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Case No: 11946155

IN THE HIGH COURT OF JUSTICE
COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 30/06/2011

Before :

THE HONOURABLE MR JUSTICE BAKER

- -

Between :

PH	**Applicant**
- and -	
A LOCAL AUTHORITY	**First Respondent**
- and –	
Z LIMITED	**Second Respondent**
-and-	
R	**Third Respondent**

- -
- -

Fenella Morris (instructed by **CVC Solicitors, on behalf of the Official Solicitor**) for the **Applicant**
Laura Davidson (instructed by **the local authority's in-house legal team)** for the **First Respondent**
Katharine Scott (instructed by **Radcliffes LeBrasseur**) for the **Second Respondent**
Amy Street (instructed by **Conroys**) for the **Third Respondent**

Hearing dates: 9th and 10th June 2011

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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 BAKER

This judgment is being handed down in private on 30 June 2011. It consists of 17 pages and has been signed and dated by the judge. The judge hereby gives leave for it to be reported.

The judgment is being distributed on the strict understanding that in any report no person other than the advocates or the solicitors instructing them (and other persons identified by name in the judgment itself) may be identified by name or location and that in particular the anonymity of the children and the adult members of their family must be strictly preserved.

MR JUSTICE BAKER :

INTRODUCTION

1. The issue arising in this case is whether PH, a forty-nine year old man, suffering from Huntingdon's Disease ("HD") has the capacity to make decisions about his residence, care and treatment.

2. The issue comes before the Court of Protection as a result of an application dated 26 January 2011 by PH under section 21A of the Mental Capacity Act 2005 seeking an order for the termination of a standard authorisation made by the local authority for the area in which he lives ("the local authority") permitting the authority to keep PH at a residential home ("Y Court") run by a company ("Z Limited"). The application challenges the conclusion of the local authority as the supervising body under the Deprivation of Liberty Safeguards ("DOLS") that PH meets two of the qualifying requirements for a standard authorisation, namely the capacity requirement and the best interests requirement, and further challenges the purposes and conditions of the standard authorisation. It has been agreed between the parties to this application that the question whether the capacity requirement is met should be dealt with as a preliminary issue. Other issues may have to be considered at subsequent hearings depending on my decision on the question of capacity, although it seems that a consensus is emerging concerning those matters as a result of negotiations that have been ongoing between the parties.

3. The narrow question I have to decide is whether the capacity requirement is satisfied, that is to say whether the local authority has proved on a balance of probabilities that PH lacks capacity in relation to the question whether or not he should be accommodated at Y Court for the purposes of being given care and treatment.

4. Under section 15 of the 2005 Act however, the Court of Protection has the power to make a wider declaration as to whether a person has or lacks capacity to make a decision and, as rule 27 of the Court of Protection Rules 2007 makes clear, that power can be exercised by the court "on its own initiative". Thus, I have been asked at this hearing to address a wider question, namely whether PH has the capacity to make decisions concerning his residence and care.

BACKGROUND

5. HD is a genetic degenerative neurological disorder that affects muscle coordination and leads to cognitive decline and dementia. It commonly begins in middle age and almost invariably leads to a gradual decline and a reduced life expectancy. As the disease advances, the patient suffers from involuntary movements called chorea which become steadily more apparent, along with a decline in cognitive abilities. In addition, the patient exhibits increased behavioural problems. There is sadly as yet no cure for HD and in the latter stages of the disease the patient requires full time care.

6. PH was born in 1961. For over twenty years he was in a relationship with another man, R. In 2000, PH was diagnosed with HD and for the next ten years he was cared for, with great devotion, by his partner R. As is invariably the case with sufferers of HD, his condition steadily deteriorated and his behaviour became erratic and volatile. As a result, he became gradually harder to look after and manage. R received a

limited amount of support from outside agencies, but PH was unhappy about being looked after by anybody other than R. Like many HD sufferers, he developed an inability to understand the extent of his care needs, and the impact of those needs on his carer.

7. Eventually, it was arranged by R and those assisting him, including PH's social worker D, that PH would be admitted to Y Court, a unit which specialises in the care of persons suffering from HD. On 25 November 2010, R drove PH to Y Court, pretending that their visit would be temporary, and then left him there. On the following day, Z Ltd, as the managing authority responsible for Y Court, gave an urgent authorisation under Schedule A1 of the 2005 Act for the detention of PH at Y Court for seven days. Not surprisingly, PH's behaviour during the initial period of his detention at Y Court was disturbed and on occasions violent.

8. On 7 December 2010, the local authority, having carried out the assessments required by the schedule and satisfied itself that the qualifying requirements were met, gave a standard authorisation for PH's ongoing detention at Y Court. It was the clear view of the doctors responsible for treating PH, and his social worker D, that he lacked the capacity to make decisions about his residence. The authorisation purported to have been backdated to 3 December, the date on which the urgent authorisation had expired. The question of whether a supervising authority has the power to backdate a standard authorisation and, if so, whether that power was lawfully exercised in this case, has not been argued so far in these proceedings.

