Neutral Citation Number: [2021] EWCOP 30

Case No: 13550699

IN THE COURT OF PROTECTION

Sitting remotely as if from
COVERDALE HOUSE
LEEDS

Date: 06/05/2021

Before:

THE HONOURABLE MR JUSTICE COBB

- -

Between:

Y CCG	**Applicant**
- and -	
KG	**Respondent**
(by his Litigation Friend)	
X LOCAL AUTHORITY	
AG (son)	
BG (son)	
DG (daughter)	

- -
- -

Dr Barbara Green (instructed by **CCG Solicitor**) for the CCG
Sam Karim QC (instructed by **Cartwright King**) for KG
Manisha Marwaha (instructed by **Local Authority solicitor**) for the Local authority
AG, BG and **DG** in person

Hearing dates: 5 and 6 May 2021

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Approved Judgment

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THE HONOURABLE MR JUSTICE COBB

The Honourable Mr Justice Cobb:

Introduction

1. The application before the court concerns a 68-year-old gentleman who I shall refer to as KG. KG is currently an inpatient at Kingsgate Hospital[1]. He has been an inpatient there since April 2016 (having been in hospital elsewhere beforehand), and has been clinically fit for discharge for over two years; he is extremely resistant to leaving the hospital.

2. The application before the court (issued on 20 January 2020) is proceeding as a *section 21A Mental Capacity Act 2005* ('*MCA 2005*') challenge to the standard authorisation granted by X Local Authority ('LA'), which was renewed on 1 March 2021 and is due to expire on 30 June 2021. In essence, it is now agreed that the Court of Protection's adjudication is required on whether KG has capacity to decide about his residence and care, and – if appropriate – a best interests decision about his future in those respects.

3. The hearing before me, over the last two days, has focused on the issue of capacity. I have heard and read the evidence of Dr S, a consultant psychiatrist and psychotherapist; I have heard and read the evidence of Ms D, who is the Clinical Lead Nurse and Ward Manager at Kingsgate Hospital. I have heard the oral evidence of KG's two adult sons (AG and BG). I have read extensively into the bundle of documents (a pared down version of the full bundle, but still exceeding 420 pages) filed in the proceedings. One of the potential witnesses, Ms M, a registered mental nurse (KG's named nurse), was unavoidably unable to attend to give evidence through ill-health. After some deliberation, none of the parties proposed that the hearing should be adjourned to ensure that she could attend.

4. I have received characteristically helpful submissions from Dr Green, Mr Karim QC, and Ms Marwaha.

5. The case has been case-managed ably by District Judge Gardner throughout 2020; he remitted the issue of capacity for determination by a Tier 2 judge in February 2021. In consultation with HHJ Troy it was agreed that I would hear the case.

6. I welcomed the opportunity to include KG in this hearing himself; as arranged, I telephoned Kingsgate hospital at 11am yesterday and spoke to KG for a little over 10 minutes. He was able to tell me about his life there, and his wishes. He told me that he was fine, and that he wished to stay put.

7. I give this *extempore* judgement, which raises no new point of legal or other principle, to explain my reasons for concluding that KG lacks capacity to decide about his future residence and care. This determination will now pave the way for a best interests hearing which I hope to list in short order.

The position of the parties

Ultimate outcome

[1] This is not the real name of the hospital but a pseudonym.

8. As to ultimate outcome, the statutory bodies, the CCG and the LA, agree that KG should now leave Kingsgate Hospital, and be moved to a suitable residential care provision. Their current principal preferred option is Windermere House[2] which is a specialist mental health residential home providing accommodation for adults who require nursing or personal care. Windermere House is located in Town A, which is also where BG and DG live. KG has also lived for periods of his life in Town A.

9. KG's views are set out above.

10. AG and BG basically agree with the authority's proposals too, but express some concerns about:

    i) why this situation has been allowed to develop at all, and

    ii) how a move can now best be achieved, particularly in light of (a) the currently identified alternative options, and (b) the practical difficulties of actually getting KG to move

    Whether the court retains any involvement over the decision on 'ultimate outcome' plainly hinges on my determination of capacity.

