Neutral Citation Number: [2020] EWCOP 66

Case No: 13408216

IN THE COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 15/12/2020

Before :

MR JUSTICE KEEHAN

- -

Re AA (Court of Protection: Capacity to Consent to Sexual Practices)

Between :

A Local Authority	**Applicant**
- and -	
AA	**Respondent**
(By his litigation friend, the Official Solicitor)	

- -
- -

Mr N Allen (instructed by **Local Authority**) for the **Applicant**
Mr J McKendrick QC (instructed by **MJC Law**) for the **Respondent**

Hearing dates: 27th November 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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MR JUSTICE KEEHAN

This judgment was delivered in private. 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 children and members of their family must be strictly preserved. All persons, including representatives of the media, must ensure that this condition is strictly complied with. Failure to do so will be a contempt of court.

The Hon Mr Justice Keehan :

Introduction

1. I am concerned with AA, a 19 year old man, who has been diagnosed as having autism ('ASD') and Asperger's Syndrome. He has interests relating to certain sexual practices including autoerotic asphyxiation ('AEA'). He has posted material about himself on the dark web, advertising his wish to be a submissive partner and his desire to be kidnapped and raped.

2. The issues for me to determine are:

   i) AA's capacity to conduct proceedings and make decisions regarding AEA, internet and social media, consent to sexual relations and contact with others;

   ii) AA's best interests in those domains where he lacks capacity to decide; and

   iii) Whether I should authorise AA's deprivation of liberty.

The Law

3. In the case of *A Local Authority v. TZ (No 2)* [2014] EWCOP 973 Baker J, as he then was, encapsulated the principles to be applied when determining whether a person had or lacked capacity to make a decision in the following terms:

> "19. Section 1 of MCA stipulates three principles relating to capacity.
>
> 20. First, a person must be assumed to have capacity unless it is established that he lacks capacity: s. 1(2). The burden of proof therefore lies on the party asserting that P does not have capacity. In this case, therefore, the burden of proof lies on the local authority to prove that TZ lacks the capacities identified above. The standard of proof is the balance of probabilities: s. 2(4).
>
> 21. Secondly, 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: s. 1(3). The Mental Capacity Act 2005 Code of Practice stresses in paragraph 4.16 that "it is important not to assess someone's understanding before they have been given relevant information about a decision". "Relevant information" is said in paragraph 4.19 to include "what the likely consequences of a decision would be (the possible effects of deciding one way or another) – and also the likely consequences of making no decision at all". Paragraph 4.46 of the Code of Practice adds that "it is important to assess people when they are in the best state to make the decision, if possible".
>
> 22. Thirdly, a person is not to be treated as unable to make a decision merely because she makes an unwise decision: s. 1(4).

Paragraph 4.30 of the Code of Practice emphasises the importance of acknowledging the difference between, on the one hand, unwise decisions and, on the other hand, decisions based on a lack of understanding of risks or inability to weigh up the information about a decision.

23. As set out above, the Act provides that 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 disturbance in the functioning of, the mind or brain: s. 2(1). Thus the test for lacking capacity involves two stages. The first stage, often called the "diagnostic test", is whether the person has such an impairment or disturbance. The second stage, often known as the "functional test", is whether the impairment or disturbance renders the person unable to make the decision. S. 3(1) provides that, for the purposes of s. 2, a person is unable to make a decision for himself if he is unable (a) to understand the information relevant to the decision; (b) to retain that information; (c) to use or weigh that information as part of the process of making the decision, or (d) to communicate his decision whether by talking, using sign language or any other means.

24. In addressing the issues of capacity in this case, I bear in mind a number of other points of law.

25. Importantly, capacity is both issue-specific and time specific. A person may have capacity in respect of certain matters but not in relation to other matters. Equally, a person may have capacity at one time and not at another. The question is whether, at the date on which the court is considering capacity, the person lacks the capacity in issue.

26. Next, as Macur J (as she then was) observed in LBL v RYJ [2010] EWHC 2664 (Fam) (at paragraph 24), "it is not necessary for the person to comprehend every detail of the issue … it is not always necessary for a person to comprehend all peripheral detail …." The question is whether the person under review can "comprehend and weigh the salient details relevant to the decision to be made" (ibid, paragraph 58).

