Neutral Citation Number: [2023] EWCOP 27

Case No: 13715813

COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 28/06/2023

Before:

MR JUSTICE HAYDEN

- -

Between:

WARRINGTON BOROUGH COUNCIL **Applicant**

- and -

Y
(By her Litigation Friend, the Official Solicitor) (1)

AB (2)

CD (3) **Respondents**

- -
- -

Mr Louis Browne KC and Ms Rebecca Clark (instructed by a Local Authority**) for the Applicant**
Ms Victoria Butler-Cole KC and Mr Neil Allen (instructed by Simpson Millar LLP**) for the First Respondent**
Mr Joseph O'Brien KC and Mr Ben McCormack (instructed by EMG Solicitors**) for the Second and Third Respondents**

Hearing dates: 27th and 28th April 2023

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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.

....

THE HONOURABLE MR JUSTICE HAYDEN

The judge has given leave for this version of the judgment to be published.

MR JUSTICE HAYDEN:

1. This application concerns Y, who is in her early twenties. Y is a natal male who identifies as female. Though she was initially taking hormone medication, which she was purchasing on the internet, she has now been referred to a gender specialist and is taking prescribed female hormone medication. Y was diagnosed with autistic spectrum disorder as a child. Her education records reveal difficulties with learning but she remained in mainstream education and was provided with support. She passed NVQ Level 1 and 2 in Engineering. In the summer of 2018, when Y was a very young adult, she sustained serious injuries in a road traffic accident. She was riding a motorbike and was involved in a collision with a car. The accident generated personal injury proceedings which are ongoing. Liability is not in issue in those proceedings, it has been admitted. Y was not at fault. Quantum of damages remains to be assessed. In those proceedings, Y's father (F) is her litigation friend.

2. Y has retained a team which includes a neuropsychologist. Her support package is overseen by a clinical lead. Establishing the package of support was challenging, complicated by the destabilising influence of Y's mother and, inevitably, exacerbated by the restrictions of the pandemic. Following an unsettled period where Y was moving between various hotels, seemingly, at her mother's direction, she eventually moved to a rehabilitation unit in Sheffield. The stability she achieved there was important and enabled her to move, in April 2022, to a rented bungalow in the North West, with a support package. Care and support is commissioned by her Deputies and managed by a case manager.

3. Prior to the issue of this application, Y's Deputies commissioned a report from Dr David Todd, Consultant Neuropsychologist. In his report Dr Todd assessed Y as lacking capacity to make a range of decisions but found that she had the capacity to engage in sexual relationships. As there was evidence that Y lacked capacity to make decisions as to her residence and care arrangements, her living arrangements served effectively to deprive her of her liberty. Authorisation for this, pursuant to sections 4A and 16 of the Mental Capacity Act 2005 ('MCA') was subsequently given by orders made by the Court of Protection, upon the application by the Local Authority. After receipt of Dr Grace's report it was no longer disputed that the Y had the capacity to decide to take cross-sex hormones and to use the internet.

4. There is no doubt that Y sustained life changing injuries in her motorbike accident. She sustained a brain injury which is classified as moderate-severe and is associated with either permanent or transient changes in cognition, behaviour, and emotional regulation. Mr Browne KC, Counsel for the Local Authority, has emphasised that alongside the brain injury was a very serious injury to her left arm. The injury is to the brachial plexus. The brachial plexus is formed from five nerves that originate in the spinal cord at the neck. The plexus connects these five nerves with the nerves that provide sensation (feeling) to the skin and permit movement in the muscles of the arm and hand. The damage has been so significant that Y has no control at all of her left arm. Mr Browne has described the arm as "dead". This injury caused a protracted period of intense pain which required significant pain relief. Y continues to have chronic pain.

5. The central issue in this case is whether Y has the capacity to take decisions in relation to her care and residence. Opinion on this is divided between Dr Janet Grace, Consultant Neuropsychiatrist, and Dr Todd. The two bring differing specialisms to bear. Whilst there are important areas of

common ground, their ultimate conclusions are very significantly different. Mr O'Brien KC, Counsel for the Deputies, has described this as a *"particularly complex and finely balanced case"*. I agree that it is complex but I do not think it can properly be described as "finely balanced". Dr Todd is very clear that Y lacks capacity to make decisions as to where she resides and the care and support, she requires. Dr Grace forcefully articulates the opposite opinion. Ultimately, the question for the Court is which of the two views is to be preferred.