9. PH continued to display difficult and occasionally violent behaviour. He telephoned the police from Y Court on a number of occasions asking to be "rescued". On 14 December, he was assessed under the Mental Health Act but found to be not suffering from a mental illness that required him to be sectioned under that Act. On 6 January 2011, a best interests meeting, attended by the relevant professionals and R, concluded that further assessments should be carried out, that a move would not at that stage be in PH's interests, and that he should therefore remain at Y Court. On 14 January, a further standard authorisation was issued by the local authority and further such authorisations have been issued thereafter. The current authorisation expires on the 7 July.

10. On 26 January, the application under Section 21A of the Mental Capacity Act 2005 was made by solicitors on PH's behalf, challenging the standard authorisation. The respondents to the application are the local authority, Z Limited, and R. Preliminary directions were given two days later by a District Judge sitting at Archway, including an that order that the case be transferred to the Royal Courts of Justice to be heard by a High Court Judge. On 7 February, the matter was listed before me for the first time. On that occasion I made an interim declaration pursuant to section 48 of the 2005 Act that there was reason to believe that PH lacked the capacity to make decisions as to where he should reside. I gave further directions, including granting permission to the parties to instruct an independent psychiatrist to provide a report on PH's capacity to litigate and to make decisions concerning his care, treatment, residence and contact. Pursuant to that direction, Dr Hugh Rickards, a consultant neuro-psychiatrist, well respected as an expert in HD, was duly instructed.

11. When the matter came back before me on 24 March, the Official Solicitor agreed to act as litigation friend for PH. I renewed the interim declaration as to PH's lack of

capacity and gave further directions for a trial of the issue to be listed on the first available date after 12 May.

12. On 8 April, Dr Rickards filed his report, in which he recorded his view that PH did have the capacity to make decisions as to his residence. As this was contrary to the view held by the medical professionals responsible for treating PH, it became clear that a contested hearing as to capacity would be required. For various reasons, the hearing on 12 May listed before Hogg J did not proceed and the matter was listed to come back before me on 26 May. On considering the evidence filed, however, it became apparent that the time allowed (one day) would be insufficient to complete the hearing, which involved taking oral evidence from seven witnesses as well as legal argument on behalf of the four parties plus extensive reading time. I was, however, able to accommodate the case on circuit on 9 and 10 June and therefore adjourned the matter to those dates. The order on 26 May recorded that PH would be willing to remain at Y Court until the hearing on 9 June on the basis that suitable arrangements were being made for alternative accommodation in the event that he was found to have capacity.

THE LAW

13. Schedule A1 of the 2005 Act permits the manager of a care home lawfully to deprive a person of their liberty provided that the person meets the requirements of a standard authorisation.

14. The six qualifying requirements of a standard authorisation include, under paragraph 12(1)(c) of the schedule, "the mental capacity requirement". Paragraph 15 of the schedule provides that "the relevant person meets the mental capacity requirement if he lacks capacity in the relation to the question of whether or not he should be accommodated in the relevant… care home for the purpose of being given the relevant care or treatment".

15. When a standard authorisation has been made by a supervisory body, section 21A(2) empowers the Court of Protection to determine any questions relating to, inter alia, whether P meets one or more of the qualifying requirements. But once an application is made to the Court under section 21A, the Court's powers are not confined simply to determining that question. In particular, once the court determines the question, it may make an order varying or terminating the standard authorisation: section 21(3)(a). In addition, once its jurisdiction is evoked under section 21A the court has a discretionary power under section 15 to make a declaration as to whether P lacks capacity to make any decision. Once such a declaration is made, the court has wide powers under section 16 to make decisions on P's behalf in relation to matters concerning his personal welfare or property or affairs.

16. When addressing questions of capacity, the Court must apply the following principles.

    i) A person must be assumed to have capacity unless it is established that he lacks capacity: section 1(2). The burden of proof therefore lies on the party asserting that P does not have capacity.

    ii) The standard of proof is the balance of probabilities: section 2(4).

iii) 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). As paragraph 4.46 of the Mental Capacity Act 2005 Code of Practice makes clear, "it is important to assess people when they are in the best state to make the decision, if possible".