27. Furthermore, in assessing the question of capacity, the court must consider all the relevant evidence. Clearly, the opinion of an independently-instructed expert will be likely to be of very considerable importance, but in addition the court in these cases will invariably have evidence from other professionals who have experience of treating and working with P, the subject of the proceedings, and sometimes from friends and family and indeed from P himself.. As Charles J observed (in the analogous context of care proceedings) in A County Council v KD and L [2005] EWHC 144 (Fam) [2005] 1 FLR 851 at paras

> 39 and 44, "it is important to remember (i) that the roles of the court and the expert are distinct and (ii) it is the court that is in the position to weigh the expert evidence against its findings on the other evidence… the judge must always remember that he or she is the person who makes the final decision". Thus, when assessing the ability of a person to (a) understand the information relevant to the decision (b) retain that information, and (c) use or weigh that information as part of the process of making the decision, the court must consider all the evidence, not merely the views of the independent expert.
>
> 28. Finally, I reiterate the further point, to which I have alluded in earlier decisions, including PH v A Local Authority, Z Ltd and R [2011] EWHC 1704 (Fam) and CC v KK [2012] EWHC 2136 (COP). In a case involving a vulnerable adult, there is a risk that all professionals involved with treating and helping that person – including, of course, a judge in the Court of Protection – may feel drawn towards an outcome that is more protective of the adult and thus, in certain circumstances, fail to carry out an assessment of capacity that is detached and objective."

4. I respectfully agree.

Background

5. AA was removed from his mother's care and was placed in the care of his father until he was 15. On 23rd November 2017 he alleged his father had asked him for oral sex. His father was arrested but the police took no further action. AA went to live with his paternal aunt but she was unable to cope and therefore on 27th November 2017 he was voluntarily accommodated by the local authority pursuant to s.20 Children Act 1989. AA was placed in a children's home.

6. The local authority issued an application for a care order. On 26th November 2018, AA was made the subject of a care order.

7. These proceedings in the Court of Protection were brought seeking incapacity declarations and a decision that it was in AA's best interests to move from the children's home to a supported living placement where his deprivation of liberty was to be authorised. On 3rd August 2020, AA moved to his new property where he has support 24 hours per day, seven days per week.

8. He is studying an animal care course at a college local to his placement which he attends every Wednesday and Friday. AA maintains contact with some members of his family, but his father does not wish to speak to him.

9. As I have mentioned, AA engages in or has an interest in various sexual practices, namely, AEA, cross dressing, abduction, rape and 'My Little Pony'. The local authority submitted that because of AA's autism these interests are at risk of becoming all consuming. Without appropriate intervention and support, it was admitted that there is a high risk of unintentional death. Members of AA's family are

further concerned that he could not only be a victim of sexual abuse and assault but also become a perpetrator.

10. His interest in AEA started at the age of 13 or 14. Whilst living with his father, he was found to have AEA videos on his phone and on one occasion fell asleep with a plastic bag over his head. His aunt had previously noted red marks around AA's neck. In March 2018, it was noted that he had made a noose with swimming goggles.

11. AA has reported that he has been 'dizzy' when practicing AEA. He has described how cutting off his circulation is 'just a nice feeling to have' and that he is addicted to it. He has said that he had a bag over his head until 'getting to a point I couldn't breathe and masturbating...didn't know the real reason I was doing it'.

12. In respect of his use of the internet and social media, I note the following:

    i) sexually explicit material has been found on his mobile telephone;

    ii) he has advertised online his desire to be a submissive partner, be kidnapped and raped;

    iii) he has posted graphic sexual content;

    iv) the police had previously found that AA has sent hundreds of explicit messages and photographs to men around the world and asked to be kidnapped;

    v) more recently, since the restrictions on the use of his mobile phone were relaxed, AA has been communicating with another male who shared sexually explicit pictures with AA and they have exchanged texts relating to 'My Little Pony', sexual preferences, submission and depression; and

    vi) AA is sometimes on his mobile phone until 4:00am or 5:00am.