6. Dr Todd considers that Y presents with Dysexecutive Syndrome, consequent on traumatic brain injury. This presentation is associated with damage to the anterior frontal regions of the brain and/or to the various white matter networks connecting these regions with other areas of the brain. He draws my attention to what is termed "*the frontal lobe paradox"* (recognised in research papers e.g., George and Gilbert, 2018):

> *"Patients with frontal lobe damage can perform well in interview and test settings, despite marked impairments in everyday life. This is known as the 'frontal lobe paradox'. Failing to take account of this when conducting Mental Capacity Act assessments can result in disastrous consequences for patients. We suggest that neuropsychologists work collaboratively with local authority social workers and care managers, who often have the final say in such assessments, to raise awareness of this issue".*

7. Dr Todd highlights the recognised cognitive aspects of 'dysexecutive syndrome', which are non-exhaustive:

   - *Perseveration in [her] thinking style and behavioural responses*
   - *Reduced generativity in thought*
   - *Poor self-monitoring of responses and inhibition of rule-break errors*
   - *Difficulties in source memory, "fixing" newly learned information to where and when it was learned, and intrusive errors in memory recall*
   - *Poor abstract reasoning ability*
   - *Reduced capacity for novel problem-solving*
   - *Reduced self-awareness, poor judgement*
   - *Post hoc rationalization, blaming others for [her] own actions and behaviour*

   The emotional elements of [her] dysexecutive syndrome include:

   - *Shallow irritability and poor frustration tolerance*
   - *Poorly regulated emotions such as anxiety and frustration*
   - *Impaired mentalising of others emotional state and intentions, leading to vulnerability to exploitation*

   The behavioural factors of [her] dysexecutive syndrome include:

   - *Impulsivity*
   - *Disinhibition – leading to blunt and rude comments*
   - *Perseverative and compulsive behaviours*

8. Dr Todd noted that in his initial conversation with Y, she displayed good verbal reasoning skills and presented as articulate, even *"erudite"* and revealed a good sense of humour. When Dr Todd met Y, she was not using female pronouns but given that she does now, I have concluded it would be respectful to her, as well as less confusing for the reader of this judgment, if I amended the earlier documentation in the way foreshadowed above. Dr Todd described Y as *"superficially plausible in discussion"* and skilled in presenting *"a compelling narrative"* but, based on his understanding of the nature of the brain injury and following a deeper, more detailed enquiry, Dr Todd considered that Y revealed difficulties in aspects of her cognitive function, including attention and memory. He considered that Y's relative strength in verbal reasoning were concealing *"the most disabling aspects of her clinical presentation",* which he identifies as a *"pervasive dysexecutive behaviour (an* ***organic*** *personality disorder)* (my emphasis) as a *"direct sequela"* which *"affects her cognitive abilities, emotional regulation and behavioural control".*

9. Dr Todd sets out a thorough account of his meeting with Y in which he identifies Y as having 'gaps in memory', 'practical issues with care'; 'showering, changing clothes, cooking'; 'cognitive fatigue and loss of energy'. He considered that the incident in which Y dislocated and fractured her ankle, in consequence of a skateboard injury, revealed an *"impulsivity placing her at risk of injury",* given that she has absolutely no use of her left arm. Dr Todd records Y as experiencing symptoms of anxiety and depression which Y said can manifest in *"tearfulness"*. Whilst in the rehabilitation unit, Dr Todd considered that the documentation suggested that Y did not engage in all the activities offered to her and withdrew from many of the therapeutic interventions. It is common ground that Y was unhappy in that unit and some thought has been given as to how her behaviour at that time should be interpreted. Dr Todd considers that Y displays an inability to organise and plan or to convert an expression of motivation into practice. In relation to the decision concerning where to live, Dr Todd considered that Y was highly suggestible and vulnerable to the expressed opinion of others.

10. Dr Grace portrays what, to my mind, is a distinctly different picture of Y's behaviour. Whilst she considers that Y is impulsive, difficult to contain and risk taking, she believes that to be largely confined to occasions in which she is *"clearly hyper-aroused".* She asserts that these patterns of behaviour were present pre-injury and believes that they are not a consequence of the brain injury but due to a combination of anxiety and autistic spectrum disorder (ASD) traits. Dr Grace says that *"in common with the rest of the population, she is at risk of making decisions that are potentially harmful when she is anxious or angry".*

11. The two central questions posed in this application are addressed in a convenient way by Dr Grace in her report. To do justice to her, I propose to set each out in full:

> *"3.3. Does [Y] have capacity to make decisions about the care package and support arrangements that she should receive?*
>
> *3.3.1. Yes. [Y] was able to spontaneously identify her physical difficulties and understand the aims of treatment and the difference between treatment for improvement and maintenance and care needs. She was able to tell me, without prompting, that she would need physiotherapy for the brachial plexus injury and general physiotherapy for her fitness. She was able to weigh up the advantages and disadvantages of treatment including both the long term and short-term impacts. She was able to tell me that she was*

likely to have permanent deficits and this would limit her function and she would need a degree of practical support.

