**IMPORTANT NOTICE**

**This judgment is covered by the terms of an order made pursuant to Practice Direction 4C- Transparency. It may be published on condition that the anonymity of the incapacitated person must be strictly preserved. Failure to comply with that condition may warrant punishment as a contempt of court.**

**Neutral Citation Number: [2020] EWCOP [2020]EWCOP21**

Case No: 13467936

**COURT OF PROTECTION**

**MENTAL CAPACITY ACT 2005**

First Avenue House
42-49 High Holborn,
London, WC1V 6NP

Date: 23rd April 2020

**Before** :

**Her Honour Judge Hilder**

**LONDON BOROUGH OF TOWER HAMLETS**

Applicant

and

**(1) A (by her litigation friend, the Official Solicitor)**

**(2) KF**

Respondents

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Hearing: 12th & 13th March 2020

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Ms. Nicola Kohn (instructed by LBTH Legal Services) for the Applicant

Mr. Parishil Patel QC (instructed by Bindmans LLP) for A, through her litigation friend the OS
KF in person

The hearing was conducted in public subject to a transparency order made on 17th July 2019. The judgment was handed down to the parties by e-mail on 23rd April 2020. It consists of 25 pages, and has been signed and dated by the judge.
The numbers in square brackets and bold typeface refer to pages of the hearing bundle.

## The Issue

1. This issues for determination in this matter at this point are:

    a. whether A presently has capacity to decide for herself where she lives (it being agreed that she lacks capacity to decide how she is cared for); and

    b. if she lacks capacity to decide where she lives, is a trial period of returning to live at home with a care package in her best interests?

2. At the end of the two day hearing, at the request of A's representatives, I indicated my decision and agreed to give written reasons as soon as possible.

3. In my judgment, A presently has capacity to make the decision as to whether she should continue to live in residential care or return to live in her own flat with a care package.

## Matters considered

4. I have considered all the documents in the hearing bundle, including the following statements and reports:

    a. Filed by the Applicant:

    Katherine Dalton dated 26th June 2019 [**G1**], 11th October 2019 [**G72**], 8th November 2019 [**G81**]

    Anna Ribas Gonzalez dated 15th August 2019 [**G47**]

    Manager of C Care Home, dated 17th September 2019 [**J29**]

    Position statements dated 1st August 2019 [**A1**], 16th August 2019 [**A28**], 29th January 2020 [**A37**], 6th March 2020

    b. Filed on behalf of A

    Laura Hobey-Hamsher dated 12th August 2019 [**G11**], 16th August 2019 [**G59**], 29th January 2020 [**G82**], 28th February 2020 [**G98**]

    Position statements dated 12th August 2019 [**A11**], 16th August 2019 [**A28**], 30th January 2020 [**A41**], 11th March 2020

c. Filed by KF

KF dated 9th August 2019 [**G6**], 13th February 2020 [**G89**], 13th March 2020 [**G126**]
RJ dated 8th August 2019 [**G5**], 15th August 2019 [**G25**]
MG dated 15th August 2019 [**G26**]
LK dated 15th August 2019 [**G45**]
Position statements dated 9th August 2019 [**A6**], 15th August 2019 [**A22**]

d. Jointly instructed expert

Dr. Mynors-Wallis dated 23rd October 2019 [**I59**], 13th December 2019 [**I114**]

5. I had a telephone conversation with A before the hearing started.

6. I heard oral evidence from Katherine Dalton, Dr. Mynors-Wallis, MG and RJ.

The Background

7. A had a long and successful career. In order to protect her privacy, I summarise the facts of this matter as lightly as possible.

8. A is now 69. She has no children and her former husband has died. She has many caring friends who have taken an active part in her life and in these proceedings. She has lived in her flat, of which she is clearly very proud, for more than twenty years.

9. About three years ago A suffered a stroke. Shortly afterwards she executed Lasting Powers of Attorney for both property and welfare. KF is one of the joint and several property attorneys, and the sole welfare attorney.

10. In 2018, A was diagnosed with Korsakoff's dementia.

11. In February 2019 A was taken to A & E after an unwitnessed fall at home. A couple of months later, on 9th April, she took herself to Moorfields Hospital complaining of pain in her left eye. Three contact lenses were removed and A was admitted to the Royal London Hospital because of concerns that she would be unable to administer the necessary eye drops at home. Over the time that A remained an in-patient, she frequently tried to leave the hospital.

These proceedings

12. By COP1 application dated 10th July 2019 [**D1**] the hospital social worker sought authority for A to be discharged from hospital to a residential placement. Standard directions [**D19**] were given and a transparency order [**D15**] made on 17th July. The matter was listed for attended hearing before me on 2nd August but the Official Solicitor had not yet been able to take up the Court's invitation to act as A's litigation friend, so the matter was adjourned for ten days.

13. On 12th August 2019, A attended the hearing herself and was able to communicate her views directly. She wanted to return home but indicated that she would be willing to reside at C Care Home for a short, pre-defined period.

14. C Care Home had previously been chosen by KF and other friends of A, particularly for its expertise in management of Korsakoff's dementia and its proximity to one of them. A's friend RJ was willing to take her the considerable distance from the hospital to the care home the following day, and back to Court for a further hearing 4 days later.

15. The Local Authority gave a preliminary indication (as recorded in the fifth recital to the order) that it "would be willing to provide a package of care comprising three visits per day, each lasting 30-45 minutes," with additional access to a day centre should A so wish, but needed 48 hours to make the arrangements. KF agreed to ensure that A's flat was habitable from 16th August. On that basis an order was made [**D33**] on an interim basis providing for A's discharge from the hospital to C Care Home, with directions for a further attended hearing on 16th August.

16. On 16th August, A did not attend the hearing. She had been visited by her solicitor the previous day. The position statement of her litigation friend [**A29**] and the statement by the social worker [**G53**] both informed the Court that A did not wish to attend the hearing. She had settled at C Care Home better than had been anticipated and was described as "calmer."

17. Directions were made by consent [an unsealed version of the order is at **D36**]. Provision was made for the proceedings to progress as a s21A application without the need for filing a separate COPDLA form as soon as a Standard Authorisation was granted. Permission was granted for the joint instruction of an expert psychiatrist to report as to A's capacity to make decisions about where she lives, how she is cared for, the management of her property, and the revocation/execution of Lasting Powers of Attorney. A round table meeting was scheduled and the matter was listed for a further hearing on 18th November.