Expert Evidence

13. Dr Hutchinson, psychologist, was instructed in the public law proceedings to give an opinion on AA's capacity to make decisions in various domains. In his report of 16th August 2018, he concluded that AA lacked capacity to conduct these proceedings and to make decisions about his residence and care. In an addendum report of 25th September 2018, he provided a risk assessment and made recommendations to address the same. AA's social worker's assessment of his capacity to make decisions in these domains reflected the conclusions of Dr Hutchinson.

14. During the course of these proceedings, Dr Burchess, a psychologist, was instructed to advise on AA's capacity to conduct these proceedings and to make decisions about his residence, care and support, contact with others and access to the internet and social media. In his report of 23rd July 2020, Dr Burchess concluded that:

    i) AA does not have a learning disability;

    ii) he does have autistic spectrum disorder, Asperger's syndrome and paraphilic disorder;

iii) AA does have capacity to conduct these proceedings;

iv) he does have capacity to make decisions as to his residence, care, contact with others, the use of the internet and social media and to engage in sexual relations; and

v) AEA should be considered as a specific decision and a domain separate from engagement in sexual relations.

15. At a hearing on 28th August 2020, I found there was reason to believe that AA lacked capacity to conduct these proceedings (notwithstanding the contrary opinion of Dr Burchess) and to make decisions regarding AEA and contact with others. It was directed that Dr Burchess should prepare an addendum report.

16. In his addendum report Dr Burchess observed that:

i) AA underestimates the extent and range of support he will require in relation to his care arrangements;

ii) despite his knowledge of the potential dangers of internet use, AA continues to expose himself to a high risk of harm; and

iii) he does not fully appreciate the dangerousness of engaging in AEA.

17. It was agreed by the parties that a psychiatrist, Dr Ince, should be instructed to report on AA's capacity:

i) to make decisions regarding AEA; and

ii) to make decisions about the use of the internet and social media in the context of his contact with others whom he meets online.

18. Dr Burchess and Dr Ince agreed that the information relevant to making decisions regarding AEA included:

i) the concept of AEA;

ii) the manner in which AA engages in AEA;

iii) the range of risks and harm associated with the practice of AEA and their likelihood; and

iv) knowledge and use of safety strategies and their effectiveness (recognising that AEA is an inherently dangerous practice and potentially life threatening).

Dr Burchess also included knowledge and experience of other strategies for obtaining sexual gratification. Dr Ince agreed but considered this was more complicated for AA because of issues relating to his diagnosis of ASD which were currently unassessed.

19. Dr Ince considered that AA lacked the capacity to make decisions regarding AEA because:

i) he had no knowledge of the risk of partial hypoxia and acquired brain injury;

ii) he was unable to cross-transfer skills and knowledge because of his autism;

iii) although he has a basic understanding of the risks in relation to plastic bags, he cannot transfer this knowledge to other similar mechanisms; and

iv) AA could not retain information related to specific breathing techniques and similar information provided to him with the educative work undertaken with him.

20. Dr Ince observed that:

> "9.5.3. In the case of [AA] the aetiology of his presentation is also worthy of consideration given that – and as set out within the previous diagnostic criteria – he further presents with the relevant circumscribed and specific interests as a component of his ASD.
>
> 9.5.4. It is additionally worthy to note his early upbringing and – similarly – the relevance of sensory factors and the possibility/likelihood that he experiences a degree of 'low registration' in that he has a pattern of sensory processing in which he has a high threshold to sensory stimulus, and either does not detect changes within the range of stimulus, or requires a higher level of sensory stimulus to achieve the same outcome – both of these scenarios would be hugely pertinent in this case given the risks related to either a greater need for hypoxia for the same level of arousal or the failure to recognise changes in consciousness levels and the risk of hypoxic brain injury or death."