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

v) 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: section 2(1). This first question is sometimes called the "diagnostic test".

vi) For the purposes of section 2, a person is unable to make a decision for himself if he is unable to (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: section 3(1). These four factors comprise the second question which is sometimes called the "functional test".

vii) The Code of Practice gives guidance as to the meaning of the four factors in the functional test. Thus, so far as the first factor is concerned - understanding information about the decision to be made – paragraph 4.16 provides: "It is important not to assess someone's understanding before they have been given relevant information about a decision. Every effort must be made to provide information in a way that is most appropriate to help the person understand".

viii) The Code also gives guidance concerning the third of the four factors – using or weighing information as part of the decision-making process. Paragraph 4.21 provides "for someone to have capacity, they must have the ability to weigh up information and use it to arrive at a decision. Sometimes people can understand information, but an impairment or a disturbance stops them using it. In other cases, the impairment or disturbance leads to a person making a specific decision without understanding or using the information they have been given."

ix) Further helpful guidance as to the interpretation of the functional test is given by Macur J in LBL v RYJ [2010] EWHC 2664 (Fam). At paragraph 24 of the judgment, the learned judge said:

> "I read section 3 to convey, amongst other detail, that it is envisaged that it may be necessary to use a variety of means to communicate relevant information, that it is not always necessary for a person to comprehend all peripheral detail and that it is recognised that different individuals may give different weight to different factors."

x) Later, at paragraph 58 of the judgment, the learned judge indicated that she agreed with the interpretation of the section 3 test advanced by the expert in

that case (which, coincidentally, was Dr Rickards) namely that it is "to the effect that the person under review must comprehend and weigh the salient details relevant to the decision to be made".

xi) In Sheffield City Council v E [2004] EWHC 2808 (Fam) (a case concerning the capacity to marry decided before the implementation of the 2005 Act) Munby J (as he then was) said (at paragraph 144):

> "We must be careful not to set the test of capacity to marry too high, lest it operate as an unfair, unnecessary and indeed discriminatory bar against the mentally disabled".

Although that observation concerned the capacity to marry, I agree with the submission made by Miss Morris on behalf of the Official Solicitor in this case that it should be applied to other questions of capacity. In other words, courts must guard against imposing too high a test of capacity to decide issues such as residence because to do so would run the risk of discriminating against persons suffering from a mental disability. In my judgement, the carefully-drafted detailed provisions of the 2005 Act and the Code of Practice are consistent with this approach.

xii) The 2005 Act generally, and the DOLS in particular, are compliant with Article 5 of the European Convention for the Protection of Human Rights and Fundamental Freedoms – see my earlier decision in G v E [2010] EWHC 621 upheld by the Court of Appeal at [2010] EWCA Civ 822 and in particular paragraphs 24-25 and 57 of the judgment of Sir Nicholas Wall P in the Court of Appeal. Just as there is no justification for imposing any threshold conditions before a best interests assessment under the DOLS can be carried out (the point taken up unsuccessfully by the appellants in G v E) so in my judgment there is no reason for adopting the approach advocated by Miss Morris on behalf of the Official Solicitor in this case, namely that a finding of a lack of capacity should only be made where the quality of the evidence in support of such a finding is "compelling". Equally, it is unnecessary for the court to adopt an approach, also advanced by Miss Morris on behalf of the Official Solicitor, that the statutory test should be construed "narrowly". The statutory scheme is, as I have already observed, carefully crafted. I agree with the submission made on behalf of Z Limited (in written submissions by Mr Vikram Sachdeva who did not appear at the hearing) that the question of incapacity must be construed in accordance with the statutory test – "no more and no less".

xiii) 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 many cases the evidence of other clinicians and professionals who have experience of treating and working with P will be just as important and in some cases more important. In assessing that evidence, the court must be aware of the difficulties which may arise as a result of the close professional relationship between the clinicians treating, and the key professionals working with, P. In Oldham MBC v GW and PW [2007] EWHC136 (Fam) [2007] 2 FLR 597, a case brought under Part IV of the Children Act 1989, Ryder J referred to a "child protection

> imperative", meaning "the need to protect a vulnerable child" that for perfectly understandable reasons may lead to a lack of objectivity on the part of a treating clinician or other professional involved in caring for the child. Equally, in cases of vulnerable adults, 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. Having identified that hypothetical risk, however, I add that I have seen no evidence of any lack of objectivity on the part of the treating clinicians and social worker who gave evidence in this case.

THE EVIDENCE

17. A substantial body of paperwork was put before me to assist in the decision as to capacity, and six witnesses gave oral evidence, namely Dr Rickards, three clinicians who have been treating PH (whom I shall anonymise to protect PH's identity), his key social worker D, and R.

Dr Rickards

18. Dr Rickards is a consultant neuro-psychiatrist employed by the South Birmingham Mental Health Trust. As set out above, he is widely respected as an expert in HD, and has conducted much research and published many articles on the topic. He presented his opinion in a report dated 8 April 2011, supplemented by answers to further questions in a note dated 28 April and a further e-mail dated 5 May.

19. Dr Rickards saw PH at Y Court for about ninety minutes on 7 April. In oral evidence he said that he considered this a sufficient time to form an opinion as to capacity. For some of the interview he asked direct questions, and at other times conducted a general conversation with PH. All of the interview contributed towards his assessment.