18. Dr Mynors-Wallis' first report was duly received, and the round table meeting took place. By then, a safeguarding incident had been raised about A's relationship with another resident of C Care Home, and all parties wanted to put further questions to Dr. Mynors-Wallis. An agreed COP9 application [**D47**] was made to vacate the hearing. A further

interim order was made on 14th November, providing for A to remain at C Care Home whilst further evidence was gathered. The matter was listed for a further attended hearing on 30th January 2020.

19. A did not attend the hearing on 30th January, although she was described as having a "sense of frustration at her confinement in C Care Home and the apparent lack of sufficient opportunities for her to leave the home..." The matter was listed for this final hearing.

20. It is now common ground between the parties, and I am satisfied, that A lacks capacity to make decisions about how she is cared for. Despite specific direction on 16th August 2019 [**D39**] and 30th January 2020 [**D55**] the Local Authority has not filed an assessment of A's care needs if she returns home. The Official Solicitor points out that there needs to be further exploration as to the minimum care package required. However, the Applicant Local Authority has prepared a "proposed support plan" [**J77**] setting out a suggested daily timetable. It is envisaged that A would have three support visits a day, seven days a week, lasting an hour on each occasion and timed to facilitate meals. Additionally, there would be visits of 2 hours duration on Mondays and Thursdays to support activities in the community for leisure, appointments, shopping and so forth.

21. The options before the Court are either that A returns to live in her flat with a care package (initially on a trial basis), or that she remains living at C Care Home.

A's views

22. A is represented in these proceedings through a litigation friend but her views are fully before the Court, both through attendances notes filed by her solicitor and by A herself having spoken to me by telephone before the hearing started. Her expressed views have remained clear and consistent.

23. On 7th February, A was visited by her solicitor who explained to her the idea of a care package being provided in terms that there may be 'conditions' to her being able to return home. The attendance note records [**G104**] A asking essentially how it would be known if the conditions weren't met, and answering her own question: "*if I damage myself, or their snooping snoops smell my breath from a quarter of an inch away*." She added "*this is blackmail*."

24. A was clear how she felt about the proposed care package, saying that she "*probably had more freedom*" at C Care Home – "*someone coming a few times a day means I am a prisoner in my own home….I don't see how it could possibly work, and I have a decent life at the same time….I thought I would do anything to achieve [*returning home*] but when faced with reality, I can't see anything other than pain and desperate frustration."*

25. In contrast, A expressed positive views about C Care Home: "*It's a decent place, run by decent people. They are there to help, not hinder unnecessarily, though obviously they*

*wouldn't let me get into trouble*." When asked if there was a part of her which would rather remain at C Care Home, A replied "*no, but I can understand why you ask that. I would never have imagined having a wobble. It is the prospect of being monitored; it feels like a prison. This place doesn't*."

26. A was visited by her solicitor again on 19th February. The proposed support plan [**J77**] was discussed. A described the proposals as "*unbearable*" [**G110**] and "*hideous*", "*very restrictive…difficult to follow.*" [**G111**] However she went on to say "*I realise I have no choice*", and that she had "*learned my lesson…I know what happens when you turn away those bastards*" (referring to carers). She referred to her working experience and said "*I can do as I'm told. It doesn't mean I have to like it*." Asked if she might change her mind about wanting to leave the care home, A said "*Not at the moment, no*" [**G112**] but, later, "*I'm not saying that's my final word.*" [**G113**]

27. The solicitor's last visit before the hearing was on 26th February. A insisted that "*There is nothing wrong with me. I can walk, talk, cook, do all the things I have before!"* [**G120**] When asked why she wanted to go home, A explained it is "*because I would have a degree of autonomy; it would be my flat, and I can live my life the way I want to live it. Within the rules. I can do my own cooking, housekeeping, have my own things around me. Wouldn't everyone prefer to be in their own home?*" [**G121**] When it was pointed out that life would be different to how it had been before, A said she could imagine that "*only too well. It is hideous to have people watching me to make sure I am following the rules*" [**G122**] and subsequently asked if there was a third option.

28. Shortly before the hearing started, I was invited to speak to A by telephone. I clarified some 'groundrules' with the representatives first. It was agreed that:

    a. I should address A by her first name;

    b. The purpose of the call was to facilitate A's participation in proceedings by expressing her wishes and feeling, as distinct from A giving evidence or the court making a direct assessment of capacity;

    c. The conversation would be recorded by the courtroom recording system, and A's solicitor would take notes which would be typed up and circulated to all parties within 3 working days;

    d. I would summarise to all parties what A had said before the hearing went any further.

29. The parties agreed the wording of an explanation which I should give to A about what the court was being asked to decide, in the following terms:

    "The Official Solicitor proposes a trial at home of initially up to four weeks.

    The following are conditions of [A] returning home/remaining at home, and, if complied with, will demonstrate that the trial return home has been a success.

    1. [A] to abstain from drinking alcohol;

2. [A] to maintain appropriate nutrition;
3. [A] to take her prescribed medication;
4. [A] to engage with the carers arranged for her.

It is proposed that, if possible, [A] (with [LK] and/or [her solicitor]) be involved in interviewing and choosing the carers.

Those conditions will be subject to review, depending on how the trial is going, but that will be the starting point.

If conditions are not complied with, the likelihood is that the trial will be brought to an end and [A] will need to return to [C Care Home]."

30. In our telephone conversation, A was very articulate. She told me that her overwhelming feeling was that she would like to get back to her flat and her life. She said she had learned a few lessons, including that she should take more care, and that she is now slightly sadder and wiser than she was previously. A said that the people at C Care Home are nice and the place is comfortable but it is not her home, not where her life is, not where she wants to be. When I explained the proposal for carers, A told me that she "*didn't have an option*." She was able to repeat back to me after a few minutes (and seemingly by reference to her written notes) all four of the "conditions" by which the success of a return home would be measured. She said "*I realise that I am not going back to my old life*."

31. When I told A that her friends were concerned about her and felt unable to provide support if she returned home, A disputed that they had given support before – "*they gave me friendship*." She said she would be sorry if she didn't see them but it would be their decision and she would accept it.