21. Dr Ince then concluded as follows:

> "9.6.10. Accordingly, I do not believe that [AA] truly understands the inherent risks related to all relevant practices, can transfer his knowledge between each practice (be it breathing techniques, use of dog collars, ligatures, plastic bags or other implements) and – further – does not have a broad knowledge of the ancillary risks aside from death, i.e. hypoxia, cognitive damage or the associated issues of being 'found' within such a position and – thus – the emotional and social impact upon others due to the behaviour itself rather than specifically his death.
>
> 9.6.11. As previously stated, it is also my view that there remains therapeutic assessment work that may firstly give a better understanding of the relevant aspects of AEA as a concept within [AA]'s sensory profile and – thus – alternative mechanisms by which interventions can be employed. I am also mindful that he referred to his interest in AEA as "an

> addiction" and – whilst sublimated to more socially acceptable (and I use that as a concept accordingly) practices – I again refer to the intrinsic compulsion related to the restrictive and circumscribed interests and – thus – the likelihood that they will be, in isolation, particularly difficult to extinguish.
>
> 9.6.12. As such, overall, it is my opinion that [AA] fails to understand and weigh the information relationship to the decision and – thus – lacks capacity to make decisions with regard to his engagement in AEA and associated practices for sexual gratification."

22. In relation to AA's capacity to make decisions in respect of the use of internet and social media, Dr Ince considered that whilst AA is able to understand and retain the relevant information, he is unable to weigh this information and cannot transfer the information from one specific scenario to another. He noted that:

> "9.7.12. I do, however, express significant concern with regard to [AA]'s ability to weigh the information relevant to the decision given his current actions and engagement with an individual of whom he has no confirmed information. I am similarly concerned that his circumscribed interests as a core component of his ASD drive his social interactions and use of social media and – thus – lead to engagement with a range of practices that are inherently risky and lead him to engage in behaviours, conversations, practices and the sharing of information that sits at the threshold between what would be considered rude and offensive and what would be considered illegal.
>
> 9.7.13. I also would suggest to the Court that [AA] demonstrates knowledge for scenarios upon which he has been taught, but cannot transfer these to current or future scenarios – [AA], as a consequence of his ASD is, through necessity, an experiential learner, however in this area, such actions may cause him and others significant harm.
>
> 9.7.14. I would agree that [AA] is at significant risk of sexual exploitation and – further – at significant risk, perhaps inadvertently, of being a perpetrator of acts or sharing images/media that are illegal or would be considered under the umbrella of extreme pornography.
>
> 9.7.15. Overall, it is my opinion that [AA] continues to lack the ability to transfer skills from one specific scenario to another, continues to engage in similar practices and the sharing of interests and sexual fantasies albeit, currently, in a manner that is within the specific boundaries that have been set for him (although with evidence that these boundaries are being challenged and pushed)"

23. In light of Dr Ince's conclusions it would follow that AA lacks capacity to have contact with others online, at least, in respect of his sexual interests.

24. During the course of his oral evidence Dr Ince noted that AA had not undergone a sensory profile assessment. He considered this was a crucial assessment which would enable a much clearer understanding of the impact of ASD on AA's life and his capacity to make decisions: it was key to his whole life. A particular focus in Dr Ince's evidence was whether AA's engagement in AEA was a feature of his ASD or a personal preference to achieve sexual gratification. In the absence of a sensory profile, Dr Ince tended to the view that it was a manifestation of his ASD and, in any event, his inability to weigh the relevant information regarding AEA and his inability to cross-transfer skills and knowledge resulted from his ASD.

25. Mr McKendrick QC, counsel for AA by his litigation friend, the Official Solicitor, put to Dr Ince that in a recent conversation with his solicitor regarding his practice of AEA, AA appeared to evidence an ability to weigh information regarding AEA, in particular, the inherent dangerousness of the practice and risks of brain damage and/or death. Dr Ince was not persuaded this was the case and observed that AA's carers were concerned that AA was adept at seeking to satisfy the expectations of the court and of the professionals involved with AA. I note Ms Y's (AA's social worker) evidence that AA is skilled in answering questions. He had a script which if he was pushed to deviate from his common response was that it was too difficult to answer. Dr Ince maintained his opinion and assessment of AA.