20. He described PH as being alert, lucid and orientated during the interview. He showed a sense of humour and was able to follow the general conversation well. He answered all the questions Dr Rickards put to him in an appropriate manner although his language was fairly "stripped down". He was able to describe being shocked and angry at being left at Y Court in November 2010 and how he had been physically restrained and medicated against his wishes.

21. When Dr Rickards asked him what he wanted to happen, PH said that he wanted to go home. When asked who would look after him, he replied "R". When Dr Rickards put it to him that R might be exhausted with caring for him and if so what might then happen, PH replied that he would still like to be at home with some other people looking after him – "a full-time carer". Dr Rickards asked him what sort of things those people would need to do as his carers, and PH replied that he thought they would have to get him up, shower him, dress him, cook meals and do washing for him and take him out everyday to visit other people and cafes. Dr Rickards then asked him what would happen if R no longer wanted to care for him and it was not possible to stay at home. PH told him that he would still like to live in his home town because

"I like it". He was familiar with places and people there as he had lived there for twenty-six years.

22. In his report, Dr Rickards describes how he asked PH about Y Court, and he said that he didn't like it there. Dr Rickards states: "he was able to see some humour in the idea that even if there was something he liked he might not tell me in case he was made to stay there". When Dr Rickards tried to persuade him to say something good about Y Court, PH told him that he really enjoyed horse riding, which he has been able to do while living there, and that he had made some good friends. Asked about his medication, PH said that it had helped his "motor skills". When Dr Rickards asked him to elaborate on this, he said: "my walking is better".

23. In his report, Dr Rickards reaches the following conclusion: "I think that PH does have capacity concerning residence. He clearly understood his residential situation. He showed me that he could process the information and give a reasonable view on how different scenarios at home could be dealt with … he communicated this decision clearly to me. In general terms, I think that PH has capacity around treatment." Dr Rickards was also asked to comment on other aspects of his capacity which are not in dispute and need not be referred to in this judgment.

24. In answer to a supplementary question, Dr Rickards replied by e-mail: "regarding care, I think PH showed to me that he had a broad understanding about different types of care regimes, particularly community versus residential care, and could give me some good reasons for choosing community-based care. PH also showed me that he could reasonably weigh up pros and cons of these different environments. This is documented in my report."

25. In his oral evidence, Dr Rickards was asked by Miss Morris to describe what it was that PH needed to understand in order to make a decision as to his residence. He replied that he thought PH needed to know what the different places might be, to have some idea about his care needs, and who would be expected to do what during the day. As he acknowledged at the end of his evidence, however, PH is aware of some but not all of his care needs. When he asked him about what he thought he might need if he lived in the community, PH said that he needed someone to go out with him but did not mention any specific risks. Dr Rickards accepted that it was for the court to decide whether PH has sufficient understanding of the details of his needs.

26. PH had not mentioned any disadvantages of going home or living anywhere else in the community and had been very reluctant to identify any advantages of staying at Y Court. Dr Rickards felt that he was so concerned about getting home that it was very difficult for him to speak of those factors. Dr Rickards accepted that he could not absolutely say that PH had showed the capacity to weigh up information.

27. In cross-examination, Dr Rickards was asked about the specific risks arising concerning feeding. On the evidence of those responsible for caring for PH, he tends to cram food into his mouth and has difficulty understanding the need to chew. As a result, there is an increased risk that he will choke and/or aspirate food. This is a common problem with sufferers of HD. Dr Rickards expressed the view, that whilst this was a problem for PH, it did not give rise to a severe level of risk. He accepted that caring for someone with HD requires specific understanding and expertise of this risk, and other risks arising with HD.

28. As described below, other clinicians have carried out mental health tests to establish the extent of the limitations of PH's cognitive abilities. Dr Rickards pointed out that these tests were not particularly designed for HD sufferers and did not give him specific information about PH's capacity to make specific decisions.

29. Dr Rickards acknowledged that during his interview, the level of capacity demonstrated by PH seemed to be greater than that observed by others. He suggested that one reason for this might be that PH perceived some of those others as being opposed to his returning home and this might have affected his attitude towards their assessment and his responsiveness during their interviews.

30. Dr Rickards acknowledged that there was a lot of emotion in PH's wish to go home. This is, of course, an entirely normal reaction which would feature in anybody's decision about where they should live. He agreed that the fact that a decision involves such an emotional component does not obviate the need for assessing his capacity to weigh up the decision, but it does make it harder.

Dr. A

31. Dr A is a consultant in old age psychiatry employed by an NHS Trust in a neighbouring county. He has considerable experience in working with patients with HD and other types of dementia.