32. A was adamant that she would never prefer C Care Home to living in her own flat with proposed carer support. She identified as benefits of the latter "*more freedom, independence and self-reliance, as opposed to being coddled.*" She said she would be "*very wary of not sticking to the rules because I don't want to be taken back*" to residential care – "*I'd value at least a modicum of independence in my own home*."

33. I asked A about the coronavirus, whose impact was then only beginning to be felt. She suggested that it might cause a delay in finding carers and acknowledged that "*none of us can guess how long it will go on for*" but she was clear that she wanted to return home as soon as possible.

Capacity: The Law

34. It is a fundamental principle of the law, set out at **section 1(2)** of the Mental Capacity Act 2005 ("the Act"), that a person must be assumed to have capacity unless it is established that he lacks capacity. It follows that those asserting that a person lacks capacity bear the burden of establishing it.

35. Two other principles underpin the determination of capacity:

a. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success – **section 1(3)**; and

b. A person is not to be treated as unable to make a decision merely because he makes an unwise decision – **section 1(4)**.

36. The "single test"[1] of capacity is set out in **section 2(1)** of the Mental Capacity Act 2005 ("the Act"):

> "A person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, his mind or brain."

37. That test falls to be interpreted by other provisions of the Act. **Section 2** goes on to provide:

> (1) It does not matter whether the impairment or disturbance is permanent or temporary.
>
> (2) A lack of capacity cannot be established merely by reference to –
>
> (a) a person's age or appearance, or
>
> (b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about his capacity.
>
> (3) …. any question whether a person lacks capacity within the meaning of this Act must be decided on the balance of probabilities.

38. A 'functional test' is set out in **section 3** of the Act:

> (1) …a person is unable to make a decision for himself if he is unable –
>
> (a) to understand the information relevant to the decision,
>
> (b) to retain that information,
>
> (c) to use or weigh that information as part of the process of making the decision, or
>
> (d) to communicate his decision (whether by talking, using sign language or any other means.)
>
> (2) A person is not to be regarded as unable to understand the information relevant to a decision if he is able to understand an explanation of it given to him in a way that is appropriate to his circumstances (using simple language, visual aids, or any other means).

[1] *PC and NC v. City of York Council* [2013] EWCA Civ 478 at para 56

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

(4) Information relevant to a decision includes information about the reasonably foreseeable consequences of –

(a) deciding one way or another, or

(b) failing to make the decision.

39. In summary, there are three elements to be considered when determining a question of capacity:

a. the "diagnostic test" - is there an impairment or disturbance in the functioning of the mind or brain?

b. the "functional test" – is the person unable to understand, retain or use/weigh relevant information, or to communicate their decision?

c. the "causal nexus" - is the inability because of the identified impairment or disturbance?

40. I have read again the decision of the Court of Appeal in *PC & NC. v. City of York Council* [2013] EWCA Civ 478. At paragraphs 35 and 40 Lord Justice McFarlane expressly approved the approach of the first instance judge (Hedley J) set out in the following terms:

> "19. ….it seems to me that what the statute requires is the fixing of attention upon the actual decision in hand. It is the capacity to take a specific decision, or a decision of a specific nature, with which the Act is concerned….
>
> 20. It follows that in my judgment…my task, as I understand it, is to articulate the question actually under discussion in the case and to apply the statutory criteria to that decision…"

41. In his position statement, Mr. Patel summarised further authorities in the following terms:

> "22. In a number of cases (*PH v. A Local Authority* [2011] EWHC 1704 (Fam), *CC v. KK & ors* [2012] EWHC 2136 and *PCT v. LDV* [2013] EWHC 272 (Fam), Baker J made a number of relevant and general observations to have regard to when a court is considering the issue of a person's capacity to make particular decisions:
>
> a. capacity is both issue-specific and time-specific. In other words, it is necessary to assess a person's ability to make a particular decision at a particular time, not their ability to make decisions in general;

b. it is not necessary for the person to comprehend every detail of the issue, but the question is whether the person "can comprehend and weigh the salient details relevant to the decision to be made" and that assessment must bear in mind that "different individuals may give different weight to different factors";

c. the court must consider all relevant evidence and that it is important to remember that (i) the roles of the court and the expert are distinct (ii) the court is in a position to weigh the expert evidence against its findings on the other evidence and (iii) the court is the final decision-maker;

d. in considering the assessment of capacity and making its decision, the court should be careful not to be drawn towards an outcome that is more protective of the adult but should consider the matter in a detached and objective way.

42. It is helpful to recall the decision of Theis J in *LBX v. K, L, M* [2013] EWHC 3230 (Fam). In that matter Theis J identified the 'information relevant' to the decisions in issue. In respect of the decision about where the protected person was to live, she identified the following list [para 43]:

> "(1) what the two options are, including information about what they are, what sort of property they are and what sort of facilities they have;
>
> (2) in broad terms, what sort of area the properties are in (and any specific known risks beyond the usual risks faced by people living in an area if any such specific risks exist);
>
> (3) the difference between living somewhere and visiting it;
>
> (4) what activities P would be able to do if he lived in each place;
>
> (5) whether and how he would be able to see his family and friends if he lived in each place;
>
> (6) in relation to the proposed placement, that he would need to pay money to live there, which would be dealt with by his appointee, that he would need to pay bills, which would be dealt with by his appointee, and that there is an agreement that he has to comply with the relevant lists of "do"s and "don't"s, otherwise he will not be able to remain living at the placement;
>
> (7) who he would be living with at each placement;
>
> (8) what sort of care he would receive in each placement in broad terms, in other words, that he would receive similar support in the proposed placement to the support he currently receives, and any differences if he were to live at home; and
>
> (9) the risk that his father might not want to see him if P chooses to live in the new placement."