    Capacity

11. As to capacity, the CCG submits that on all the evidence available at this hearing, it is sufficiently clear on the balance of probabilities that KG does *not* have capacity to make decisions about his residence and care; it maintains that he is unable to retain, or use/weigh the information relevant to the decision on residence/care. The CCG accepts the evidence of Dr S and Ms D in this regard. The LA shares this view.

12. At the outset of the hearing the Litigation Friend for KG indicated that he wished to hear/test the evidence before reaching a position on capacity; he was, at that point, unconvinced that the presumption of capacity was on the evidence displaced in this case, and wanted to consider the evidence specifically relevant to:

    i) KG's lack of engagement with the decision-making process;

    ii) The support available for him to make the decision;

    iii) The suggestion of fluctuating capacity.

    At the conclusion of the hearing, i.e., following the evidence, the Litigation Friend acknowledged (on a fine balance) that the presumption of capacity has indeed been displaced in this case, and that KG lacks capacity to make decisions about his residence and care. Mr Karim QC argues that the evidence shows that KG *can* understand and *can* retain relevant information to make the decisions (if supported and this is reinforced) but *cannot* use/weigh the information about residence and care. He accepts that KG's mild cognitive impairment materially affects his executive functioning in this regard.

[2] Also a pseudonym

13. KG's adult children are of the view that their father *has* capacity to make decisions about his residence, but submit that:

    i) He is able to show capacity in a number of respects;

    ii) KG *chooses* not to make a decision;

    iii) He should not be required to go to Windermere House, which is the favoured option of the statutory bodies;

    iv) The case should never have come to court; the money spent on the litigation should have been spent on helping their father;

    v) Now that the issue *is* in court, they would prefer that the Court of Protection maintains its role, with judicial continuity in overseeing the next steps for KG.

    I took time at the hearing to explain to AG and BG that the Court of Protection would obviously only have a future role if I were to find that their father lacks capacity.

The law

14. In reaching a determination on the issue of capacity in this case, I have applied the core principles of the *MCA 2005*, starting with the statutory assumption that KG has capacity unless it is established that he does not (*section 1(2) MCA 2005*); that he 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) MCA 2005*); and that he is not to be treated as unable to make a decision merely because he makes an unwise decision (*section 1(4) MCA 2005*).

15. I recognise that I must satisfy myself that he satisfies the diagnostic criteria under the *MCA 2005* ("a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain" *section 2 MCA 2005*), and the 'functionality' test: namely that he is unable to make a decision for himself if he is unable to understand the information relevant to the decision, to retain that information, to use or weigh that information as part of the process of making the decision, or to communicate his decision (whether by talking, using sign language or any other means). Proof of lack of capacity is established on the balance of probabilities (*section 2(4) MCA 2005*).

16. I have followed the guidance offered by the Court of Appeal in *PC v NC and City of York Council* [2013] EWCA Civ 478 at [35], namely that the court should consider the issues specifically:

> "The determination of capacity under *MCA 2005, Part 1* is decision specific…. all decisions, whatever their nature, fall to be evaluated within the straightforward and clear structure of *MCA 2005, ss 1 to 3* which requires the court to have regard to 'a matter' requiring 'a decision'. There is neither need nor justification for the plain words of the statute to be embellished."

17. What the 'relevant information' is under *section 3(1)(a) MCA 2005* will depend on the decision to be made but includes the reasonably foreseeable consequences of the decision or failure to make a decision (*section 3(4)*). I recognise that it is important not to overload the test with peripheral detail, but to limit it to the "salient" factors (per *LBL v RYJ* [2010] EWHC 2664 (Fam) at [24], and *CC v KK & STCC* [2012] EWCOP 2136 at [69]). On the issue of *residence*, I follow the guidance offered by Theis J in *LBX v K, L, M* [2013] EWHC 3230 (Fam) (at [43]), and on the issue of *care*, dicta in the same case at [29]. I accept that these formulations are "to be treated and applied as no more than guidance to be adapted to the facts of the particular case" (*B v A Local Authority* [2019] EWCA Civ 913 at [44][3]).