32. He first saw PH in clinic in July 2008 and has reviewed him subsequently on a number of occasions. He undertook a specific capacity assessment on 23 September 2010 and has seen PH on a number of occasions since his admission to Y Court

33. Reviewing the records of his assessments since 2008, Dr A observed that there is a persistent theme of concerns about PH's cognitive processing powers. He would say repeatedly during those assessments that he wanted to stay at home and not allow or see any reason why R should have a break or go on leave. Dr A thought this was evidence that PH had no insight into his increasingly significant care needs. He describes how PH would not enter any discussion into this or any discussion into wider topics. He could not see that there was any problem or why he could not remain at home.

34. Dr A interviewed PH at Y Court on 19 May 2011, six weeks after Dr Rickards' interview. On this occasion PH was quietly spoken and his speech was markedly hesitant, and repetitive. Dr A undertook formal cognitive testing including a mini-mental state examination and the Addenbrooke's cognitive Examination (ACE-R). Dr A states that both of these rating scales are well validated for use in dementia. PH's score under the mini-mental state examination placed him in a moderate scale for dementia although that examination process has no real tests of frontal lobe function which is a problem in HD. For that reason, Dr A conducted the ACE-R examination which specifically includes frontal lobe testing. PH's score was well below the cut off for dementia. Summarising the outcome of these tests, Dr A said that a prominent feature of these was inattention and lack of concentration plus prominent short term memory impairment. His scores were "significantly lower and reflect the prominent cognitive impairment this patient is experiencing." Dr A then spoke to PH about his future residence. When asked what he would like to happen, PH instantly replied: "I would like to go home". Dr A explored the implications of

his returning home and suggested that R had found it difficult to care for him prior to his admission to Y Court. According to Dr A's report: "PH looked genuinely surprised and taken aback and initially denied that this was the case". He records that PH said: "I don't know why he would find it difficult to look after me". When asked by Dr A what he would need for him to return home, PH replied that he would need someone to look after him, make sure he got up in the morning and had a bath,: "that sort of thing". He told Dr A that he was "protective of people looking after me". When Dr A clarified what this meant, he agreed that he would only want certain people looking after him, and that having a lot of carers would be difficult. When Dr A said to him that it would be impossible to provide care at home with only one carer, PH said "I would deal with it".

35. Dr A conducted a further short interview with PH on 23 May. On this occasion PH was unable to recall Dr A's name. When Dr A asked him what would happen if R could not look after him, PH said that he would see if someone else could come and look after him. He said he thought it would be alright if there were several carers. He then spoke of how R owed him money - £1m – and then went on to say "R would have to come and look after me". He added that he would use the £1m which R owed him to pay for carers.

36. In the conclusion to his report, Dr A addressed the specific factors in section 3(1) of the 2005 Act. He concludes that PH is unable to process complex information due to inattention, lack of concentration and lack of cognitive function. In Dr A's opinion, his residence and care needs amount to complex information. PH, in Dr A's view, clearly cannot understand his need for intense twenty four hour care". Dr A further believes that his ability to retain information is limited because of his prominent short term memory impairment. As to the capacity to use or weigh up the information, he concludes: "PH has prominent attention difficulties and lack of concentration which severely impair his ability to weigh up information. He can clearly decide whether he wants to drink or a cup of tea but on more complex matters such as where he is residing [he] is unable to understand and process and assess the difficulties that are involved in such a decision." Dr A accepts, however, that while finding speech difficult, PH has the ability to communicate a decision.

37. Dr A adhered to his opinion in his oral evidence. Whilst having the ability to communicate a decision, he lacks the three other specific capacities defined in section 3(1). He reiterated in reply to Miss Davidson on behalf of the local authority that PH is very limited in insight about his care needs. While he says that he is able to manage it, Dr A does not think he appreciates the extent of those needs. Cross examined by Miss Morris on behalf of the Official Solicitor, Dr A acknowledged that there is an emotional element in the question of future residence but "there are other processes going on". Miss Morris also asked whether, if PH lacked the capacity to make a decision about his residence at this stage, he could acquire such capacity at a later date by the concrete experience of being at home with carers. Dr A thought this was unlikely.

Dr. B

38. Dr B has been the general practitioner for Y Court for the last eighteen years. During that time, he has cared for more than two hundred patients with HD. Thus, in contrast

with most GPs, who will see only a handful of HD sufferers during their entire careers, Dr B has very considerable experience of this disease.

39. Dr B has seen PH on a number of occasions since his admission to Y Court. In his report dated 9 May 2011, he describes, how over the course of the previous five and a half months since his admission, "there is no doubt that PH's condition has deteriorated. Physically he has lost weight and his mobility is increasingly compromised… there is also a transparent cognitive decline. His conversation – previously with greater scope and range – has become very one-dimensional. He lacks insight into the needs of other residents, not from malice but diminished comprehension as his ability to register the situations around him is evaporating." Dr B describes how PH is not orientated in either time or space and is "ever fixated on his wish to go home".

