Neutral Citation Number: [2020] EWCOP 50

Case No: 13462068

COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 22/07/2020

Before :

THE HONOURABLE MR JUSTICE HAYDEN

- -

Between :

A COUNTY COUNCIL	**Applicant**
- and -	
LW	**1st Respondent**
- and -	
AN NHS SOCIAL CARE PARTNERSHIP TRUST	**2nd Respondent**

- -
- -

Ms Winsome Levy (instructed by **Invicta Law**) for the **Applicant**
Ms Fiona Paterson (instructed by **Edwards Duthie Shamash on behalf of the Official Solicitor**) for the 1st **Respondent**
Mr Conrad Hallin (instructed by **Head of Legal at the NHS and Social Care Partnership Trust**) for the **2nd Respondent**
Hearing date: 22nd July 2020

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Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

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THE HONOURABLE MR JUSTICE HAYDEN

This judgment was delivered following a remote hearing conducted on a video conferencing platform and was attended by members of the public and the press. The judge has given leave for this version of the judgment to be published on condition that (irrespective of what is contained in the judgment) in any published version of the judgment the anonymity of the respondent and members of their family must be strictly preserved. All persons, including representatives of the media, must ensure that this condition is strictly complied with. Failure to do so will be a contempt of court.

Mr Justice Hayden :

1. This application is brought by A Local Authority who are today represented by Miss Levy. At the centre of the application is LW, who is a 60-year-old lady living at the G Unit in Kent. It is troubling she has been there since July 2017 although for many months, perhaps as many as 12 months, the professional consensus is that it is not the best place for her. That is not to be in any way critical of those providing her care, but simply reflects the fact that the unit is not equipped to meet her needs at this stage in her life.

2. When she was admitted she was initially detained under the Mental Health Act 1983. At the time of her admission, she was in a truly parlous condition. She was described as *"emaciated"* and her personal hygiene was very neglected. The general practitioner who referred her to mental health services noted that members of the public had been concerned about her. She had been stopping traffic and acting disinhibitedly, often talking in rather extravagant language about what were vaguely religious concepts. She was also expressing and articulating suicidal thoughts.

3. I am quite clear that when she was admitted to the G Unit nobody imagined she would still be there today. LW was able, despite some technical challenges, to speak to me during the course of this hearing, via a video conferencing platform. The other parties were able to hear what she had to say. LW was taken sensitively through her evidence in chief by Ms Paterson, on behalf of the Official Solicitor.

4. It is important to contextualise LW's evidence by setting it in the background of her mental health difficulties. Dr N has observed that LW has, throughout her life, had a variety of diagnoses reflecting the evolution of knowledge and understanding within psychiatry. In 1991 LW was diagnosed as having Bipolar Affective Disorder. Her condition has necessitated in-patient admissions throughout her life. However, for the most part, she has managed to achieve independent living. I am told that she had a strong relationship with both her mother and sister. As Ms Paterson is correct to emphasise, there is a great deal more to LW than her mental health diagnosis. She has in the past, undertaken training as a nurse, though she was unable ultimately to complete the course. I understand also that she worked, on a casual basis, in care homes. She enjoyed reading, current affairs, played the piano, enjoyed music and took great delight in going out for cake and tea. Despite her illness, LW has displayed a consistent enthusiasm for all aspects of life that she identifies as open to her.

5. The central challenge to LW's life, I regret to say, is that she formed a relationship with a man, known as MG, whom she described to me as her *"long term partner."* It is important to say that even the most cursory analysis of the extensive evidence available points clearly to this relationship as being abusive, exploitative, coercive and wholly inimical to LW's welfare. As I have read the papers and heard the evidence, I have wondered how this has been permitted to continue for as long as it has. On a rational and objective analysis, LW derives nothing from this relationship at all. She expresses a strong wish for it to continue, though her behaviour often indicates that the relationship is stressful and disturbing to her. For reasons that I will identify below this relationship is corrosive of her welfare and significantly impedes her capacity to enjoy life which has been identified, historically, as intrinsic to her personality. I consider that some of MG's behaviour has a sadistic component to it.

6. MG has lived in LW's home for approximately four and a half years. They had been living together for 18 months before her hospital admission in March 2017. As the evidence has emerged it has become clear that she was emaciated because he had restricted her food intake. Salad and one potato a day were all that she was allowed. LW has reported this to various professionals and it is certainly corroborated by her physical condition on admission. She has since been able to eat healthily and is physically very much restored. I have heard, from care staff, how MG has controlled LW with his own distorted perceptions on religion. MG has made her say prayers at quite extraordinary length and often on a daily basis. These prayers have a veneer of Roman Catholic liturgy but veer off in to content which is fantasy and distortion. MG has insisted that LW recites these extensive prayers in a particular order which is something she becomes highly agitated and anxious about. It is particularly alarming that LW has reported that MG made her smash her own piano apart so she could no longer play. MG believed that LW's enjoyment of the piano was inconsistent with the religious faith which he purports to expound. MG has also forbidden LW from wearing underwear. On at least on one occasion this has put LW in an embarrassing position and compromised her dignity. Whilst LW has been in hospital her property has been neglected and fallen into disrepair. MG has refused admission to the Local Authority to assess the property. MG has declined many requests by the Local Authority to meet with them. In this relationship he is also highly manipulative.