3.3.2. [Y] was aware that her mood was low and was anxious and that she at times became agitated and needed someone to keep her safe. She had a good knowledge of the broad treatment categories for treatment of anxiety and depression (both pharmacological and psychological). She had a healthy scepticism about the risks of anti-depressant information but was able to understand and weigh up the advantages and disadvantages of accepting treatment. She described herself as thinking about antidepressant medication at our first assessment and had made the decision to accept medication by the time I spoke to the case manager. There was no evidence of impulsivity in her consideration of support for her mood and anxiety symptoms.

3.3.3. I have reservations about forming an opinion regarding day-to-day support due to my concerns about the credibility of the information provided by [Y]. [Y] is able to understand, retain and weigh up the information provided by the care team and believes that she needs two people with her at any time she is in the community to keep her safe if she becomes hyperaroused.

3.3.4. If my hypothesis that [Y]'s presentation is not entirely of possibly even partially mediated by organic injury is correct, there is little indication for two to one care and overprovision of care may be driving her behaviour and fostering dependency. [Y] was able to understand, retain and weigh up information pertaining to the risks as they have been explained to her by the treating team (that she has a severe and disabling brain injury and is at risk) however I disagree with the formulation that has been presented to her.

3.3.5. At times [Y] is clearly hyperaroused. At these times she is likely to be impulsive, difficult to contain and take risks. These patterns of behaviour were present pre-injury and I am of the opinion that they come about due to a combination of anxiety and ASD traits. In common with the rest of the population, she is at risk of making decisions that are potentially harmful when she is anxious or angry.

12. Very little, if anything, of what is written above strikes me as conflicting, factually, with what Dr Todd says but I note that Dr Grace has not focused upon Y's ability to organise and plan. Dr Todd strikes me as giving this particular feature of his perception of Y's behaviour, considerable weight. I turn to the second question:

"3.4. Does [Y] have capacity to make decisions about her residence?

3.4.1. Yes. [Y] was able to identify, understand, retain and weigh up information relating to place of residence, taking into account multiple factors including tolerance of her lifestyle choices, access to

airports and cultural events and access to family. She told me that there was a good chance that her mother would move back to the USA and so she did not need to take her mother's UK place of residence into consideration. She understood that if she moved to Brighton, she would be further away from her father but on reflection told me that they mainly contacted each other online (which was corroborated by [F]). Following a discussion, [Y] was able to understand retain and weigh up more negative information related to living in the south of London such as increased expense. Overall she was able to weigh up the advantages of living "somewhere like Brighton" with the disadvantages. She was able to weigh up the disadvantages of moving from the northwest in terms the effect it may have on her treatment and rehabilitation. Although somewhat dismissive of the support workers, she was able to tell me that she was happy to see psychologists on line and would need to find new physiotherapists. [Y] reflected on the effect that moving would have on her contact with her legal team and case manager and said she would be happy to carry on working with them remotely.

3.4.2. [Y] was able to understand, retain and weigh up information about the longer term. She said she did not see her next home as necessarily permanent and she may move in the future, possibly to the USA or another town in the UK. She told me that was also considering Manchester which had a similar appeal to Brighton in terms of tolerance LGBTQ+ lifestyle and cultural events. She was able to explain that she was happy to be considering these options and felt in no hurry to make a decision – ie there was no evidence of impulsivity.

13. It is important to record that Dr Todd considered that Y's suggestion that she move to live *"somewhere like Brighton"* was superficial, without recognition of the practical challenges of obtaining accommodation, getting packages of support, contact with her legal team and case manager etc. Y considered that these arrangements could be maintained working *"remotely",* which on some level is not without force. Thus, analysis of broadly similar behaviour by both doctors' results in widely divergent conclusions.

Experts meeting

14. Dr Todd and Dr Grace met on 24th March 2023 to discuss the clinical formulation and capacity issues relating to Y and, in particular, to focus on their difference of opinion. As I have, to some extent, foreshadowed above, it is striking how much common ground there is between them. They unhesitatingly agree that Y has a Mayo moderate-severe brain injury. Within this classification, they both agree that Y falls towards the lower end of it. The cognitive and behavioural signs that Dr Todd listed (see para. 7 above) are recognised by both as common in brain injuries of this type, whether transient or permanent. They both agree that clinical formulation in this case is, as Mr O'Brien rightly submitted, *"complex"*. There are 4 striking facets of this complexity:

- *[Y]'s mental health/psychological presentation is likely to be the product of more than one process.*

- *[Y] gives contradictory information and at times her presentation is at odds with recognised clinical patterns of brain injury.*

- *The time course of [Y]'s recovery is unusual with an apparent worsening of symptoms over time. This is atypical of the trajectory seen in brain injury patients where a slow, although not necessarily linear, recovery over time is seen.*

- *The loss of pre-injury autobiographical memory is not typical of brain injury and suggests a different cause, possibly dissociation or feigned symptoms.*

15. In the course of evidence, Dr Todd emphasised how in the 12 months following the brain injury, Y was also suffering from the impact of an extremely serious physical injury. As I have already discussed above, the brachial injury is regarded as a very significant and painful one. It certainly had a very marked physical impact on Y in that early period of treatment. Dr Todd considers that the focus on this, the pain generated by it and the extent of the pain relief medication required, may either have obscured the clinical picture or distracted professional focus from the impact of the brain injury. Thus, the apparent atypical trajectory of a brain injury which seems to have worsened over time, might in fact, be inaccurate.