43. In respect of the protected person's care arrangements, Theis J identified the following relevant information: "what areas [P] needs support with, what sort of support he needs, who will be providing him with support, what would happen if he did not have any support or he refused it and, lastly, that carers might not always treat him properly and that he can complain if he is not happy about his care…"

44. This decision by Theis J was referenced in another matter, to which I was referred by both Counsel, namely the Court of Appeal's decision in *B v. A Local Authority* [2019] 3230 WLR 685. I have reread that judgment carefully and draw from it the following observations:

    a. The "important questions" of the appeal were "as to the factors relevant to making the determinations of capacity" and "as to the approach to assessment of capacity when the absence of capacity to make a particular decision would conflict with a conclusion that there is capacity to make some other decision." [para 4]

    b. The first instance judge, Cobb J, had set out the list of information relevant to a decision on residence which had been formulated by Theis J in *LBX v. K, L, M* [2013] EWHC 3230 (Fam).

    c. The Court of Appeal observed [para 62] that "we see no principled problem with the list provided it is treated and applied as no more than guidance to be expanded or contracted or otherwise adapted to the facts of the particular case."

    d. Cobb J had concluded that B did have capacity to make decisions in relation to residence but did not have capacity to make decisions about her care.

    e. The Court of Appeal identified [para 35], broad principles in the following terms:

> "Cases, like the present, which concern whether or not a person has the mental capacity to make the decision which the person would like to make involve two broad principles of social policy which, depending on the facts, may not always be easy to reconcile. On the one hand, there is the recognition of every individual to dignity and self-determination and, on the other hand, there is a need to protect individuals and safeguard their interests where their individual qualities or situation place them in a particular vulnerable situation…."

    f. The Court of Appeal restated [para 36] that the determination of capacity is to be "by reference to a particular decision."

    g. The appellant's criticism of Cobb J's decision in respect of capacity to decide residence was that it failed to take account of relevant information relating to the consequences of the decision, produced a situation in which there was irreconcilable conflict with his decisions in respect of other domains of capacity, and made the provision of care to B practically impossible. These criticisms followed from an

approach which analysed capacity in respect of different decisions as self-contained "silos" without regard to the overlap between them. [para 63]

h. The Court of Appeal agreed with that criticism [para 64]. It was identified that the first instance decision as to residence had declined to take into account the implications (and therefore the reasonable consequences) of living with a particular person (Mr C), and there was conflict between:

    i. the conclusion that B did understand in broad terms the care she would receive if she lived with Mr C (and by implication could use or weigh that information as part of a decision on residence), and the conclusion that she did not have capacity to make decisions about care [paras 64 and 67]; and
    ii. the conclusion that B lacks capacity to decide the persons with whom she has contact, and the conclusion that she had capacity to decide to live with Mr. C [para 65]; and
    iii. the conclusion that B lacked capacity to consent to sexual relations, and the conclusion that B has capacity to live with Mr C, when one of B's explicit motivations for moving to live with Mr C was to have his baby [para 66].

45. I was also invited to consider:

a. *London Borough of Tower Hamlets v. NB* [2019] EWCOP 27, where the Vice-President emphasised the need to focus upon the individual's circumstances when applying tests formulated in case law;

b. *PCT v. P, AH and The Local Authority* [2009] COPLR Con Vol 956, and *Re SB* [2013] EWHC 1417 (COP) as authority for the proposition that, even though a person may be unable to use or weigh some information relevant to the decision in question, they may nonetheless be able to use or weigh other elements sufficiently to be able to make a capacitous decision;

c. the decision of MacDonald J in *Kings College NHS Foundation Trust v. C and V* [2015] EWCOP 80, and in particular paragraph 38, where he said in respect of using and weighing relevant information:

> "It is important to note that s3(1)(c) is engaged where a person is unable to use and weigh the relevant information as part of the process of making the decision. What is required is that the person is able to employ the relevant information in the decision making process and determine what weight to give it relative to other information required to make the decision. Where a court is satisfied that a person is able to use and weigh the relevant information, the weight to be attached to that information in the decision making process is a matter for the decision maker. Thus, where a person is able to use and weigh the relevant information but chooses to give that information no weight when reaching the decision in question, the element of the functional test comprised by s3(1)(c) will not be satisfied. Within this context, a person cannot be considered to be unable to use or weigh information simply on

the basis that he or she has applied his or her own values or outlook to that information in making the decision in question and chosen to attach no weight to that information in the decision-making process."

Capacity: The Evidence

46. Assessment by Katherine Dalton, dated 3rd May 2019 [**J1**]: Ms. Dalton is a social worker. She considered A's capacity to decide "where [she] will reside to receive appropriate ongoing care and support to maintain her health and well-being." She identified two diagnoses, namely "F106 amnesiac syndrome alcohol drug use (Korsakoff)" and "F011 Multi infarct dementia." She concluded that A is able to understand information regarding where she will live "on a basic level" but is not able to understand "vital information regarding her care needs which affect this decision." She considered that A is "not able to retain information longer than a few minutes" and therefore could not use or weigh such information. She considered that A lacked capacity to make the decision identified.

47. In her written statements Ms. Dalton said that:

    a. She started working with A in December 2018, visiting at least monthly but at times weekly [**G3**];

    b. A "struggled to accept that she needed support" and Ms. Dalton believed that to be "because [she] was not able to remember key facts about her needs, such as diagnosis, symptoms and risk" [**G3**];

    c. "Each time I have met with [A] I would need to explain who I was, why I had come and why I was involved in her care [**G3**]

    d. "At times, [A] was able to partly orientate with her diary but this could also often lead to further confusion" [**G3]**

    e. A is "unable to repeat back concerns expressed plainly, within a very short space of time, approximately 30 seconds - 1 minute" [**G3**]

48. In oral evidence, Ms. Dalton confirmed to Mr. Patel her view that, because she lacked capacity to determine her care needs, A could not make decisions about living at home. Mr. Patel put to her that, if best interests decisions were made about care provision, A did not need to understand how the care decision was reached in order to make a choice between living at home with such care provision, or living in residential care. Ms. Dalton initially said that she was "feeling a bit lost"; then agreed with Mr. Patel's analysis. After a somewhat confusing assertion that "I believe that in order for her to weigh up the options, [A] needs to understand why those things are being weighed up," Ms. Dalton said that A "does understand the options, yes" but maintained her view that understanding the need for care was "intrinsic" to being able to make the choice between the options.

49. Ms. Dalton agreed that A has, in the words of the care home manager, "come a heck of a long way" since she first moved into residential care, that her circumstances now are therefore different to before she was admitted to hospital, and that the aim was to adopt the least restrictive option. However, she did not agree that a trial return home was "worth giving a go." She considered that "the risks are too high" and she believes it would be "bound to fail". For that reason, Ms. Dalton says, "a decision has to made on her behalf." She considered that, if A returned home, she would not remember her time in residential care.