26. Dr Burchess had listened to Dr Ince's evidence but this had not caused him to change the opinions as expressed in his reports. He agreed it was important that AA underwent a sensory profile assessment which would inform a better understanding of AA's ASD and its impact on his life. Dr Burchess considered there was a lack of clarity about AA's needs and requirements. AA needed the support of a well-led multidisciplinary team to:

    i) formulate an intervention plan;

    ii) provide therapeutic support;

    iii) psychological education; and

    iv) a risk management plan.

    He was concerned that AA had limited scope for social interaction.

27. When asked whether AA was able to use and weigh information about the practice of AEA, he said he did not know and was unaware of who had spoken to AA about the risks of AEA. He later observed that AA underestimated his need for support. Dr Burchess told me he had not been instructed to assess AA's capacity to engage in AEA: in fact, as Mr McKendrick QC pointed out to the doctor, the request to assess AA's capacity on this issue had been included in Dr Burchess' letter of instruction.

28. Ms Y spoke of her good working relationship with AA. She told me about the extensive efforts the local authority had made to provide support for AA particularly

in relation to his engagement in AEA: all to no avail to date. The current care arrangements and restrictions on AA's liberty are:

i) one to one staffing at all times with visual checks every 10 minutes throughout the day and every 15 minutes when he is asleep;

ii) no unsupervised access in the community or social time;

iii) his mobile phone is checked every evening by a member of staff; and

iv) his bedroom is searched by the staff twice per day.

29. When I met with AA prior to the hearing, he was clear that he found these restrictions too invasive and he wished for them to be removed or reduced. Ms Y told me that the current care provider would not be able to maintain the placement if these restrictions were reduced because of the risks of AA harming himself or unintentionally causing his own death. She did accept that the local authority should consider a reduction in the restrictions to give AA some private time and increase his autonomy. If AA engaged in therapeutic support when available, she would then be encouraged to take steps to reduce the support/ restrictions.

Submissions

30. Mr Allen, counsel for the local authority, invited the court to accept the evidence of Dr Ince and to make declarations that AA lacked capacity to make decisions about engaging in AEA and to make decisions about his use of the internet and social media. If I made the declarations, it was submitted that I should also authorise the current package of restrictions on AA, set out at paragraph 28 above, which amount to a deprivation of liberty.

31. The provisions of s.27 of the Mental Capacity Act 2005 preclude the court from making a decision on behalf of a person in the context of family relationships and specifically, in the context of this case, to consenting to have sexual relations: s.27(1)(b) Mental Capacity Act 2005. Accordingly, Mr Allen submitted that if I found that AA lacked capacity to engage in AEA, no best interests on this issue fell to be made.

32. The local authority will be referring AA to the Complex Care Team to obtain the multidisciplinary support which Dr Burchess advised that he requires. The local authority recognised the need to prepare a comprehensive TZ care plan for AA.

33. The Official Solicitor submitted, in accordance with the opinion of Dr Burchess, that AA had capacity to make decisions in respect of:

i) his residence;

ii) his care and support arrangements;

iii) his contact with others; and

iv) to consent to sexual relations.

The local authority agreed with these submissions.

34. I was reminded of the purpose of the Mental Capacity Act 2005 by reference to two observations of Baroness Hale:

    i) In *Aintree v* James [2013] UKSC 67 at paragraph 18 where she said "The Act is concerned with enabling the court to do for the patient what he could do for himself if of full capacity, but it goes no further"; and

    ii) In *N v A CCG* [2017] UKSC 22 where she held at paragraph 1 "The Mental Capacity Act 2005 established a comprehensive scheme for decision-making on behalf of people who are unable to make the decision for themselves. The decision-maker - whether a carer, donee of a power of attorney, court-appointed deputy or the court - stands in the shoes of the person who is unable to make the decision - known as P - and makes the decision for him. The decision has to be that which is in the best interests of P. But it is axiomatic that the decision-maker can only make a decision which P himself could have made."

35. Mr McKendrick QC noted there is no reported case law on capacity to make decisions in respect of AEA. He submitted that this is a different decision from one to consent to sexual relations, not least because the relevant information is plainly different.

