. In her submissions, the applicant's agent emphasized that D has a health issue that needs to be

managed; but she did not peril her case on establishing an imminent risk of death and I do not regard this a necessary precondition for the imposition of the proposed order. On the basis of the points that I have identified above I accept the applicant's position that D's low weight is a cause for concern and requires to be managed. In particular, D's weight, diet and state of health need to be monitored; and he needs to be assisted to attend the dietitian and other medical appointments as necessary. In reality, I do not understand this to be controversial: it was submitted on D's behalf that he will engage with social services for this purpose on a voluntary basis, which implies acceptance that some level of support is necessary. And the evidence which was led on D's behalf from Dr L was to the effect that D should be allowed to engage voluntarily and that if his weight should fall below the 3rd centile, an intervention would be justified.

[104] While I did not understand counsel for the respondent to challenge the need for D to be supported, she questioned the value of the guardianship to date on the ground that D's weight has been stable but has not increased during its currency. This accorded with D's evidence that he does not believe that he benefits from the order. By contrast, CR acknowledged that a sustained improvement in D's diet and weight had not been achieved, but she suggested that the guardianship had made it possible to monitor the position, with the result that D's weight had not fallen. This corresponds with my view: while the order has not proved as successful as might have been hoped to date, it has had the virtue of allowing D's weight and health to be monitored.

[105] Could the same ends reasonably be achieved without an intervention? D would have to engage with social services on a voluntary basis. It was submitted on his behalf that he should be allowed the opportunity to demonstrate that he would do so. Regrettably I do not think that this is a feasible option. While D said that he would engage, I do not accept

his evidence on this point as I have explained above (see paragraph [24]). AN and CR gave evidence of his limited engagement while subject to the guardianship order. According to them, D has rarely taken up the full level of support that he has been offered. CR also said D had told her that he wished to get rid of the order so that he could take as much or little support as he chose. Also relevant is CR's evidence regarding D's father, who has mental health difficulties, and who has at times been reluctant to allow the social workers access to the family home. In light of this it seems unlikely that D's father could be relied on to encourage D's voluntary engagement with social services. Indeed, one can foresee that in the absence of an order D's father might refuse the social workers entry to the house, thereby impeding their efforts to check on D's welfare. The evidence of AN and CR was detailed and convincing on these points and I am propelled to the conclusion that D would not be likely to engage on a consistent and reliable basis.

[106] If D disengages, or does not engage consistently, the risks are that he will not attend scheduled dietician and medical appointments and that any deterioration in his health will go unidentified and unaddressed. I consider these to be material risks in view of CR's evidence that (a) D generally requires to be accompanied to medical appointments; (b) at present D does not proactively seek medical assistance if the need arises, but instead waits to tell his social worker when she next attends his home; and (c) D's father cannot be relied on to encourage D to eat properly, monitor his health and seek medical assistance should D require it, as is evidenced by his failure to do so on a previous occasion when D became unwell, despite his subsequent statement to CR that he thought D might die.

[107] Counsel for the respondent highlighted that during the pandemic D received no support for several months, yet no crisis occurred in his health or welfare. While I appreciate the logic of this submission, I do not draw from this fortunate fact the conclusion

that the risks are not real or significant. I place particular weight on the final factor that I have identified in the paragraph above - i.e. the fact that D does not have an adequate safety net in the form of family members who are equipped to monitor D's health and manage his needs. In light of this it seems to me that the risks associated with refusing the application are so substantial that it is possible to go further than to find merely that the renewal of the guardianship would be in D's "best interests". The higher test provided by section 1(2) is satisfied: the management of D's weight, diet and health under the proposed guardianship would constitute a benefit that could not reasonably be achieved without an intervention.

[108] For similar reasons, I am satisfied that guardianship would represent the least restrictive option in relation to the freedom of the adult, consistent with the purpose of the intervention, as per section 1(3). The alternative canvassed at the proof was that in the event that there should be the need for an intervention either a Compulsory Treatment Order or an Emergency Order could be obtained, under sections 72 and 26 of the 2003 Act. Counsel for the defender submitted that this would be preferable to taking what she described as an "anticipatory" approach by imposing a guardianship before any crisis had arisen. The difficulty with this is that it creates the risk of any decline in D's weight and health - and ultimately of a crisis in D's health - going undetected, given that (a) D has not previously sought medical assistance when required; and (b) his father cannot be relied on to do so. As I observed earlier, a process of management and monitoring is required in the hope of maintaining D's health and avoiding the need for medical intervention; but failing which to ensure that any necessary medical assistance is obtained promptly. In my view, the proposed renewal of guardianship represents the only feasible means of achieving this; and it is therefore the least restrictive means of doing so.

[109] In terms of section 1(4)(a) I am required to take account of D's wishes when determining if an intervention is to be made and, if so, what intervention is to be made. As I have noted already, D does not wish to be subject to a guardianship, as he does not believe that he benefits from it and he maintains that he would engage with social services voluntarily. His views are strong and long-held. I do not neglect this and I recognise that D's views should not be overridden lightly. Renewal of the guardianship will mean an interference with D's autonomy and an intrusion into his life. Unfortunately, for the reasons set out above notwithstanding D's wishes, I think that the proposed order is necessary to ensure the appropriate management of D's weight, diet and health.