50. COP3 assessment by James Lee-Davey, Consultant Psychiatrist, dated 21st June 2019 [**J7**]: Mr. Lee-Davey undertook his assessment whilst A was a hospital inpatient. He considered her capacity to decide "where she resides for care and treatment (and conveyance to this place)." He identified A to have a diagnosis of "F106 – Mental and behavioural disorders due to use of alcohol / Amnesic syndrome / Korsakoffs/Alcohol related brain damage." His view was that that A was unable to understand relevant information, but he did not identify the information which was not understood. He described A's denial of memory problems and support needs, and concluded "as such she cannot weigh the … risks and benefits of a package of care or residential placement." He concluded that A lack capacity to make the decision identified.

51. DOLS Form 4 by Dr Akoo, dated 4th September 2019 [**F19**] : Dr Akoo saw A on 4th September 2019 at C Care Home. In DOLS form 4 he identifies "alcohol-related brain damage." He reports that A did not understand her care and accommodation needs but that she was able "to retain pertinent information long enough, to consider the question asked and respond with her own thoughts and beliefs." He considered that A "did not appear to have the ability to weigh pertinent information." He observed that she is "able to communicate really well with language." Overall, he concluded that she "does not have the capacity to make decisions about her care and accommodation needs."

52. DOLS Form 3 by Helen Mallourides, dated 5th September 2019 [**F26**]: Ms. Mallourides is a Best Interests Assessor. In so far as it relates to capacity, Ms.Mallourides' assessment merely sets out the comments and conclusions of Dr. Akoo.

53. The evidence of Dr. Mynors-Wallis: Dr. Mynors-Wallis is an independent consultant psychiatrist of 25 years' experience, jointly instructed by the parties. He completed an initial report dated 23rd October 2019 [**I59**] and subsequently gave written responses to supplementary questions in an addendum report dated 9th December 2019 [**I114**].

54. Dr Mynors-Wallis

    a. reviewed A's medical records. He refers [**I71**] to a number of instances from June 2018 where A sustained injuries without remembering how, and to reports of concern about A made by her friends to her GP [**I72**]. He sets out [**I79-80**] the previous history of lack of engagement with District Nurses, the Alcohol Liaison Service outpatients clinic, and carers.

b. describes [**I85**] his meeting with A on 4th October, and her recollection that he had had to change the date of the appointment. He describes [**I86**] A's note-taking during the meeting and subsequent use of her notes to remind herself of his profession.

c. notes [**I86**] A's positive account of KF: "*although we have had our differences, she is deeply honest and trustworthy*."

d. records his explanation [**I87**] to A that others had raised three concerns about her ability to manage independently: "her poor memory, her excessive alcohol use and her history of falling."

e. records [**I87**] A's view about remaining in residential care: "*I wouldn't be happy, I can't think of a more desperate situation. I would be one of a herd of poor sods whose lives had been taken from them and can't decide what to do and where to go. Please don't do that to me.*"

f. sets out an account of discussions with the manager of C Care Home [**I88**], KF [**I88**] and A's social workers [**I89-90**].

g. opines [**I90**] that A has dementia, likely of a multi-infarct type, and therefore "unlikely to significantly improve with stopping the alcohol." However, he notes that "if [A] drinks to excess she will be vulnerable to accidents and confusion because of her underlying dementia."

h. additionally gives two further diagnoses [**I91**]:

    i. "It is my opinion that the periods when [A] has been confused relate not only to dementia but also to an additional diagnosis of delirium" due to a leg infection.
    ii. "It is my opinion likely, on the balance of probabilities, that [A] also has a diagnosis of alcohol dependence." He observes that she "is currently abstinent" but "there is a risk that [she] will return to drinking if placed in a less restricted environment."

i. concludes that "[A's] dementia…meets the Mental Capacity Act requirement for an impairment of, or disturbance in, the functioning [of] the person's brain or mind. [A]'s dementia does affect her decision-making ability." [**I92**] (It is important to be clear that Dr. Mynors-Wallis does <u>not</u> make any reference to the other two diagnoses in reaching his conclusion as to causative link between mental impairment and functional incapacity.)

j. considers each domain of capacity separately and concludes that A

    i. lacks capacity to make decisions about property and financial affairs [**I93**], to make significant decisions about her health and care [**I94**], to conduct these proceedings [**I95**], and to make decisions about Lasting Powers of Attorney [**I96**]; but

ii. has capacity to make decisions about residential care. [**I96]**

k. addresses particularly the question of deciding where A lives, and concludes that A "is able to retain the information for at least a time with regards to the risks of returning home and the conditions required for her to live at home safely. She was able to repeat back to me what the possible conditions were. She is also able to write down information and refer to it later. It is my opinion that she would be able to write down the necessary conditions and have a system whereby she is reminded of these when living in her home…. [She] is able to understand that if she doesn't comply with the requirements to keep her safe, there is a risk that she will not return home…It is my opinion that she would rather risk falling at home than to remain in a nursing home*."*

l. acknowledges [**I96**] that his opinion differs from the Local Authority's, and suggests that this "may reflect the fact that [A] was physically well when I saw her. She was abstinent from alcohol and well nourished – reflecting her care in the nursing home. She also had had the experience of being in a nursing home rather than in her own home."

m. identifies [**I97**] several factors which might assist A and mitigate the risks of a return home: "the key intervention ..is that she abstains from alcohol" but she also "needs to be assisted with memory aids" and "would benefit from the provision of some form of structured social activity."

n. acknowledges that A "is unlikely to fully comply with any conditions set regarding a safe return home, reflecting her past history, her poor memory and the background of alcohol dependence." However, "although the probability of compliance does not reach over 50%, there is a possibility that [A] will comply with conditions required for her to remain at home safely, reflecting the fact that she does retain some memory and is so clear in her wish that she would do anything not to remain in a nursing home*."*

o. proposes that "a reassessment of [A]'s capacity once she has been in her own home for a period (eg one or two weeks) might be of assistance to the Court…"

55. In answer to written questions Dr Mynors-Wallis clarified that:

a. "an example of a major decision about care would be a decision as to how much social care was required at home to keep [A] safe" [**I117**]

b. for a trial at home to be considered the requirements would be [**I119**] that A agrees, that she remains abstinent from alcohol for the duration of the trial, that she lets in carers "with a frequency of say twice a day" and that she co-operates with an 'activities of daily living' assessment at the care home or otherwise accepts a carer preparing food for her at least once a day;

c. failure to comply with such conditions "would lead to a re-assessment of her capacity to make a decision about where she lives."

d. the present situation can be distinguished from past attempts to assist A with care at home because of three factors [**I122**] – her "understanding that the alternative to compliance with support measures may mean that she spends her remaining days in a care home," her present health and abstinence from alcohol, and the possibility of best interests decisions being made on her behalf in respect of matters pertaining to finances and care.