36. I was referred to the decision of the Court of Appeal in *B v Local Authority* [2019] EWCA Civ 913 where capacity to engage in the use of social media was in issue. The court approved Cobb J's list of relevant information namely:

> "i) Information and images (including videos) which you share on the internet or through social media could be shared more widely, including with people you don't know, without you knowing or being able to stop it;
>
> ii) It is possible to limit the sharing of personal information or images (and videos) by using 'privacy and location settings' on some internet and social media sites;
>
> iii) If you place material or images (including videos) on social media sites which are rude or offensive, or share those images, other people might be upset or offended;
>
> iv) Some people you meet or communicate with ('talk to') online, who you don't otherwise know, may not be who they say they are ('they may disguise, or lie about, themselves'); someone who calls themselves a 'friend' on social media may not be friendly;
>
> v) Some people you meet or communicate with ('talk to') on the internet or through social media, who you don't otherwise know, may pose a risk to you; they may lie to you, or exploit or take advantage of you sexually, financially, emotionally and/or physically; they may want to cause you harm;

> vi) If you look at or share extremely rude or offensive images, messages or videos online you may get into trouble with the police, because you may have committed a crime."

As the Court of Appeal observed, at paragraph 44 of the judgment, this list is only guidance which must be tailored to the individual case. Albeit on the facts of this case, the Official Solicitor submitted that Cobb J's list could be applied to AA without amendment.

37. In relation to the issue of capacity to engage in AEA the Official Solicitor made the following helpful submissions:

> "33. The following specific points must be made:
>
> a. In as much as [AA] has unusual sexual interests and derives pleasure from those, as long as they remain within the law, these are private matters for him and all professionals must approach him and his interests in a non-judgemental fashion;
>
> b. AEA is dangerous and [AA] is at risk of injury or death should he continue to practise it;
>
> c. It is very important, whether he has or does not have capacity, that he is assisted to be offered, and accept, a package of sexual education that embraces his sexual interests and the safe(r) AEA practices;
>
> d. his decision making should be seen in the context of Dr Burchess' cogent conclusions that [AA] has capacity in all areas of life and in particular he has capacity to consent to sexual relations, which incurs the risk of life altering sexually transmitted disease; and
>
> e. [AA] is currently being deprived of his liberty because of the risks to his health of AEA - these are significant restrictions for a young man about to turn 19.
>
> 34. The following broader points are also made:
>
> a. all adults, whether capacitous or not, are entitled to a zone of private life in which they can explore their sexuality and seek solitary pleasure, whether from masturbation, other self-stimulatory behaviour, watching pornography or using sex toys;
>
> b. the state must be vigilant to afford those who are considered to be of borderline capacity, autistic or learning disabled a clear zone of privacy in respect of solitary sexual practices, the state has very limited role to assess capacity or

> make best interests decisions in these area: every incursion is an affront to human dignity and private life; and
>
> c. professionals must be alive to the fact that unusual sexual practices may be difficult to assess from the perspective of capacity, because the mechanics of such acts and the pleasures derived from them are unchartered and/or unknown territory.
>
> 35. The Official Solicitor submits than in the vast majority of self-stimulatory sexual practices there is no role for capacity assessments and best interests decisions. That is because there are limits to the state's entitlement to interfere with adults' private lives. A failure to respect this boundary is a gross incursion into the dignity and humanity with which all adults are entitled to lead their lives. There is a risk of discrimination against the learning disabled and others with incapacity, should private practices become the subject of public assessment.
>
> 36. That being said, the state must also accept where those self-stimulatory sexual practices incur a risk of serious harm, the state has a role to protect adults who lack capacity to make such decisions. The Official Solicitor has considered, as a matter of public policy and statutory construction, whether the applicant, and this court, have any proper role to conduct a capacity assessment of [AA]'s decision making in respect of AEA. There is an argument that unlike sexual relations which involves another partner, the state's role should be limited and circumscribed. But, on balance, the risk of death/hypoxia of AEA leads to the conclusion that unlike most other self-stimulatory practices, a capacity assessment is not inconsistent with public policy and the language of the Act."