40. It is Dr B's clear view that PH lacks the capacity to make the decisions about his future residence. "PH, like many other patients with his condition, has developed an obsession, his being his desperation to return to live at home. He no longer has the mental ability to evaluate the practicalities that this would entail, and lacks the insight required to assess the overall situation." Like Dr A, Dr B addresses in his report the four specific features of capacity in section 3(1) of the 2005 Act. Like Dr A, Dr B believes that PH has the ability to express himself but is lacking in respect of the other three features. He describes how during his visit on 9 May, PH repeatedly asked the charge nurse for some chocolate and was unable to recall her repeated explanation that they had run out of stock and that had sent out for more. Dr B observes that as PH is unable to understand that there is no chocolate in the building, he is "equally incapable of understanding the far more complex issues relating to where he is to live". Given that he was unable to recall what he had been told about the chocolate, he would, in Dr B's view, be equally unable to retain any information regarding the issue surrounding where he is to live. Furthermore, Dr B believes that he cannot process even the simplest of information. Dr B concludes: "my assessment is unequivocal. PH does not currently have capacity and will never regain it."

41. Dr B visited PH again at Y Court on 25 May and conducted another mini-mental health assessment which reached the same conclusion as that carried out by Dr A.

42. In his oral evidence, Dr B stressed that he did not think that PH needs to stay at Y Court. He believes that he should be living in the community. However, Dr B stressed that this is a very different question from whether he has the capacity to make that decision.

Dr. C

43. Dr C is another GP with specific additional expertise in this field. As well as being a police surgeon, he has qualifications in medical law including a Master of Law degree. Since the implementation of the 2005 Act, he has been an independent DOLS assessor on the regional DOLS register. He has carried out various assessments of PH's mental capacity and mental health since his admission to Y Court.

44. He saw PH last on 5 April 2011 to carry out a further assessment. He conducted a further mini-mental health examination which produced results similar to those given by the examinations conducted by the other doctors and demonstrated that PH is

suffering from cognitive impairment. According to Dr C, he was not orientated in time, although he was to place and person, and his short term memory was significantly impaired. Dr C concluded that PH was not able to weigh up the information concerning his future residence due to poor insight into his physical and mental health condition adding to the limitation of his own capabilities and what his care needs entail. Dr C observes: "this lack of insight and understanding of limitations prevented him from balancing the pros and cons remaining at Y Court".

45. Dr C was particularly concerned about PH's lack of understanding about his problem with personal hygiene and swallowing and his reluctance to accept help with these problems. In oral evidence, Dr C reiterated that PH has poor insight into his health condition and the limitation of his abilities, and what his care needs are. He insisted to Dr C that he was able to do things for himself, which he manifestly is unable to do. Dr C pointed out that the swallowing problems are particularly acute, given that one third of people with HD die with problems of aspiration or associated pneumonia. Cross-examined by Miss Morris, Dr C described how he had discussed this issue with PH. He had told him that according to staff he was now having difficulty with swallowing and eating but for PH, it was "not a problem". In Dr C's opinion, this minimisation of the problem demonstrates his lack of understanding as to his care needs and his incapacity to weigh up the pros and cons involved in the decision about his future residence.

D, the allocated social worker

46. D is employed by the local authority in its team working with older people and persons with physical disability and has been PH's allocated social worker since 28 July 2010. On that date, she carried out an assessment of his capacity, and since his admission to Y Court has carried out four further capacity assessments. On each occasion, she concluded that he did not have the mental capacity to make an informed decision about his place of residence.

47. Her latest assessment was carried out on 7 June, two days before the hearing. In that assessment, she dealt, as on previous occasions, with the specific factors in the functional test in section 3(1). She concluded that PH could not understand that, due to his own physical limitation and the risks that are currently present, he required twenty-four hour supervision. He wishes to return to his former home but was, on the occasion of her visit on 7 June, explicit in saying that he did not wish R to reside in the property with him. D felt that, due to PH's limited insight into his own abilities and care needs, he does not appear to be retaining information with regard to his place of residence or care needs. During her assessment, he became confused and disorientated and was unable to recall information such as what he had had for lunch, or the name of the horse he rides on a regular basis. He appeared fixated on the notion of returning home and would not consider any alternative form of accommodation. He said that he needed the help of one male carer with cooking but no other assistance with activities or daily living in the community. According to D, he seemed unable to consider the risk that may be present to himself and others in the community. She concluded that he was unable to weigh up the information that they were discussing with regard to either to his place of residence or to his care needs. D thought that PH did have the ability to communicate verbally, although not always in an appropriate manner.

48. D concluded: "on reassessment, PH appears to have mentally deteriorated. At the time of assessment he was fixated on the notion of returning to R's property but had limited insight into the practicalities of this idea, and I was unable to negotiate and reason with him. He did not appear to understand the information that we were discussing, nor was he processing the information in a manner that allowed for the decision-making process to be considered. PH appeared to have no insight into the risks that would be present in the community and he was unable to discuss with me the options for ensuring that the risks were manageable and positive."