16. Perhaps unsurprisingly, both Dr Todd and Dr Grace agreed that Y meets the criteria for ASD. Both doctors noted that formal cognitive testing was itself complicated by failure of effort testing, since December 2019. This, they both agreed, suggested that Y had not applied herself fully to the testing. Although that fits with Dr Todd's analysis, it is right to say that both doctors agreed that pain or mood disorders might also legitimately explain this apparent disengagement. Though Dr Grace had placed some emphasis on the apparently deteriorating trajectory of the brain injury, as pertinent to her view that ASD was predominately causative, both she and Dr Todd alert me to a number of important facts:

    i. In younger patients (as here), recovery from brain injury is a slow process which may take many years;
    ii. It is not possible, in the light of the above, to be confident that the last valid tests undertaken are accurately reflective of Y's current cognitive function;
    iii. There may have been improvement but this is capable of neither of proof nor refutation;
    iv. Deterioration in cognition, both agree, is highly unlikely in any event.

17. There can be no doubt that the MRI scan shows right temporal, inferior frontal and right occipital injuries which are in keeping with deficits on frontal testing. Again, this is common ground, as is the countervailing point, namely that, neuroimaging does not correlate well with cognition and function.

18. It is necessary to set out the record of the discussions concerning Y's capacity to take decisions in relation to her care. The document is prepared by Dr Grace, advanced as a statement and hers is the narrative voice:

2.9.1. I remain of the opinion that [Y] retains capacity to make decisions about care. However, Dr Todd is of the opinion that she lacks capacity to make decisions about care. This point was discussed at length.

2.9.2. Dr Todd is of the opinion that [Y]'s lack of insight is pivotal in her lack of ability to make decisions about care. Dr Todd is of the opinion that this is secondary to the executive/frontal deficits identified on cognitive testing giving rise to a phenomenon called the frontal lobe paradox (FLP), whereby people have an intellectual awareness of the relevant information but do not act on it due to neurocognitive changes. Dr Todd phrases this as "does not translate into emergent or anticipatory awareness". He notes that [Y] has not fully engaged and has missed sessions. She also does not consistently follow advice and recommendations.

2.9.3. I partly agree with Dr Todd's formulation as detailed in his report. I note that [Y] was able to identify the areas of need and understand and weigh up the pertinent information in both assessments. I also agree that there is a risk that [Y] will not follow best advice and may disengage. I note that [Y] has frequently but not consistently engaged with therapies and care.

2.9.4. The area of disagreement between us is then that Dr Todd ascribes this lack of engagement to a facet of [Y]'s acquired brain injury (the frontal lobe paradox) and I see this as a capacitous, if unwise, choice.

2.9.5. Conceptually, the idea of a frontal lobe paradox is complex and there is no test for it per se. A recent meta-analysis found very sparse data on the FLP, with a preponderance of single case reports and policy documents and little research.

2.9.6. The first case in the literature was an unusual patient who had had a complete ablation of his frontal lobes and retained an IQ of 130 while presenting as chaotic in his daily life. The literature on this topic focusses on patients who perform well in cognitive testing and badly in real life. [Y] is currently performing badly in cognitive testing although this is likely to be due to poor effort.

[Y] – Capacity Report March 2023
2.9.7. Diagnostically, there is a focus on a lack of insight as a reason to fail to make use of resources and compensatory strategies. In clinical assessment with me, [Y] had good insight into her disabilities and their subsequent needs and produced these in a concise format. She was able to identify needs in the community and needs related to her mental state and brachial plexus injury and could predict the foreseeable consequences of her choices.

2.9.8. The FLP has been used to argue that a person does not act on information they can understand, retain and weigh up because of neurocognitive changes and therefore they lack capacity. I am of the opinion that a dissociation between knowing and doing is not necessarily pathological and can be part of normal everyday behaviour.

2.9.9. Having considered the frontal lobe paradox as a possible reason for [Y] lacking capacity to make decisions about care, I am of the opinion that it is not relevant in [Y]'s for the following reasons.

2.9.9.1. Typically, people with frontal lobe paradox pass effort tests.

2.9.9.2. Typically, engagement is persistently poor in FLP.
2.9.9.3. [Y] has good insight.

2.9.10. Furthermore, on reviewing Dr Todd's narrative regarding decisions about care and residence, particularly the latter, it is clear that [Y] was giving markedly less full answers than she was able to give me. In assessment with me, [Y] was able to switch topics and weigh up complex information. Based on my clinical assessment when [Y] presented as lucid, organised and coherent with no evidence of impulsivity and only minimal irritability (once her anxiety had
abated), I remain of the opinion that she retains capacity to make decisions about care and treatment.