38. If the court concluded that AA lacked capacity to make decisions about contact with people who he met online, then the Official Solicitor submitted that the local authority should be directed to draft a *TZ (No.2)* care plan for the court's approval.

39. If the court concluded that AA lacked capacity to make decisions about engaging in AEA, then the Official Solicitor submitted that the best interest decision is more complex. The following written submissions were made:

> "48. First, it is submitted the court should not step into [AA]'s shoes to make a best interest decision for him. The court cannot weigh up and use the relevant information (pleasure versus risk of harm) on [AA]'s behalf as the court cannot weigh up the highly subjective factors of sexual pleasure and risk in an objective way to reach a decision.
>
> 49. Secondly, such an approach is consistent with section 27 MCA which imposes a statutory prohibition on best interests decisions being made in respect of P's consent to sexual

> relations. A solitary sexual practice, whilst very different from sexual relations, should be approached in broadly the same manner.
>
> 50. Thirdly, it would amount to a violation of [AA]'s Article 8 ECHR right to respect for a private life, for his intimate, private sexual life to be analysed in this way.
>
> 51. Overall, it is contrary to public policy for the court to make a best interests decision whether AEA is or is not in P's best interests, notwithstanding the fact that AEA is not unlawful.
>
> 52. Does this have the effect that the court is powerless to protect [AA] from serious harm if he lacks capacity to decide about AEA? It is submitted, that if he does lack that capacity, then the court must assess whether or not he has capacity to accept support, should he decide (incapacitously) to carry out AEA. The written evidence does not directly touch on this point and it may need to be explored in questioning."

40. At the conclusion of the evidence of Dr Burchess, Dr Ince and the social worker, the Official Solicitor's primary submission was that the local authority had failed, on the balance of probabilities, to rebut the presumption of capacity in respect of decisions about engaging in AEA and to have contact with people he met online. In respect of the former, the local authority had failed to establish that AA's ASD caused him to engage in AEA or precluded him from making a capacitous decision in respect of this domain.

41. In respect of the latter, the Official Solicitor invited the court to accept the evidence of Dr Burchess that AA had capacity to make decisions in respect of contact with people he met online, notwithstanding that by having contact AA would put himself at risk of harm and could well make unwise decisions. It was submitted that, once again, the local authority had failed to rebut the presumption of capacity.

42. The Official Solicitor's (very much) secondary position was that if the court was minded to conclude that AA lacked capacity to make decisions about AEA or contact online, the court should not make s.15 declarations, but instead should make s.48 declarations on the basis that the court had reason to believe that he lacked capacity to make those decisions.

Analysis

43. The restrictions under which AA currently has lived are indeed burdensome and invasive. I am satisfied they have been necessary and were in his best interests. I have to determine what capacity he has or does not have in various domains and to determine whether these restrictions are legitimate in light of his capacity or incapacity and whether, if so, they are necessary and proportionate.

44. Without reservation I accept the conclusions of Dr Burchess that AA now has capacity to conduct these proceedings and to make decisions about his residence, care and to have sexual relations. The issues in dispute are whether AA has capacity to

make decisions about his engagement in AEA and in relation to his contact with people he meets online.

45. I accept the general principles and approach advanced by the local authority and by the Official Solicitor. I accept that these issues engage the most private and personal of AA's Article 8 rights and that the State should be very slow and cautious to interfere with the same.

46. Capacitous individuals engage in AEA notwithstanding that it is an inherently dangerous practice which carries a very real risk of acquired brain damage or unintentional death. Many capacitous individuals engage in contact with strangers on the internet or on social media which puts, or may put them, at risk of physical, sexual, emotional or psychological harm. They are entitled to make an unwise decision.

47. I also accept that in approaching the issues in this case I must not adopt an approach based on a moral judgment about AEA or on contacting strangers on the internet or social media. Nor must I adopt a protective stance towards a person when determining whether they have capacity to make a decision to engage in AEA notwithstanding that they are very likely to make an unwise or risky decision.