56. In oral evidence on the second day of the hearing, Dr. Mynors-Wallis confirmed and amplified his written conclusions:

a. He explained that A's dementia, being multi-factorial (and as distinguished from alcohol-induced dementia), will persist and worsen. She has some impairment of her ability to make new memories, but she retains at present the ability to use techniques such as note-taking to help reduce the impact of that.

b. He agreed that A tends to 'normalise' alcohol consumption as a feature of her profession and that, if she returned to drinking alcohol, an attempt to live at home would fail but he identified a change from previous experience in that A is aware of that explicit link in the sustainability of any return to live at home. He acknowledged the "*significant chance*" that A would drink alcohol again if she returned to live at home. He considered that the agreed care package would mitigate the risks of this through the frequent visits of carers. He was clear that the response to any resumed alcohol consumption would need to be proportionate.

c. When questioned by Ms. Kohn, Dr Mynors-Wallis confirmed his view that A did understand when he met her in October "that her ability to remain at home depended on factors relating to her care." She understood "the stark choice" between residential care and living at home with the agreed care package. He acknowledged that A's test attainments have worsened over time "but she is still at a higher level than many people going into care…. The level of her dementia is not such that, on its own, I would have concern about her going home." He pointed out that her weight is now normal, and under the care package carers would let themselves in. He considered that A "understands the reality of people being in her flat, and she's able to retain it long enough to weigh, and she's certainly able to communicate her view on it." He recognised that she may find the presence of carers distressing at first, and for that reason consistency of provision would be important, but he considered that she would become accustomed to it. It was his view that, if an attempt to live at home failed, A would be disappointed but she would also be "assured that everything had been done to accommodate her as best as possible."

57. As KF points out [**G89**], A's friends have known her "on average 50 years each." They are not qualified capacity assessors but they have clear views as to A's abilities:

a. RJ gives an account of A's presentation after the first hearing:

> "Between Court and the hospital she lost her phone, had little memory of the proceedings, who was there, what was said and what it was about. She knew we were going to [C Care Home] next day. The journey went smoothly, despite her anxiety about her phone and a card in her wallet that she could not locate for 20 minutes. We arrived at [C Care Home] around 6pm, she had forgotten why we were there and said she thought we were going on holiday and wouldn't have come if she had known. She couldn't remember the court recommendation that she stay [at C Care Home] until Friday. I left her in some distress, with a carer. I returned the next day at 11am to find her playing scrabble with another carer – she was happy – a transformation from the day before." [**G25**]

He is clear that he would not be able to continue giving the level of support her has provided in the past – "I will continue to be her friend but I will not support the crises as I have previously. It takes a toll on me and I have other people to consider."

b. MG gives a very vivid account of his long acquaintance with A whom he described in oral evidence as "extraordinary when I met her," even then "incapable of rational decisions, crazy in lots of ways." He observed that now A's "emotional self-sufficiency gives the impression of someone far more intelligent and in control of life than is actually the case." [**G27**] His account of difficulties A experienced since March 2017 is movingly told but, he says, he never realised that there was such a significant issue with alcohol. He too concludes that, if A returns home, he "would resign all further responsibility for being involved in helping to look after her… To send her home under the illusion that she is an independent intelligence capable of making decisions that are in her own best interests, even with multiple carers visiting and preparing her meals, would only be to hasten her decline still further." [**G43**]

c. LK is the friend who lives closest to C Care Home. She says [**G45**] "As you will know, [A] is a very clever lady. Since she has been in hospital and off alcohol for approximately 4 months, she has regained some cognisance which is encouraging. She can present on the moment as reasonably normal however she is far from being able to look after herself. If you question her you will find that she has almost no short term memory…"

d. KF herself contends that A's capacity to decide where to live, to make decisions about care at home and to manage her property and finances are "inextricably linked" [**G89**]. She says that A "will not understand or accept that her desired 'return' state will not be possible." She points out that A's "anger and anxiety" in respect of previous care packages were significant, and the current proposals "would be significantly more onerous and restrictive." [**G90**] She does not think that A has capacity to make the decision about where she lives [**G126**]

58. The views of the care home manager are also recorded in the attendance note of A's solicitor:

a. "her memory is getting better. She's not as forgetful as when she first came." [**G116**]

b. the reason for that was "Some of the thiamine, good food, taking regular medication, regular food at regular times, routine." [**G117**]

c. "when I saw her in the summer, she didn't know where she was…She has come a heck of a long way." [**G117**]

d. "I don't think we are going to get much further in this environment; we are only maintaining. [**G118**]

Capacity: The Positions of the Parties

59. The Official Solicitor's position is as follows:

a. There needs to be further exploration as to the minimum care package which would be required to manage the risks of A living at home. A has considerable means. If the Local Authority is not prepared to fund any greater care package than that which is proposed, her own funds can be used to commission a more significant care package.

b. There is no dispute that A meets the diagnostic test. She suffers from dementia and alcohol dependence.

c. There is no dispute that A lacks capacity to conduct the proceedings, make significant care and treatment decisions, or manage her property and affairs;

d. As to capacity to decide whether she should continue to live at C Care Home or return to her flat on a trial basis, the evidence of Dr. Mynors-Wallis is accepted;

e. There is no inconsistency in Dr Mynor-Wallis' conclusions as to residence and care. He has not separated the two into separate silos. Rather he has made an individualised assessment that best interests decision will be made in respect of an appropriate care package and, in those circumstances, A is able to understand, retain, use and weigh the relevant information in coming to a decision on residence.

f. A's lack of insight into her care needs presents significant challenges to the sustainability of a return home, even on a trial basis.

g. If residence is determined as a best interests decision, a decision *not* to attempt a trial return home means inexorably that A will remain in residential care for the rest of her life, and the Court should only reach that conclusion where it is plain and obvious

that there is no alternative. A trial return home, with strict conditions, whilst A's place at C Care Home remains open, is a viable alternative.