18. As referenced in the foregoing paragraph, the widely accepted test of 'information relevant to a decision' on residence is that which is set out in Theis J's decision of *LBX v K, L, M* namely:

    i) what the two options are, including information about what they are, what sort of property they are and what sort of facilities they have;

    ii) in broad terms, what sort of area the properties are in (and any specific known risks beyond the usual risks faced by people living in an area if any such specific risks exist);

    iii) the difference between living somewhere and visiting it;

    iv) what activities P would be able to do if he lived in each place;

    v) whether and how he would be able to see his family and friends if he lived in each place;

    vi) in relation to the proposed placement, that he would need to pay money to live there, which would be dealt with by his appointee, that he would need to pay bills, which would be dealt with by his appointee, and that there is an agreement that he must comply with the relevant lists of "do"s and "don't"s, otherwise he will not be able to remain living at the placement;

    vii) who he would be living with at each placement;

    viii) what sort of care he would receive in each placement in broad terms, in other words, that he would receive similar support in the proposed placement to the support he currently receives, and any differences if he were to live at home; and

    ix) the risk that his father might not want to see him if P chooses to live in the new placement.

19. In relation to care, I have had regard to what Theis J said in *LBX v K and others* namely:

    i) what areas he needs support with;

[3] And, per [62], "we see no principled problem with the list provided that it is treated and applied as no more than guidance to be expanded or contracted or otherwise adapted to the facts of the particular case".

ii) what sort of support he needs;

iii) who will be providing him with support;

iv) what would happen if he did not have any support or he refused it and,

v) carers might not always treat him properly and that he can complain if he is not happy about his care.

The evidence of Dr S and Ms D

20. I heard from the mental health clinicians who have worked with KG for many years, Dr S and Ms D. As Baker J rightly in my view observed in *PH v A Local Authority* [2011] EWHC 1704 (CoP) at §16, the opinions of those who work with 'P' can be just as important and in some cases more important than those of an independently instructed expert.

21. It is unnecessary for me to rehearse the background mental health history of KG in this judgment; it is sufficient for me to record that he has been known to mental health services for over 35 years and has had many periods of inpatient treatment prior to the current extended stay.

22. Dr S is of the view that KG has a diagnosis of:

i) Acquired brain injury; this derives from a diagnosis of Japanese encephalitis some years ago;

ii) Chronic treatment resistant depressive illness; Dr S told me that the condition was difficult to treat through chemical anti-depressant, mood stabiliser and anti-psychotic medication; this particularly affects his problem-solving abilities;

iii) Mild cognitive impairment; and

iv) Probable vascular dementia with demonstrable infarcts and damage observed on MRI scan in the frontal and parietal lobes of his brain.

23. Dr S has known KG since he was admitted to Kingsgate Hospital in 2016, initially under *section 3 Mental Health Act 1983* with a very serious depressive illness, anxiousness, hopelessness, disturbed sleep, psychosis, and poor memory; he told me that the medical team there have been able to treat him for the last five years, as an inpatient. I was told that KG is less depressed now; his mood has improved; his helplessness and guilt have improved; his food and fluid intake has improved; his personal hygiene has not – and this is said to be down to his cognitive impairment. His memory and concentration remain impaired. Psychotic symptoms have improved.

24. It was evident from the evidence which I heard that Dr S, and indeed all the staff at Kingsgate Hospital are very fond indeed of KG, and in spite of this application and their support of it, will be sad to see him go.

25. Dr S has kept KG's capacity as a decision-maker under review for as long as he has known him. In the documents filed for these proceedings I was provided with historic capacity assessments, which have been materially supplemented by a recent capacity

assessment undertaken by Dr S with Ms D on 23 February 2021. That assessment yielded broadly the same outcome as earlier assessments, but with greater conviction and clarity. Dr S believed when assessed by reference to the diagnostic test and functional assessment test, KG's deficit lies in his inability to retain information, and/or to use or weigh that information as part of the process of making the decision. To be clear, Dr K opines that KG *is* able to understand the information relevant to the decision, and is able to communicate his decision.