2.9.11. Other more fluid factors, such as anxiety, maybe affecting capacity.

19. Both Dr Todd and Dr Grace agree that the issues of care and residence are closely linked in this case. Indeed, I consider it virtually impossible to disentangle them. Dr Todd considers Y lacks capacity and Dr Grace considers that she has capacity and for identical reasons, on both sides, to the analysis set out above concerning care. I do not propose to repeat it in this context.

20. Towards the end of Mr O'Brien's examination, Dr Grace indicated that she would feel more comfortable with her recommendation if she could undertake a series of further assessments which, as I understood her evidence, might involve speaking to Y's mother and further evaluating Y's impulsivity of behaviour, in the light of various examples put to her by Mr O'Brien. Ms Butler-Cole KC, on behalf of the Official Solicitor, has not engaged with that concession. She advances the OS's case, as I infer it, on the basis that Dr Grace's expressed misgivings were, in effect, unjustified and that the behaviours drawn to her attention must have been in her contemplation at the time of writing her report as she refers to other and similar examples. With characteristic diligence, Ms Butler-Cole prepared detailed written closing submissions, they are a comprehensive critique of Dr Todd. Mr Browne who had adopted a neutral position told me that the Local Authority, on balance, preferred the evidence of Dr Grace but also identified strengths in Dr Todd's analysis.

21. Recently, in *A Local Authority v H* [2023] EWCOP 4, I reviewed the applicable law in this sphere. It is convenient to read that into this judgment.

22. The basic principles of the Mental Capacity Act 2005 (MCA) were conveniently and uncontroversially summarised in *A Local Authority v H* [2023] EWCOP 4

> *"[12] From this statutory regime and the case law dealing with the statutory test the following principles can be drawn, as summarised in my decision in Kings College NHS Foundation Trust v C & V [2015] EWCOP 80 and the decision of Cobb J in WBC v Z and Anor [2016] EWCOP 4. Those principles are as follows:*
>
> *i) An individual is presumed to have capacity pursuant to s 1(2) of the Mental Capacity Act 2005.*
>
> *ii) The burden of proof lies with the person asserting a lack of capacity and the standard of proof is the balance of probabilities.*
>
> *iii) The determination of the question capacity is always decision specific. All decisions, whatever their nature, fall to be evaluated within the straightforward and clear structure of ss 1 to 3 of the 2005 Act, 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 state to be embellished.*
>
> *iv) 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 (Mental Capacity Act 2005 s 1(3).*
>
> *v) A person is not to be treated as unable to make a decision merely because he or she makes a decision that is unwise.*
>
> *vi) The outcome of the decision made is not relevant to the question of whether the person taking the decision has capacity for the purposes of the Mental Capacity Act 2005.*
>
> *vii) In determining the question of capacity, the court must apply the diagnostic and the functional elements of the capacity pursuant to ss 2 and 3 of the Mental Capacity Act 2005. Thus:*
>
> *a) There must be an impairment of, or a disturbance in the functioning of the mind or brain (the diagnostic test); and*
>
> *b) The impairment of, or disturbance in the functioning of the mind or brain must cause an inability to understand the relevant information, retain the relevant information, use or weigh the relevant information as part of the process of making the decision in question or to communicate the decision made.*
>
> *viii) For a person to be found to lack capacity there must be a causal connection between being unable to make a decision by reason of one or more of the functional elements set out in s 3(1) of the Act and the 'impairment of, or a disturbance in the functioning of, the mind or brain' required by s 2(1) of the Act.*
>
> *ix) With respect to the diagnostic test, it does not matter whether the impairment or disturbance in the functioning of the mind or brain is permanent or temporary.*
>
> *x) With respect to the functional test, the question for the court is not whether the person's ability to take the decision is impaired by the impairment of, or disturbance in the functioning of, the mind or brain but rather whether the person is rendered unable to make the decision by reason thereof.*

> *xi) An inability to undertake any one of the four aspects of the decision-making process set out in s 3(1) of the 2005 Act will be sufficient for a finding of incapacity provided the inability is because of an impairment of, or a disturbance in the functioning of, the mind or brain. The information relevant to the decision includes information about the reasonably foreseeable consequences of deciding one way or another."*

23. In *A Local Authority v JB* [2021] UKSC 52, the Supreme Court considered the question of capacity, as defined in the MCA 2005, for the first time. The judgment clarifies the order in which the questions, identified above, are to be addressed. Lord Stephens stated at para 61 that the MCA 2005 applies a *"function"* or *"understanding"* approach to capacity which *"focuses upon the personal ability of the individual concerned to make a particular decision and the subjective processes followed by him in arriving at the decision."*

24. As Lord Stephens sets out (paras 66-79), an assessment of capacity requires the court to address two questions:

> *"(a) first, whether the person is unable to make a decision in relation to a particular matter; and only if so*
>
> *(b) second, whether that inability is caused by an impairment of or disturbance in the functioning of P's mind/brain*."