49. In her report and in her oral evidence, D reported on how the difficulties involved in caring for PH are worsening. She gave an example, provided by PH's occupational therapist, of how he was becoming increasingly difficult to manage in the community because he appeared to lack an appreciation of the dangers posed by moving vehicles. D felt that the problems with his swallowing, mobilisation, cognitive impairment and difficulties involved in supervising him in the community, coupled with his lack of tolerance of people he dislikes, would pose challenges to his carers.

50. D reiterated her conclusions in her oral evidence in which she stressed how PH did not appreciate the need for twenty-four hour care saying: "I can do it myself". She thinks that he envisages going back to how it was before. She said in answer to Miss Scott on behalf of Z Limited that she had explained to PH that living in the community would be different from how it had been before, but that he did not understand. "When I say that R was exhausted and could not continue, he doesn't answer".

51. Miss Morris suggested to D that she had wanted to find that PH lacked capacity. She indignantly denied this. She said: "standing here trying to persuade a judge that he lacks capacity is absolutely foreign to me. If I had any doubt about PH's capacity I would be stating that". She added, however, that she had no doubt that he lacks capacity.

R

52. The final witness was PH's former partner R. In his statement and in the witness box, R gave moving and compelling evidence about the strain and difficulties he has experienced in caring for PH in recent years. He said in his statement that it is quite difficult to categorise the current status of their relationship, but he looks upon it "as a very deep friendship or companionship within which I have previously been a carer for PH". He described movingly how he had reached breaking point and decided that the only option was for PH to be admitted to Y Court for a period of assessment. He says on the advice of the professionals he did not tell PH of these plans. As a result, the process of taking him to Y Court and leaving him there was extremely traumatic for both of them. R describes it as the worst day of his life. Since his admission, R has visited PH about once every ten days. He thinks that more frequent visits would be distressing for both of them. During each visit, PH asks R if he will take him home. Initially, PH would try to leave the unit with him at the end of each visit.

53. R is clear that the care and support that PH is receiving at Y Court is of an extremely high standard. However, he is now willing to agree to PH returning home, provided there is a structured care regime in place with twenty-four hour care provided.

54. R is of the opinion that PH does have the capacity to decide where he should live. He said in his statement that, from discussions he has had with him, he feels that PH understands the differences between living at Y Court and at home, and appreciates that, were he to move back, he would require care. As a result, R strongly agrees with Dr Rickards' findings as to PH's capacity.

ANALYSIS AND CONCLUSIONS

55. Having considered the evidence of these witnesses and the other relevant documents drawn to my attention in the papers, I am in no doubt that PH lacks the capacity to make decisions concerning his future residence and care.

56. I acknowledge the expertise of Dr Rickards and find his approach to his assessment to have been appropriately objective and professional but I was struck by the fact that his report, and the answers to the supplementary questions posed by the other parties, seemed somewhat superficial. This may have been a reflection of the fact that he was basing his opinion on a single interview of ninety minutes. It would be an over-simplification to describe it as a snapshot but it is, to my mind, a disadvantage that the assessment was based on a single visit.

57. Dr Rickards himself acknowledged that his assessment suggested that PH was more capacitous than had appeared from the assessments carried out by the other doctors. He suggested that this could have been because he perceived the others as being opposed to his wish to return home, or associated in some way with the regime at Y Court, and was therefore less inclined to cooperate with them. Having had the benefit of hearing Dr Rickards' evidence first, and having heard him express this suggestion, I looked carefully for evidence of this in the testimony of the other witnesses. I found little to support that view. In particular, Dr A and D, his allocated social worker, knew PH before he was admitted to Y Court, and were clear that his lack of capacity pre-dated his admission. I think it unlikely that their earlier conversations with him could have been influenced in the way suggested by Dr Rickards.

58. Although neither Dr A nor Dr B nor Dr C has a curriculum vitae as academically distinguished as Dr Rickards, in my view they each have obvious and valuable expertise in HD. Interestingly, each of them brings a slightly different type of expertise to the case – Dr A as a consultant psychiatrist specialising in old age and dementia, Dr. B as a GP but with a unique depth of expertise in HD through his years working at Y Court, and Dr C, with his expertise in mental capacity assessment and interest in medico-legal matters. With respect to Dr Rickards, I consider that the overall expertise of Doctors A, B and C, coupled with their much greater experience of PH as a patient, justifies the court attaching greater weight to their combined views in this case. In addition, D, although not as experienced as the clinicians, was to my mind a manifestly fair and perceptive witness whose opinion demands very great respect.