60. The Applicant Local Authority's position is as follows:

a. In her position statement, Ms. Kohn states that "the view of LBTH is that [A] requires 24 hour specialist care such as that currently provided to her at [C Care Home]. The care and support plan dated 17th February 2020 also states this "recommendation" [**H41**].

b. The care and support plan dated 17th February 2020 states:

i. "to maintain good physical health, to take her medication accordingly and to be able to use her home safely minimising the risks of falls" the recommendation of the local authority is that "these needs would be best met in a 24 hours care environment… If [A] were to move back home, it would be advised that she would have visits at multiple points throughout the day to prompt and support with medication to ensure safe and consistence (*sic*) compliance." [**H43**]

ii. "to have therapeutic interventions and engage in leisure activities to bring meaning and well-being to [A's] life" the recommendation of the local authority is that "leisure, social and therapeutic needs will be better met in a specialist 24 hour environment…If [A] were to return home, she would require highly skilled interventions, with a low likelihood of engagement with a 1:1 worker…" [**H44**]

iii. "to meet [A's] nutritional needs in a safe and therapeutic way" the local authority states that "the likelihood of successfully meeting this outcome at home is tenuous but could be attempted through exploring home care agencies and carers who would be willing to provide such service." [**H45**]

iv. How A may "have access to necessary facilities and services in the community" if she returns to live in her flat is not addressed in the relevant section of the plan [**H46**]

v. "to maintain… mental health and to make steps towards recovery and preventing further cognitive decline" it is noted in the plan that "Home carer could provide support, advice and monitoring and another referral could be made to RESET. However, there is no service which could ensure she does not drink alcohol whilst she is living independently in the community." [**H47**]

vi. In respect of "personal hygiene and toileting needs" it is noted in the plan that A "does not require support in these areas." [**H47**]

vii. "To maintain family and personal relationships" it is noted in the plan that "home care could be provided to help mitigate the risk" of social isolation. [**H48**]

c. Ms. Kohn in oral submissions summarised the "crux" of the Local Authority's position as being that considerations of residence and care cannot be separated in a determination of A's capacity to decide where she lives.

d. The conclusions of Dr. Mynors-Wallis are not accepted because "an understanding of the kind of care required is fundamental to any decision on residence", relying on *B v. A Local Authority* [2019] EWCA Civ 913 paragraphs 63-64.

e. A cannot recall and does not accept her historical difficulties, and therefore cannot use and weigh that information in making decisions about the care she requires or, as a consequence, the place in which she needs to live in order to receive such care. She cannot understand the reality of living at home with a care package – "it's words with no substance."

f. A return home, even on a trial basis, would not be in A's best interests. "It's just bricks and mortar – not a loving family embrace. There is a high likelihood of failure."

61. KF, and indeed all the friends who are not formally joined as parties to these proceedings, consider that A does not have capacity to make a decision about where she lives, and a return to living in her own flat would be positively harmful to her. KF confirmed that she agreed with Ms. Kohn's closing submissions.

Capacity: Determination

62. In cases which come to the Court of Protection for determination, decisions about where a person lives and decisions about what care a person receives are usually considered as individual domains of capacity. That approach is seen in both *LBX v. K, L, &* M and in *B v. A Local Authority* referred to above. It is also seen in this matter in the joint letter of instruction to the independent expert [**I47** at paragraph 201 and **I51** at paragraphs 216 - 219].

63. Such an approach is clearly in keeping with the Act's "issue-specific" approach to decision-making. Comparison of the relevant information identified for residence and for care decisions, as set out by Theis J in *LBX v. K, L &*M, immediately illustrates that decisions about residence and care require different factors to be understood, retained, and used or weighed. To that extent, in my judgment Ms. Kohn goes too far in her analysis (in closing submissions) of the "crux" of the issue in this matter. There is ample authority for considering residence and care as individual domains of capacity.

64. It does not follow from such approach, however, that residence and care are decisions which are made in separate "silos." There are differences in the information relevant to

making each decision but there is also overlap. Again, comparison of Theis J's two lists immediately illustrates the point - item (8) in respect of a decision about *residence* is "what sort of *care* [P] would receive in each placement in broad terms…"

65. Overlap does not however imply that a decision in respect of residence somehow *incorporates* a decision in respect of care. In my judgment, Ms. Kohn conflates the two domains of capacity when she submits [at paragraph 13 of her position statement] that "understanding of the kind of care required is fundamental to any decision on residence" - as is made clear when she goes on to spell out that "[A] cannot recall and therefore neither accepts nor acknowledges her history and past difficulties and therefore cannot use and weigh this information in making decisions regarding the care she requires nor, *as a consequence,* the place in which she needs to live in order to receive such care." [emphasis added] In my judgment, it is not necessary to make a capacitous decision about care in order to make a capacitous decision about residence. Rather, as Theis J identified, what is required for A to make a capacitous decision about where she lives is a *broad understanding* of the sort of *care which would be provided* in each of the two places of residence potentially available to her.

66. In this matter, it is not in dispute that the care to be provided to A falls to be determined on her behalf, as a best interests decision. I accept the evidence of Dr. Mynors-Wallis that, because of multi-infarct dementia, A lacks capacity to determine the care she should receive. (To be clear, I am not satisfied that the required causal nexus presently exists between A's functional incapacity in this regard and either of the other diagnoses which Dr. Mynors-Wallis identifies. None of the parties sought to suggest that it did.)

67. The information before the Court is that living in a specialist residential placement is one way of A receiving appropriate care; having a support package delivered in A's own home may be another. Broad proposals for the latter [**J77**] envisage at least three support visits every day, including assistance with her meals and medication, and additional support to engage in community-based activities.

68. The 'question actually under discussion'[2] in this matter is, therefore, whether A should remain living at C Care Home or return to living at home with a package of care provided on a trial basis.

69. Applying the statutory criteria to a determination of A's capacity to make that decision, there is no dispute as to the diagnostic test. All parties, and I, accept the evidence of Dr. Mynors-Wallis.