26. Dr S is of the opinion that it is principally KG's mild cognitive impairment which impacts his ability to exercise any form of executive functioning (memory and judgment) in his decision-making; his depressive illness and probable early vascular dementia contribute to his mental impairment. Dr S is of the view that the condition is static and in his view would be unlikely to improve.

27. In performing his assessment, Dr S took KG through the prospectus for Windermere House; Dr S explained to him what facilities were available there, what arrangements would be made for visitors and the level of care he would receive. KG was unable to repeat back to Dr S much of what he had been told. He was taken through the prospectus for a different residential care provision, Coniston House; again, he was unable to remember with what areas he needed support when given information, and could not remember what would happen if he did not have any support or if he refused it. He was taken through the prospectus for a further residential home, namely Derwent House; again, he struggled to remember with what areas he needed support, and was unable to remember what activities he would be able to undertake if he lived there.

28. KG simply told Dr S that he would prefer to stay at Kingsgate Hospital. KG's principal objection to Windermere House is that it appears that some of the residents in the past have been admitted there on discharge from prison; this is no longer thought to be so. KG objects strongly to the idea of sharing his "home" with former prisoners, and further to the location of Windermere House. Dr S told me that:

> "KG cannot let go of this. The professionals had attempted to persuade him to accept that the situation had changed, but he totally went beyond that, and showed no mental flexibility, and totally disregarded all of the advantages of the residential care in the particular town where this is located, where he is in fact still a member of the cricket club. He was not able to retain key information."

29. Dr S told me that KG lacks any understanding of the consequences of making or not making this decision. He also told me that he disagreed with Ms M whose view was that KG displayed fluctuating capacity. Dr S described KG's presentation as indicating fluctuating levels of *engagement* not fluctuating *capacity*. Dr S expressed a concern – and notably, AG agreed with this assessment – that KG does not have the ability to weigh up the information relevant to his care and treatment. Dr S emphasised to me that KG has a real need to be compliant with his medication, and if he is not, he could become very seriously unwell again.

30. AG (acting in person) asked Dr S about the diagnosis of probable vascular dementia. Dr S, sensing the anxiety which lay behind the question, acknowledged the regrettable but commonplace stigma around dementia, and recognised that this diagnosis created

different and potentially more difficult pathways for KG's future care. However, Dr S was clear that it is crucial that KG's probable dementia should not be ignored, and it should be monitored because if it progresses it has serious treatment and prognostic implications. In answer to further questions from BG, Dr S explained the implications of the diagnosis of probable vascular dementia on KG's life expectancy.

31. Dr S, in answer to further questions from AG, emphasised that he and his team have endeavoured conscientiously to take all practicable steps to help "P" to make a decision in compliance with the statutory expectation under the *MCA 2005*. He did so in this case, adding: "we have not left any stone unturned" in this regard. He further explained, in answer to a question from AG, that while psychotherapy would theoretically be available to KG to assist him come to terms with his situation, KG has been resistant to all efforts to deliver this.

32. Dr S told me that KG is ready to move out of hospital to a less restrictive placement in the community. KG would require 24 hour supported accommodation with trained staff. He would need a consistent approach continuing with the current drug therapy, a person-centred approach providing care and support according to his needs and this would be in his best interest. KG would need to be subject to deprivation of liberty restrictions as he is currently.

33. It is relevant for me to point out that when I spoke with KG on the telephone, he told me that it was "all right" speaking with Dr S. For my part, I find that reassuring, for it indicates that KG was probably relaxed in submitting to the capacity assessment rather than resistant to the same.

34. Ms D, ward manager at Kingsgate Hospital, told me that she had jointly undertaken the recent capacity assessment of KG with Dr S. She concurred with Dr S's view that KG is unable to use or weigh information relevant to the decision about his care or residence. She was more equivocal about his ability to retain information.

35. She told me that the risks to KG are around self-neglect; he shows some physical aggression when this is raised with him, and he has difficulty in understanding and/or receiving treatment for his diabetes; he is further unable to understand how his medication impacts on his physical and mental health. He is apathetic. She said: "I can discuss football and sport with him, but cannot have the same discussion with him about his care needs, and he shuts off".