59. All four of those witnesses – doctors A, B and C, plus D – are clear that PH lacks the capacity to make the decision as to his future residence. Specifically, I accept their evidence and I am satisfied that the evidence demonstrates that PH lacks capacity to understand and to weigh up many of the salient features involved in the decision as to his future residence. Although he wants to go home, he has no understanding of what being at home would now be like. I think that it is likely that he believes that, if he

went home, life would continue as before. Although he has on occasions expressed an understanding that he would have to receive a greater degree of care at home, I am satisfied that he has in fact no clear understanding of what it would be like to receive care twenty-four hours a day, from a range of different carers, some of whom he would like but others of whom he would undoubtedly dislike. Although he has said different things at different times, I find on balance it is likely that he believes that R would continue to be his sole or at least his principal carer when in fact R has made it clear that this is not now an option. PH has frequently asserted that it is "not a problem" and that he "will deal with it". To my mind, those assertions demonstrate that he lacks any real understanding of the complexities of his situation.

60. On specific matters, I accept the evidence that PH lacks a true awareness of his need for personal care, in particular with eating because of the dangers of choking and aspirating food. I am also satisfied that he has little if any, appreciation of what will be involved in caring for him in other ways including when he is out in the community. He is unaware of the extent of his own behavioural problems and therefore cannot appreciate how difficult it will be for carers to manage them. He has increased problems with mobilisation, which requires support at a level that I anticipate he will find difficult to accept. Although he said to Dr Rickards that he accepted that he needed twenty-four hour care, looking at the evidence as a whole, in particular evidence of his comments to others before and after Dr Rickards' interview, I do not believe that he has any real appreciation that this is what is involved. Miss Morris submits that he knows that, if he wishes to remain at home, he will have to tolerate twenty-four hour care. That submission, to my mind, is not supported by the evidence, considered as a whole. On the contrary, I am satisfied that he is unable to consider the realities of what life will be like if he were to go home.

61. I agree with the submissions advanced by Miss Davidson and Miss Scott on behalf of the local authority and Z Limited respectively to the effect that PH has little appreciation of the nature of his condition, or of the deterioration in his capabilities or of the extend of his needs, including his need to be kept safe or that he needs to be looked after by a team of appropriately-trained and experienced carers to meet his complex needs. I agree with Miss Scott that he does not really know what going home means. The evidence, in particular that of Dr A, satisfies me that he has no real understanding of the fact that living at home broke down last year, or the reasons why it broke down, and therefore has no awareness of the risk that it would break down again should he return there. Dr Rickards candidly conceded that he had not seen evidence that PH could weigh up the pros and cons of a move home. I am satisfied, on the evidence of the professionals taken as a whole, that he lacks that capacity. I agree with Miss Scott that there is nothing before the court on which I could say that he has the capacity to weigh up and use information even if he has the ability to understand and retain it.

62. I acknowledge that, whenever any question of returning home arises in circumstances such as this, there is inevitably an emotional component in the decision-making process. But I accept Miss Scott's submission that, if someone lacks capacity to understand, retain and weigh up information, the question of whether or not there is an emotional component is irrelevant.

63. I salute R's dedication to PH and the way in which he has cared for him for the past ten years. For that reason, I fully respect his view concerning PH's capacity. I find,

however, that his view is not supported by the overwhelming balance of professional evidence from Doctors A, B and C and the allocated social worker D.

64. I therefore find that PH manifestly does not meet three of the four components of the functional test in section 3(1) of the 2005 Act, namely, to understand the information relevant to the decision as to his future residence, to retain that information or to use or weigh up that information as part of the process of making that decision. Accordingly, on the narrow question of the application under Section 21A, I find that PH lacks capacity in relation to the question on whether or not he should be accommodated in Y Court for the purposes of being given care and treatment.

65. The evidence is also sufficient to lead me to the conclusion that PH lacks the capacity to make any decision as to his future residence or care. I therefore make a declaration to that effect pursuant to section 15 of the 2005 Act. But Miss Morris, on behalf of the Official Solicitor, urges that, if I find that the circumstances are justified in making such a declaration, I should express it as an interim declaration, for two reasons. First, the focus of the Official Solicitor's case at this hearing has been on the application under section 21A and he wishes to have the opportunity to adduce further evidence before a final declaration is made. Secondly, given the terms of section 1(3) to which I have already referred, namely that 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, the court should not make a final declaration until further steps have been made to assist PH to acquire the capacity. Although I have very considerable doubts as to whether it would ever be possible for PH to re-acquire the capacity to make decisions as to his future care and residence, I accept Miss Morris' submissions on this point.

66. Accordingly, I make the following declarations.

i) PH lacks capacity in relation to the question on whether or not he should be accommodated at Y Court for the purposes of being given care and treatment; and

ii) PH lacks capacity to make a decision as to his residence and care.

The second declaration shall remain in force for a period of six months. The question of whether a further declaration shall be made shall be reviewed by me on a date to be fixed in the Autumn term 2011.