In practice, the evaluation commences with diagnosis directed to establish that such an impairment/disturbance exists: this is a pragmatic approach, since if there is none, the assessment need go no further. Ms Roper submits, and I agree, that following the analysis in *Re JB,* which reflects the earlier case law, the question of causation should only be considered if the functional inability to make the decision has been established.

25. In considering the first, functional question, Lord Stephens emphasised the importance of identifying (1) the precise matter upon which the person's decision is required [68] and (2) the information relevant to that decision [69]. An assessor of capacity and the court must therefore ask as a preliminary matter, (1) *what is the decision to be made?* and (2) *what is the information relevant to that decision?*

26. The relevant information, defined in s3(4) MCA, which includes the reasonably foreseeable consequences of making or not making the decision, must be set within the specific factual context of the case [70]-[72], see: *PC v City of York Council [2014] 2 WLR 1*. The impact of this approach is that the assessment must be unique to P, and to P's specific circumstances. Thus, previous case law, suggesting that any particular type of decision must be assessed in a prescriptive way, must be approached with considerable caution.

27. Depending on the factual circumstances of the case, the reasonably foreseeable consequences within s3(4) may include the consequences not just for P but for other people [73].

28. The evidence of a psychiatrist is likely to be determinative of the issue of whether there is an impairment of the mind for the purposes of s2(1). However, the decision as to capacity is a judgment for the court to make: *Kings College Hospital NHS Foundation Trust v C* [2015] EWCOP 80 at [39], citing *Re SB* [2013] EWHC 1417 (COP) at [36]-[38]. In *PH v A Local Authority [2011] EWHC 1704 (COP)* Baker J helpfully identified the *"broad canvas approach"* to evaluating evidence of capacity at [16 (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] EWHC 136 (Fam), 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".*

29. The danger of elevating the instinctive need to protect a vulnerable adult to such a degree that it corrupts the integrity of an objective assessment of capacity, is an ever-present danger in this sphere of work and requires vigorously to be guarded against. Paternalism has no place; protection of individual autonomy is the magnetic north of this court.

30. As is clear from *Re JB,* this demands a highly fact specific approach. The practice of applying identified tests rigidly and *'as if they had the force of statute'* was deprecated in *LB Tower Hamlets v NB & AU [2019] EWCOP 27 at [42]-[43],* approved by the Court of Appeal in *Re B [2019] EWCA Civ 913 at [44].*

31. Primary evaluation of capacity requires not only identification of the decision itself – which though often clear, is not ubiquitously so, but also, the relevant information which informs the decision. This will be both fact and person specific.

32. It is not necessary for a person to use and weigh every detail of the potentially relevant information, merely the salient factors, *CC v KK and STCC* [2012] EWHC 2136 (COP) at [69] and *Heart of England NHS Foundation Trust v. JB* [2014] EWHC 342 per Jackson LJ at [25]. Lord Stephens considered that whilst the gravity of the consequences is a relevant issue, pragmatically, there must be:

> *".. a practical limit on what needs to be envisaged as the "reasonably foreseeable consequences" of a decision, or of failing to make a decision, within section 3(4) of the MCA so that "the notional decision-making process attributed to the protected person with regard to consent to sexual relations should not become divorced from the actual decision-making process carried out in that regard on a daily basis by persons of full capacity": see In re M (An Adult) (Capacity: Consent to Sexual Relations) at para 80. To require a potentially incapacitous person to be capable of envisaging more consequences than persons of full capacity would derogate from personal autonomy. [75]"*

33. Even though a person may be unable to use and weigh some information relevant to the decision in question, they may nonetheless be able to use and weigh other elements sufficiently to be able to make a capacitous decision: *Re SB* [2013] EWHC 1417 (COP).

34. *King's College Hospital NHS Foundation Trust v C & V* [2015] EWCOP 80 at [37]-[38]:

> *"Within the context of s 3(1)(c) it is not necessary for a person to use and weigh every detail of the respective options available to them in order to demonstrate capacity, merely the salient factors (see CC v KK and STCC [2012] EWHC 2136 (COP) at [69]). Even though a person may be unable to use and weigh some information relevant to the decision in question, they may nonetheless be able to use and weigh other elements sufficiently to be able to make a capacitous decision (see Re SB [2013] EWHC 1417 (COP)).*
>
> *It is important to note that s 3(1)(c) is engaged where a person is unable to use and weigh the relevant information as part of the process of making the decision. What is required is that the person is able to employ the relevant information in the decision-making process and determine what weight to give it relative to other information required to make the decision. Where a court is satisfied that a person is able to use and weigh the relevant information, the weight to be attached to that information in the decision-making process is a matter for the decision maker. Thus, where a person is able to use and weigh the relevant information but chooses to give that information no weight when reaching the decision in question, the element of the functional test comprised by s 3(1)(c) will not be satisfied. Within this context, a person cannot be considered to be unable to use and weigh information simply on the basis that he or she has applied his or her own values or outlook to that information in making the decision in question and chosen to attach no weight to that information in the decision-making process."*