36. Notwithstanding the very many conversations which Ms D has had with KG about Windermere House, she told me that the only information he can retain is the name of the town where it is situated (Town A: a town he knows, where BG and DG live), and the approximate location of the home in the town. Ms D told me that he struggles to retain more abstract information about his support needs, activity levels which he could access there, and the like.

37. She told me that she has spoken to KG about his future residence possibilities on approximately 40-50 occasions. However, she felt that the assessment of capacity undertaken in February 2021 was the first time for a while that she and Dr S had had a reasonable opportunity to assess KG. Up to this point, she told me, KG had generally tended to shut down, and was getting increasingly hostile to efforts to engage him in this regard; "he would stand up and tell me to get out of his room". When he did this,

she told me that "it was difficult to go back and get him to engage". She described the different presentations of KG, willing and able to engage in discussion when not on the subjects which he does *not* want to talk about; but the subjects of football and cricket he can speak about fluently and easily and when he does so "he is a joy to be with". In this regard, I particularly noted Ms D's evidence that she tried to have the conversation with him about his future residence and care while watching a football match on the television, so that he would at least be settled and relaxed. This was to no avail. She added: "I have tried all things in all ways; he shuts down on me and becomes quite distant… he gets irate and annoyed. This is the most difficult case I have been involved with in relation to capacity". She told me that she has even offered to take him to Windermere House "and then out for fish and chips", but he has turned her down. She told me that he is "fixated" on staying put.

38. She accepted that moving him from Kingsgate Hospital may be a problem. Ms D agreed with AG that KG is now settled and institutionalised, that he is burying his head in the sand in relation to his future and that he is not fully aware of all his treatment requirements. She was worried about his sense of isolation following any move.

39. I should add that the parties had agreed that a SJE should be instructed, Dr Patrick Quinn, Consultant Forensic Psychiatrist. However, Dr Quinn was not able to undertake any effective assessment, as KG was not willing to engage fully with him and therefore Dr Quinn prepared only the briefest of reports outlining his limited involvement. Dr Quinn nonetheless offered this general comment, which I found useful:

> "By way of general observations the individual can present as a reluctant historian born out of anxiety about decisions being made about their care particularly if they do not wish to leave their current address. In clinical practice (inpatient settings) it has been the author's experience that those detained in hospital particularly for lengthy periods are often unwilling to leave hospital having become familiar with and content with the care provided at their address. This familiarity and degree of content is such as to raise anxiety when discharged/transferred to another address is suggested. The reality for some individuals (this is a general observation and not meant to specifically apply to [KG]) is that moving to another address i.e. a community facility particularly in the absence of family/meaningful friends is a daunting/terrifying prospect for individuals as the only carers they will have in a community setting are professional carers. This is a general observation and cannot be concluded as that which might explain [KG]'s lack of participation in the examination."

40. Finally, I should record that Ms M commented that KG requires support with the following areas of his care: medication administration and management; mental health/behaviour management and potential aggression; physical health management regarding diabetes, refusal to attend medical assessments/have health checks completed; self-care prompts in relation to hygiene and dressing; shopping; housekeeping; social inclusion and activities; community access; continued finance management. Ms M was of the view that KG could pose a risk to himself and potentially others if he did not receive care support as outlined above; she added,

importantly, that when KG has agreed to discuss his care and support needs it is evident that he has not been able to retain or use or weigh the more complex medical information in relation to certain aspects of his care and support (i.e. medication regime, diet control).

The evidence of the family

41. KG's two adult sons gave evidence before me. AG, a mental health nurse who lives some distance from KG, told me that he felt that his father had been "marginalised and overlooked in society by the very people who are supposed to be helping him". He feels that the professionals have failed to maximise his capacity with regards to the specific decision about his future residence. In a witness statement he expressed concern that KG may not be part of the final decision-making process, a concern which I hope I have dispelled by speaking directly and personally with KG before the hearing began yesterday. He expressed a clear and rational concern that KG has become institutionalised (see above), and needs help and support in recognising the benefits of the move. He is concerned that any alternative placement may not be able to contain his father, and/or meet his care needs holistically.