7. It is important to emphasise, that MG would have been entirely aware of LW's striking deterioration and decline, particularly in the lead up to her admission in 2017 and he did absolutely nothing to help her. LW is unable to analyse these behaviours or process, in her own mind, the reality of her relationship with the man whom she considers to be her partner. In what is recognised as a paradigm of domestic abuse, MG has alienated LW from her family and from any other support, leading to her becoming ever more dependent on him.

8. In the course of her written and oral submissions Ms Paterson, on behalf of the Official Solicitor, has characterised this behaviour as *"controlling," "abusive"* and "*cruel.*" She is, I consider, entirely right to do so.

9. As the years have gone by it is apparent that MG has extended his control to the professionals involved in LW's care. He writes the *"script"* as to what she should tell the doctors and the carers. Staff are aware of this but have not felt able to intervene. During the course of her evidence I asked LW about the piano incident and as Ms Paterson rightly identified, she swiftly blocked any conversation about the past with perfunctory remarks (in which she was manifestly reflecting MG's views) that this was incompatible with her faith which she considers to be Roman Catholic.

10. The entire team surrounding LW, including Dr N, is now of the clear view that she will benefit very considerably from a total cessation of contact with MG. In recent months, the contact has been, of necessity, by telephone. These telephone conversations have been regarded as a kind of 'indirect contact' which has been thought to provide a barrier to the infliction of harm. The reality is MG has continued to abuse LW on the telephone, insisting on a liturgy of prayers which often kept LW up late into the night and consequently prevented her from achieving that which she was capable of during the following day. The prayers, as I have stated, provoked a real anxiety in LW. I am told she has a strong wish to please MG and her concern about not getting the prayers in the correct order lead her to becoming unsettled and *"makes her sad,"* as she reports. The

contact by telephone was supervised but it is plain that those supervising the contact were in the invidious position of sitting and listening to exchanges which were manipulative, controlling and injurious to LW's welfare without always fully appreciating its impact on her. When LW, who would very much like to go home, questions MG about obtaining quotes for repairs to the property, he quickly changes tack and counters that she *"does not love him"* and contrives to cast himself as the victim in this situation. LW has a sense of fragility in this relationship. She identifies it as her passport to the outside world and realises that she has no other friends or family to turn to at present. Her reaction is to try to avoid distressing MG. She has no recognition that this distress is manufactured to manipulate her. She is reported as being regularly anxious, both before and after these telephone conversations.

11. I recognise that a judge has a significant advantage, reviewing all of the evidence in the forensic calm of a court room. Those working with LW on the ground, have not, until recently, had the same opportunity to weave the material together to gain a clear picture of the distorted and abusive nature of this relationship. That said, I reiterate my concern that this contact has been permitted to continue for as long as it has.

12. I entirely agree with Dr N and the team that LW would benefit from complete cessation of the contact. Dr N has come to know LW well and sensitively anticipates that the cessation of contact with MG, at the same time as a move to a residential unit, runs the very real risk of overburdening her psychologically and risks retriggering an episode of mental illness. Dr N suggests that that situation should be addressed by providing an eight-week interim period so that LW can be supported, as she comes to terms with the absence of MG in her life. In this regard there are two important observations to make. Firstly, in the past, when contact has been severed, the consequence for LW was in fact a marked and obvious improvement in her mental health and wellbeing. Secondly, it seems clear from her own developing disappointment with MG's lack of action in effectively facilitating her return to him that she has started to question, perhaps in only the gentlest way, his reliability and commitment to her. It is her false perception that MG has been able to meet her needs that has led her to become so dependent on him. That dynamic Dr N has told me is reflected in LW's interaction with other men at the unit where she is living. LW has no real understanding of her mental health issues. Indeed, she has indicated that if she were to return home, she would seek to wean herself off her medication which would have very serious consequences.

13. Although I have tried to emphasise the positives of LW's character and personality, it is clear that she will struggle to live independently for all the reasons Dr N sets out in her s.49 report. She is unlikely to attend for treatment after her discharge; road safety has also been a persistent challenge to her for many years. MG has entirely blocked the planning process. It has ground entirely to a halt and necessitated this application. It is the influence that MG asserts over LW's fragile personality that compromises her capacity to weigh and evaluate the questions relating to her care and where she should live. This is compounded by her inability to understand her own mental health needs. All this had led Dr N ultimately to come to the conclusion that LW lacks capacity to take key decisions. That is a conclusion with which everyone agrees. It is perhaps important to mention that in her earlier report Dr N had expressed herself more cautiously in relation to LW's capacity. This is because on so many levels LW is able to communicate her views eloquently and articulately. She is a charming lady who inspires affection. This was obvious even in the glimpse that I had of her with those

caring for her. To some degree this masks the more pervasive factors Dr N has identified. In any event, I am entirely satisfied that she lacks capacity to take the interrelated decisions relating to contact with MG, where she should live and the nature and extent of the care she requires.