70. For the purposes of the functional test, in my judgment the relevant information to make this decision is:

[2] Per Hedley J, as quoted in *PC & NC v. City of York Council* [2013] EWCA Civ 478

a. what the two options are;

b. in broad terms, the care which would be provided to her in each place (including that, in her own flat, carers would visit her several times each day);

c. that the option of living in her flat would be initially on a trial basis for up to 4 weeks;

d. that the trial of living in her flat would be considered successful if A engages with the carers, takes her medication, maintains appropriate nutrition and abstains from alcohol;

e. if the trial of living in her flat is not considered successful, it would end and she would return to C Care Home.

71. When this relevant information has been discussed with A, the factors by which the success or otherwise of the trial return to her flat will be assessed have been referred to as 'conditions.' There is an authoritarian tone to this word which, in my view, does not accurately capture the legal analysis of assessing capacity to determine residence and care as distinct decisions. However, with some reluctance, I accept that it is an appropriate term to convey to A the idea of provision of care which she lacks the capacity to decide for herself.

72. As to whether A meets the functional test of capacity to make the decision in question, there are conflicting views to be considered:

a. Ms. Dalton is the professional who has had the longest acquaintance with A. However, her initial assessment of A's capacity was completed very shortly after the period of her hospitalisation began, before she had received a sustained period of care and supported nutrition, before she had had a sustained period of abstinence from alcohol, and before she had experience of residential care.

Ms. Dalton acknowledges that A has "come a heck of a long way" since then. In oral evidence, Ms. Dalton accepted that A understands the two options currently under consideration. However she understood capacity to choose between these options as dependent on A having understanding of her care *requirements*. In so doing, in my judgment, she conflated decisions about residence and care when it is not appropriate to do so.

Ms. Dalton's firmly held and clearly expressed view is that a trial of A living at home with a package of care provided is 'bound to fail.' She may be proved right but the impression I formed of her evidence is that – no doubt with the best of intentions - a protective imperative has overtaken an objective assessment of whether A, after a sustained period of care, is now able to decide between the two identified options for herself.

b. Mr. Lee-Drury and Dr. Akoo each assessed A around the time when she was discharged from hospital. Since then, A has benefitted from a further period of sustained care, and additionally experienced life in a residential placement. To a significant degree, in my judgment, their assessments are now 'out of date.'

c. KF, RJ, MG and LK have maintained friendships with A over a very long period. They have demonstrated an impressive degree of commitment to her wellbeing. A is very fortunate to have such friends. However, the experience of supporting A has taken its toll on them. For A, and for themselves, they are understandably reluctant to risk losing any of the improvements in A's health and safety which they have seen whilst she has been receiving residential care. All of that is understandable and, in my judgment, well-intentioned but I am concerned that such risk-aversion leads them to overlook the distinction between being unable to make a decision and making a decision which they consider to be unwise. I acknowledge their collective view that A will not be able to meet the requirements of a successful trial but I am concerned that such view does not take sufficient account of A's improved health, her experience of residential care or the mitigating effects of the care package which will be provided.

d. Taking all the circumstances of this matter in consideration, I prefer the evidence of Dr. Mynors-Wallis. He is an independent assessor, jointly instructed by all parties. He has many years of professional experience relevant to making capacity assessments. He has fully considered A's medical records, has seen A in person, and has considered the views of relevant others. He conducted his formal assessment at a time when A had benefitted from a sustained period of care and abstinence from alcohol, and gained experience of residential care.

   I agree with the submissions of the Official Solicitor [paragraph 43(d) of Mr. Patel's position statement] that there is no inconsistency between Dr. Mynors-Wallis' conclusions on residence in the one hand and care on the other. I am satisfied that he has not considered the individual domains of capacity in separate silos. Rather, he has made an individualised assessment of A's capacity to decide where she lives, in circumstances where decisions about the care which will be provided in each of the options will be made on her behalf.

73. I am fortified in my evaluation of the conflicting evidence as to A's functional capacity by my own impressions of A, formed by consideration of her solicitor's attendance notes and in my telephone conversation with her. Nothing in my impression casts doubt on Dr. Mynors-Wallis' conclusions. Rather, in her own robust terms, A's participation in these proceedings seems to me to confirm them.

74. I do not doubt that A's present level of functioning owes much to the expert care she has received for many months now. However, I am satisfied that A presently has capacity to decide for herself whether to remain living at C Care Home or to return to her flat with a package of care for a trial period, notwithstanding the diagnoses of impairment of or disturbance in the functioning of her mind or brain.

75. A has not yet given her "final word" on the "stark choice" which is presently open to her. When the full details of the care package for a trial period of living in her flat are known, she may yet decide that she prefers "being coddled" and the new friendship she has made to the frustrations of being in her old home but not her old life. If she chooses to remain at C Care Home, it is my impression that A will value having been able to make that decision for herself.

76. However if, when the details of the care package are settled, A chooses a trial return home and even if ultimately it is not successful, I would not characterise that decision as "unwise." Had I reached a different conclusion as to A's capacity, on the basis of her current wishes and feelings, it is highly likely that I would have agreed with the Official Solicitor that the proposed return to live at home with a package of care should be tried. For A as much as anyone, home is more than "just bricks and mortar."

Post script

77. After I had given the parties my decision, Ms. Kohn sought clarification of the implications for the current Standard Authorisation in respect of A's residence at C Care Home until the package of care for the trial return home could be put in place, and therefore for the continued funding of her representation.

78. Mr. Patel referred me to paragraph 15 of Schedule A1 to the Act, which provides that the relevant person meets the mental capacity requirement under that Schedule if he lacks capacity in relation to the question whether or not he should be accommodated in the relevant hospital or care home for the purpose of being given the relevant care or treatment.

79. The determination of the Court is that A lacks capacity to make decisions about the care she needs but where there is a choice between alternative places in which to receive appropriate care, A has capacity to make that choice. Unfortunately, until the package of care for the trial return home is arranged, there is no choice: the only option before the Court in respect of A's care is for it to be provided as part of the residential placement at C Care Home. It is imperative that the package of care which makes trial return to A's flat an option is arranged as quickly as possible. Until it is, on an interim basis, the determination that A lacks capacity to determine the care that she should receive necessarily means that she lacks capacity within the meaning of paragraph 15 of Schedule A1.

HHJ Hilder

23rd April 2020