[110] I am also required to take account of the views of D's nearest relative, who is his father, insofar as it is reasonably practicable to do so, as per section 1(4)(b). D's father did not give evidence, but I heard evidence of his circumstances from CR and AN, in particular that (i) he suffers from mental health problems, (ii) he does not look after his own health and dietary needs, (iii) his property is in a poor state, (iv) he does not interact with D to any great degree, and (v) he is considered to be an obstacle to the operation of D's care package, as when the social workers attend he restricts their access to the property and engages them in relation to his own difficulties. Although I was not directly addressed on the point, I infer from these circumstances that it would not have been reasonably practicable to have taken evidence from D's father. But from what I heard of his attitude to the social workers it seems that he might have been unsupportive of the guardianship being renewed. This would not have changed my view that the guardianship is necessary, for the reasons set out above.

[111] Insofar as section 1(4)(c) and (d) are concerned the applicant is D's guardian under the present order and is therefore self-evidently in favour of a renewal of the guardianship. I do not think that I require to take views of any other persons.

[112] Having considered the general principles contained in section 1(2) to (4), I conclude that the concerns regarding D's weight, diet and health justify the granting of the powers sought under craves 1 [b], [c] and [e] of the application, referred to above.

Social Interaction, Activities and Travel

[113] The applicant also seeks the power to make decisions and arrangements regarding D's participation in educative, vocational or social activities, holidays, travel and other pastimes.

[114] In my view the existing guardianship benefits D insofar as these matters are concerned and the order's renewal would continue to benefit him, as D has limited contact with the outside world and is at risk of becoming socially isolated. This was clear from the evidence of AN, who spoke to the infrequency with which D leaves the house and the limited success of D's badminton sessions. Similarly, CR gave evidence that D is liable to become anxious when leaving the family home and she spoke to D's fairly limited engagement with his support package. D gave evidence of occasions when he leaves the house, including to visit his sister, to play badminton and to speak to school pupils. While I accept that D does venture out of his home at times, the overall impression that I formed was that D remains at risk of social isolation and that the guardianship serves as a mechanism for encouraging him to engage with the community.

[115] It was submitted on D's behalf that his support package is of limited value because D has never taken up all of the support that he has been offered. Certainly AN and CR both

acknowledged that the support package has not proved as successful as had been hoped. Both cited D's father as an impediment to the support workers' ability to engage with D. But I do not think it follows that the order has no value - there has been some qualified success in facilitating social interaction. For example, D has at least attended some badminton sessions. He has also started visiting his sister regularly. While he does this without supervision, the visits were initiated by CR and can, therefore, reasonably be viewed as a product of the guardianship. It seems to me that while the ambition of widening D's social network and improving his physical and mental wellbeing has not been fully realised to date, the guardianship has allowed modest steps to be taken in this direction. A renewal of the guardianship would preserve the opportunity for further engagement and progress, albeit this would depend in part on D. Conversely, if the guardianship is not renewed, the worry is that D will become more isolated, increasing the risk of boredom, purposelessness and poor mental health. It follows that D would benefit from the proposed intervention, in terms of section 1(2).

[116] I do not think that this benefit could reasonably be achieved without the proposed intervention. In principle, voluntary engagement on the part of D might be an alternative to imposing the order, but as I have already explained, I do not think that D would engage in the absence of the order (see paragraphs [24] and [105]).

[117] It also seems to me that the proposed guardianship is the least restrictive option in relation to D's freedom, consistent with the purpose of the intervention, as per section 1(3). Given that a continuing process of management is in contemplation rather than a one-off intervention, it is difficult to see how this could be implemented other than under the auspices of a guardianship order.

[118] Similarly, I am satisfied that empowering the applicant to take decisions regarding travel and holidays will benefit D. I base my conclusion on this point on CR's evidence of D's proposed trip to Japan. Given that D is liable to become anxious when leaving his home and in view of his health issues, CR's concern that D would be vulnerable while abroad is well-founded. It was apparent from CR's account that D did not understand the risks associated with undertaking international travel, negotiating a language barrier and braving a busy foreign country. D's own evidence was consistent with this view: when he was asked in cross-examination if he had considered these risks he replied that he had been focused on being with his friend, which seemed to suggest a lack of insight on his part. Against this background it seems to me that it would benefit D to have the applicants manage any travel that he should undertake.

[119] I do not think that the same outcome could reasonably be achieved without the proposed intervention. An alternative might have been for D to have agreed any future travel plans with the applicant. Unfortunately, I doubt that D is capable of cooperating in this way given that (a) his past conduct suggests otherwise: when the proposed Japanese holiday came to light, D was not prepared to give the social workers details or the identity of the friend with whom he planned to travel; and (b) D seems not to appreciate the risks associated with travel, as I have explained. Accordingly, any possible travel cannot be managed other than by way of an intervention, in my view. In addition, as there is a need for the ongoing management of any potential travel plans as opposed to a one off intervention, guardianship is the only appropriate form of order and its imposition is therefore the least restrictive option in relation to D's freedom, consistent with the purpose of the intervention, in my opinion.