35. This case had last been before me on 14th February 2023, to consider various case management directions. However, by that hearing, Dr Grace's report had arrived, expressing the conclusions that have been set out above. I was troubled about whether the criteria for an order pursuant to Section 48 MCA 2005 continued to be met i.e., was there reason to believe that Y lacked capacity in the contemplated spheres. I heard from Dr Grace and I found her evidence to be persuasive and well-reasoned. I asked if Dr Todd could be contacted. He was, but he remained firm on his own conclusion. Provision was made for a full transcript of what Dr Grace said to this Court to be prepared and sent to him for consideration. This was done but Dr Todd, again, respectfully, retained his view. Though it has been possible, as illustrated above, for both experts to identify clear and helpful areas of agreement and disagreement, I repeat, their ultimate conclusions on the key issues remain entirely different. It is important that I highlight that this is not a case where the two experts have been sucked into an ideological battle in which both have retreated to a defence of their amour propre. There is a genuine difference of opinion in which both have engaged in an intellectually honest dialectic. Having heard evidence from Dr Todd, I found his evidence to be persuasive and well-reasoned too.

36. It is this conflict of opinion rooted, on both sides, in measured and rigorous reasoning that presents the 'complexity' that Counsel have identified. As ever, the Court can only approach this by scrutinising the canvas of the broader evidence. The evidence of Y's father (F) strikes me as having a particular resonance. In his statement, dated 22nd February 2023, F is, in my assessment, doing his absolute best to describe Y and the way she functions. I recognise that there is a personal injury claim in the background and that, inevitably, those proceedings cast their shadow.

However, what is very clear from F's statement is the sincerity, precision and detail of his accounts. Moreover, they have what strikes me, if I may say so, a 'dad-like' quality to them. The following extracts are noteworthy:

> *"I gradually noticed that [Y] was becoming more withdrawn and seemed to lose some of the maturity that she had shown before the accident. She also seemed to have lost the confidence that she had gained whilst at college.*
>
> *I noticed changes to [Y]'s behaviour fairly soon after the accident but I did not worry about her head injury because I was told that it would clear up. The emphasis was on [Y]'s shoulder injury. I don't think that [Y]'s behaviour or difficulties have improved since then."*

37. In the above extracts, F is reflecting his understanding of the medical evidence. I very much doubt that he was ever told that the "head injury" would "clear up". But I do recognise his account as a layperson's interpretation of what I have been told is the prevailing medical consensus i.e., that there is often a period of noticeable improvement in the months following the injury. F also emphasises the extent to which the shoulder injury dominated treatment at this point. Reading the papers in this case and having regard to the issue in focus i.e., capacity, it is very easy to be distracted from the enormity of this physical life-changing injury. Mr Browne, and I make no apologies for repeating this, is entirely right to give it the prominence he does. F, it seems to me, is doing very much the same. The significance of this, in Dr Todd's view, is that this may have altered the conventional changes immediately following the frontal lobe injury or alternatively, they may have been present and eclipsed by the focus on the shoulder injury.

38. However, as F's statement continues, it strikes me, incrementally, as chiming far more closely with the analysis of Dr Todd, in particular, those features which he identifies as 'dysexecutive syndrome'.

> *"Before the accident [Y] had a good vocabulary, however since the accident she sometimes seems to struggle to find words. She is easily distractable now and particularly if there is noise in the background. If more than one person is speaking [Y] seems to find it difficult to filter out one conversation from another. She is easily overloaded with information and is forgetful, particularly in relation to her short-term memory which is really poor. She does not seem to be able to sequence things which is something that she could do before the accident. She starts something but then cannot remember what to do next. [Y] doesn't seem to be able to understand what is required and cannot initiate things herself or work things out in the way she did before the accident. Sometimes [Y] appears to shut down."*

39. Mr O'Brien had drawn my attention to the passage in F's statement below which he drew upon, rightly in my view, as illustrative of Dr Todd's opinion that Y displays an inability to organise and plan or to convert motivation into practice.

> *"Just a few weeks before the accident [Y] had carried out MOT prechecks on her motorbike, taken it for MOT and then filled in necessary paperwork at the post office for getting the vehicle taxed. Before the accident she could disassemble and reassemble things*

(e.g. Replaced a damaged bearing) in sequence. This was done with only an outline discussion with myself and no detailed support. She could plan things for the weekend earlier in the week and go and do the activity with friends."