14. These issues now having been determined, it should be possible to progress the planning process. Miss Levy has assured me that the Local Authority will be active in liaising with the Property and Affairs Deputy to secure MG's eviction from LW's home and to use their best endeavours to ensure that this is achieved in a way which minimises the risk of further damage to the property, which Dr N contemplates as a likely reaction on MG's part. This is a sensitive situation. The pace of progress will very much depend on LW's reaction to this judgment. The timescales that Dr N indicated must not be regarded as *"set in stone,"* progress must be at LW's own pace. It is LW's needs that should drive the timetable not the exigencies of the litigation.

15. What is envisaged is an order permitting the parties to return to court to submit a finalised care plan. I have no doubt the plan is contrary to LW's expressed *"wishes."* Whether it is contrary to her *"feelings"* though, remains to be seen.

16. Mr Hallin, acting for the NHS Social Care Partnership Trust, observes that neither the Official Solicitor nor the Court lightly goes against the clear and consistently expressed wishes and feelings of an incapacitated person, but here, were I to permit her to return to her flat with MG, I would be exposing her to a regime of insidious controlling and abusive behaviour which is both corrosive of her personal autonomy and entirely irreconcilable with her best interests.

17. I delivered this judgment, ex tempore, on 22nd July 2020. For the reasons I have set out above, I regarded the evidence as compelling and took the view that a decision was required quickly and that the parties (sitting remotely) should hear something of my reasoning. At Counsel's request, I ordered a transcript of the judgment to assist those drafting the care plan. Subsequently, a view has been expressed that the judgment should be placed in the public domain. As I read the judgment, I have seen the force in that suggestion. Though the conduct I have described above appears obvious and extreme, individual instances of behaviour, observed in isolation, do not always signal to the professionals the malevolent undercurrent beneath. Controlling and coercive behaviour of this kind requires an effective assessment of a pattern of behaviour, the impact of which is cumulative.

18. This judgment provides a timely opportunity to highlight both the insidious nature of controlling and coercive behaviour and the extreme vulnerability of those lacking mental capacity in facets of their decision making. With this in mind and pursuant to the principles in **Piglowska v Piglowski [1999] UKHL 27**, I have added the following paragraphs.

19. In September 2012 the Government published guidance to assist prosecutors better to understand the nature and features of controlling or coercive behaviour. Domestic violence and abuse is defined as:

> *"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members,*

> *regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological, physical, sexual, financial and emotional."*

20. The Government definition also outlines the following:

> *"Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim*
>
> *Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour"*

21. I reiterate that it is understanding the cumulative impact of this behaviour that is crucial to effective safeguarding. The Statutory Guidance published by the Home Office, pursuant to Section 77 (1) of the **Serious Crime Act 2015** identifies examples of the kind of behaviour that is useful to highlight to those working with incapacitous adults, many of whom are particularly vulnerable to emotional, financial and psychological abuse. Examples within the Statutory Guidance highlight paradigm behaviours. I have emphasised those which, sadly, are seen with some frequency by those concerned with the welfare of vulnerable adults:

- **Isolating a person from their friends and family**
- **Depriving them of their basic needs**
- Monitoring their time
- Monitoring a person via online communication tools or using spyware
- **Taking control over aspects of their everyday life, such as where they can go, who they can see, what to wear and when they can sleep**
- Depriving them access to support services, such as specialist support or medical services
- Repeatedly putting them down such as telling them they are worthless
- **Enforcing rules and activity which humiliate, degrade or dehumanise the victim**
- Forcing the victim to take part in criminal activity such as shoplifting, neglect or abuse of children to encourage self-blame and prevent disclosure to authorities
- **Financial abuse including control of finances, such as only allowing a person a punitive allowance**
- Control ability to go to school or place of study
- Taking wages, benefits or allowances
- Threats to hurt or kill
- Threats to harm a child
- Threats to reveal or publish private information (e.g. threatening to 'out' someone)
- Threats to hurt or physically harming a family pet
- Assault
- **Criminal damage (such as destruction of household goods)**
- Preventing a person from having access to transport or from working
- Preventing a person from being able to attend school, college or University
- Family 'dishonour'

- Reputational damage
- Disclosure of sexual orientation
- Disclosure of HIV status or other medical condition without consent
- **Limiting access to family, friends and finances**

22. It is important to emphasise that this list is not exhaustive. It does not, for example, include controlling intake of food and nutrition, which was such a striking facet of the evidence here. Abusive behaviour of this kind will often be tailored to the individual circumstances of those involved. The above is no more than a check list which should prompt questioning and enquiry, the responses to which should be carefully recorded so that the wider picture emerges. That which might, in isolation, appear innocuous or insignificant may in the context of a wider evidential picture be more accurately understood.