[120] Turning to the requirements of section 1(4), as I have already noted D is not supportive of the order. It is likely that his father does not support it. D's existing guardian seeks the order's renewal and there are no other persons from whom I consider it necessary to obtain a view. I take account of D's views, but ultimately I consider them to be outweighed by the benefits that D will derive from renewal of the guardianship - i.e. protection from the risks associated with greater social isolation or attempting to undertake unmanaged travel.

[121] In my view, these considerations justify the granting of the powers sought under crave 1, letters [b], [d], [e] and [g] of the application.

Determination of Residence

[122] I deal next with the power sought by the applicant to determine where D resides on a permanent or temporary basis. The background to this is that the applicant's witnesses spoke to the dirty and cluttered state of D's residence, which prompted an application for an intervention order in 2021 that was ultimately not insisted upon. D himself acknowledged that the property is cluttered. A connected issue is that D's father takes up the communal areas of the house, meaning that D is effectively restricted to his room, upstairs. As I have already mentioned, the applicant contends that D's cohabitation with his father has proved an impediment to the effectiveness of his support package to date. For his part, D gave evidence that his home is his favourite place to be.

[123] While the respondent opposed renewal of the guardianship in its entirety, his counsel emphasized that if I were to grant the application, the proposed inclusion of a power to determine residency within the order's terms was unjustified. I accept her submission on this point: I am not satisfied that granting the power sought would be a

benefit that could not be reasonably achieved without the proposed intervention. D's current living arrangements are not ideal given the state of the property and the difficulties that D's cohabitation with his father are said to pose. But it was not suggested that the applicants would seek to move D imminently if they were empowered to do so. Indeed, in 2021 the applicants dropped their proposed intervention order because the state of the property was not considered to amount to a health hazard and in light of D's wish to remain in his home. As there is no plan to move D at present, it is difficult to see where the benefit lies in granting the power to do so, particularly as D does not want to move. The applicant's agent submitted that the power would allow them to act in the event of an emergency, pointing to CR's evidence of the issue that had arisen in relation to the property's smoke alarm. However, she properly conceded that if a situation such as this should arise it would be open to the applicants to make a fresh application for an intervention order. In these circumstances, I conclude that (i) granting the power would not benefit D; and (ii) should the need to move D arise this could reasonably be achieved via an application for an intervention order.

[124] Accordingly, I am not prepared to grant the power sought under crave 1 [a]. The prospect of being removed from his home has understandably been a source of consternation for D. It is to be hoped that he will take reassurance from the fact that the power to do so will not form part of the guardianship order.

Correspondence and Communication

[125] The applicant seeks the power to deal with correspondence on D's behalf, including communicating on his behalf with the local authority, the Department of Works and Pensions, Banks, and other fiscal organisations. This power forms part of the existing order.

[126] As I have already indicated, in my view D does not have capacity in relation to tasks of this nature (see paragraph [86], above).

[127] D's correspondence therefore requires to be managed, from which it follows that granting the power to so do will benefit him. It does not appear that this could be achieved without an intervention. Given that there will be a continuing requirement for D's correspondence to be managed, the granting of the power under the auspices of a guardianship order is the least restrictive means of achieving this.

[128] I recognise that D is opposed to the application, but as there is a need for his correspondence to be dealt with I consider that it is necessary to grant the power to do so to the applicant.

[129] Accordingly I shall grant the power sought under crave 1 [f].

Duration of the Order

[130] The applicant seeks a term of three years for the order. By contrast, D's counsel submits that I should impose it for the shorter period of one year, in view of his opposition to renewal of the guardianship. I prefer the position of the applicant for the following reasons.

[131] First, it is appropriate that the period of imposition should not be excessive. This is because (i) D opposes the order; and (ii) he may be found to have capacity in the future. As I set out earlier, Dr M opined that D's incapacity is permanent but he explained that as the assessment process is subjective, the opposite view might be reached in a future assessment. This means that the present assessment of D's capacity cannot be regarded as being forever set in stone. This militates in favour of placing a reasonable time limit on the order.

[132] Second, notwithstanding the need to limit the duration of the order, I think that a period of one or two years is too short. Both parties submitted that both D's participation in the current proceedings and the requirement for him to undergo assessment by medical experts have been sources of anxiety for him. If the order were to be imposed for only one or two years then D would face having to attend further medical examinations and to deal with looming court proceedings in the relatively near future, which might well be to his detriment. By contrast, imposition of the guardianship for the three-year term sought by the applicant would represent a reasonable but not excessive period during which the position would be settled.

Disposal

[133] In all of the circumstances I shall grant the application for renewal of guardianship. I shall grant the powers that the applicant craves, with the exception of the power that is sought to determine D's residence, which I shall refuse.

[134] The parties were agreed that I should make no award of expenses due to or by either party.