42. He told me that he felt that it would be better for KG to be in the town which KG knows (where Windermere House is located) where he could be nearer his old friends and family; he told me that he realised "how hard my dad is to engage" and that he is "quite selective" on what he is prepared to discuss.

43. He did not think that his father was happy at Kingsgate Hospital "but he is not unhappy". When giving evidence yesterday he told me "we (by which I assume he meant the family) all want him to move to [Town A]". He went on to say that he felt that the money which had been expended on litigation across the board could have been better spent in helping his father:

> "I think that there are better ways to have gone about it… even though he is hard to engage. He has been left to fester… He has become too institutionalised. … This is the most stability he has had in his life… I think we may have 'missed the boat' with him."

44. BG has filed a short statement; he told me that he had attempted to take his father to Windermere House but failed in this endeavour as his father did not wish to visit it. KG's reported concern was that some clients at Windermere House have been discharged directly from prison there. BG was of the view that this perfectly rational explanation for his resistance to a move supported his contention that KG has capacity to make this decision.

Conclusion

45. On the evidence which I have heard, I find that even though KG has been able to understand the issues around his future residence and care, and can articulate/communicate reasonable objections to a proposed move from Kingsgate Hospital, he is unable to retain abstract information about his future potential residence arrangements and care needs even when encouraged to do so, and is further unable to

use and weigh the information relevant to the decision about his future residence and care.

46. I accept the evidence that his mild cognitive impairment has so adversely impacted his executive functioning that he no longer has the ability to use or weigh the information relevant to the decision about his future. Moreover, he lacks insight into his medical condition, and has no real appreciation of his need for ongoing treatment; without that treatment he would, I am satisfied on the evidence of Dr S, become seriously unwell.

47. I am satisfied that all practicable steps have been taken (*section 1(3) MCA 2005*) to help KG to retain and use or weigh information relevant to the idea of moving from Kingsgate House and to reach a capacitous decision in relation to future residence and care, having regard to the various pros and cons; I accept the evidence of Ms D that she has tried and tried again to KG to see the whole picture about Windermere House, through discussion (in multiple varied contexts), brochures, videos, and offers of a visit (even with the offer of a lunch of fish and chips). I further accept Dr S as evidence that he has "left no stone unturned" in trying to engage KG meaningfully with this decision.

48. The consequence of my finding is that the Court of Protection will remain engaged in considering the future best interests of KG in the plans for his future residence and care. I shall reserve the case to myself. At the welfare stage, it will be necessary to grapple with a range of issues including, but not limited to:

    i) Is it in KG's best interests for him to leave Kingsgate Hospital? There is a broad consensus as to the answer to this question, but I consider that it ought nonetheless to be asked and answered given KG's clear views/opposition;

    ii) Which alternative residential care establishment would best meet KG's needs? Is this likely to be Windermere House? Or another resource in Town A or elsewhere? It was previously said that a resource called Thirlmere in Town A may be a suitable placement but no places were available at the date of the previous hearing. The LA and the CCG have confirmed that if they become aware of a vacancy at this placement prior to the final hearing the litigation friend would be notified.

    iii) What steps can/should be taken to prepare KG for any move?

    iv) How, physically, and emotionally, can KG be moved in a way which best meets his needs, fulfils his best interests, and offers the least restrictions?

    v) If he is to move when and in what circumstances should the decision be communicated to him?

    vi) How should it be communicated to him, and what support should be offered to him at that time;

    vii) Does the conveyance plan in the bundle of documents need to be reviewed?

    viii) What is the status of the physical control and restraint policy filed by the CCG, and in what circumstances would it be deployed?

ix) Who should be involved in preparing KG for any move, and for effecting any move? What role will the family play in that endeavour?

x) What are KG's views about the proposals?

49. I will direct that the CCG and LA file evidence which addresses these, and possibly other, relevant questions. To be clear, I am aware that Windermere House is available, but in my view the search should be extended beyond simply the offer of Windermere House at this stage. This is particularly so given that it is known, and has been reinforced during this hearing, that KG, AG, and BG all currently oppose this particular option.

50. That is my judgment.