48. I accept the evidence of Dr Ince that the impact of AA's diagnosis of ASD is largely unassessed and that a sensory profile assessment is required to begin to understand the same. Nevertheless on the current understanding of the impact of AA's diagnosis of ASD and on the basis of his assessment of AA, Dr Ince is of the view that AA's engagement is a manifestation of his ASD. Moreover Dr Ince is of the opinion that because of his ASD, AA is more likely to be preoccupied with and obsessively engage in AEA than would otherwise be the case. Furthermore Dr Ince is satisfied that AA's ASD renders him incapable of weighing relevant information about AEA and cross-transferring information from one specific situation to another.

49. I accept the relevant information for AA to make a decision in respect of AEA is as set out in paragraph 18 above. I have considered whether the impact on others (e.g. close family members) in the case of acquired brain injury or death as a result of engaging in AEA is a relevant factor. I have concluded it is not. I accept it would set the bar too high in comparison to capacitous adults who engage in the practice of AEA.

50. I accept Dr Ince's evidence and his conclusions that, on the current evidence, there is reason to believe that AA's engagement with AEA is a manifestation of his ASD (the diagnostic test) and that he is unable to weigh information about this practice or cross-transfer information because of his ASD (the functional test).

51. I note and I am particularly concerned by Dr Ince's opinion that:

    i) AA potentially has a high threshold to sensory stimulus and thus may require a higher level of stimulus to achieve the same outcome; and

    ii) AA's 'addiction' and intrinsic compulsion to engage in AEA, and other restrictive and circumscribed interests, are likely to render it difficult to change his behaviour.

Accordingly, in my judgment AA is at high risk of being unable to regulate his engagement with AEA and therefore at greater risk of serious harm or death.

52. I also prefer and accept the evidence of Dr Ince that AA does not have capacity in relation to contact with those people he meets online because of his ASD and because of his inability to weigh information and to cross-transfer information.

53. Neither Dr Burchess nor Dr Ince had considered the issue of whether AA had the capacity to consent to support when he engaged in AEA. Both considered the issue and the concept difficult. Neither felt able to offer an opinion. In the premises I propose to 'park' this issue and return to it at a later stage if clear and cogent evidence is available to enable me to determine this issue.

Conclusions

54. I find on the balance of probabilities that there is reason to believe that AA does not have capacity to make decisions in respect of engaging in AEA nor in respect of contact with people he meets online. Accordingly I consider the interim criteria of s.48 of the Mental Capacity Act 2005 are satisfied.

55. In relation to AA's engagement in AEA, I accept the agreed position of the parties that no best interest decisions fall to be made because it would be contrary to s.27(1)(b) or, at least, the philosophy of this provision for the court to make a decision in respect of AEA on AA's behalf.

56. In relation to AA's contact with others he meets online, I agree the local authority should draft a care plan for the court's approval.

57. In this case a best interests framework needs to be developed which:

    i) enables the professionals and the court to be better informed about the impact of AA's ASD on his life and his functioning;

    ii) enables the professionals and the court to better understand how AA can be supported to gain capacity to make decisions about these two issues; and

    iii) permits AA sufficient autonomy of decision making and respects his right to a private life whilst balancing the need to protect him from harm.

58. It is crucial that a sensory assessment of AA is undertaken as soon as possible.

59. With the benefit of this assessment, the local authority must draft a detailed care and support plan. AA needs to be provided with an education program to enable him to understand alternative means of obtaining sexual gratification other than by engaging in AEA and enable him to contact others online safely and securely or, at least, to be able to weigh and understand the risks at which he places himself by this activity.

60. It is essential that therapy is made available to AA to deal with his past experiences and to explore how his ASD has an impact on his day-to-day life. I have no doubt that AA will readily engage with this therapeutic process.

61. AA is subject to very invasive restrictions. At the moment they are necessary to protect him and to ensure his life is not unnecessarily endangered. I would hope that the local authority and the care provider will give anxious consideration to the degree, if at all, to which some of the restrictions may be reduced, pending the outcome of the assessments, education and therapy referred to above. Such reductions if safely achievable will recognise AA's right to a private life and will increase his autonomy.