40. Though it is not relevant to the issues that I am required to determine, I have noted F's reaction to Y's resolve to live life as a woman. It seems to me that the intuitive kindness, honesty and integrity with which he addresses an issue which might be challenging for many fathers, reinforces my impression of his integrity generally, in his approach to the wider capacity issues.

> *"[Y] has told me that she is trans and has started taking hormones and wishes to live as a woman and be known as [Y]. That has been a shock and I and [Y]'s wider family are coming to terms with it. I did wonder whether the accident had caused this. [Dr J] ([Y]'s treating psychologist in relation to gender issues) has told me that [Y] says that she had these feelings before the accident, and that her brain injury has meant that she has lost the ability and indeed the will to hide them. [Dr J] advises that even if the accident did cause the feelings, they are real to [Y] and given that her brain injury will never be fixed, it is a moot point. [Y] has disclosed that she is trans and wants to live as a woman and sees herself as a woman and wants to become a woman by taking cross sex hormones and ultimately having confirmation surgery."*
> *I don't think the [Y] fully appreciates the extent of her needs. She is a bit like a teenager who does not realise what goes on in the background to make things happen, she does not see that things are being taken care of and takes it for granted. She does not see how much effort it takes for things to happen and thins it happens automatically like the "laundry fairy". [Y] has no awareness of anything beyond her own needs.*

41. All these remarks strike me as having the hallmark of authenticity. The inability to plan, which F identifies, and the evidence pointing to Y's general inability to organise herself, strike me as being a long way from the young person who could strip down her motorbike and organise its general roadworthiness. These behaviours also strike me as 'pervasive' and in the way that Dr Todd suggests and not confined to occasions when she is "hyper aroused" as Dr Grace considers. I note the following:

> *"Prior to the accident, [Y] was very careful with money almost to the point of being miserly. Now she is profligate. She spends on impulse. She is like a child and jumps from one thing to the next when she is out in the shops and wants to buy half of what she sees. Taking her shopping is like managing a toddler in a supermarket. She jumps from one thing to another and wants what she sees. Given access to her own money, that is what she would do. In my view she is not capable of managing a budget to allow her to do the weekly shop; to pay bills; to deal with the unexpected expenses like a broken boiler or a broken down car and to re-budget accordingly. She could not manage that even with help, she is disinclined to budget and becomes distressed when discussions turn to money or budgeting or control of spending, or she simply goes blank and disengages. That has not improved, and I can't see that it will in the future."*

42. There is a further incident which F relates which may show features which support both professional perspectives. I include it for that reason but also because it strikes me as illustrating something of the way that Y now functions, more generally:

> *"[Y] finds making choices difficult. Whilst she was with me and the family over Christmas, we went out to an Indian restaurant. [Y] likes Indian food. However, it was not a place that she had been to before. She found it very difficult to stay focused and struggled with choosing from a menu. For example, she likes naan bread. The restaurant did very large ones for sharing and she could not deal with the fact that they were larger than normal and order one to share. She could not commit one way or the other to making a decision. This wasn't a disinclination to share. It was an inability to manage the difference. She found it difficult to choose from the menu. She just could not engage when the group were selecting what they wanted to eat. We were all ordering dishes to share, so that everyone could have a taste of a wide variety of curries. She went blank and disengaged when being asked what she wanted, and I had to order a number of dishes for her. If she had been offered a choice between A & B, then she would likely have been able to choose if told she had to choose A or B. Left to her own devices, she would choose neither or both. Having multiple choice, and having to select things to share, and having to think what would go well with some other selection was a wider decision tree in a fairly mundane context and she just could not manage. It was noticeable to me and the wider family, but we did not make a fuss about it."*

43. This passage, having heard the evidence from both doctors, strikes me as encapsulating the first ground of agreement emerging from the expert's meeting (see para. 14 above), namely that Y's mental health/psychological presentation is likely to be the product of more than one process.

44. Ms Butler-Cole advances full-throated support for the views of Dr Grace. She places great weight on the fact that Dr Grace has had more involvement with Y than Dr Todd who saw Y in May 2022 and has not seen her since. Ms Butler-Cole suggests that it is a deficiency of Dr Todd's analysis that he has not been able to speak to either of Y's parents. In her closing written submissions, Ms Butler-Cole states:

> *"Dr Todd's evidence at every point came back to his strongly held view that [Y] does not understand 'fully' the nature of her brain injury, its impact on her functioning and therefore its implications for her care needs. It was abundantly clear that Dr Grace does not share Dr Todd's view about the impact of [Y]'s brain injury on her functioning – it cannot be right to rely on [Y]'s alleged failure to grasp these matters when the court-appointed expert does not agree with them, and when Dr Todd accepted that was a reasonable view to take."*

As will be clear from my analysis above, I do not consider that to be an entirely accurate characterisation of Dr Todd's opinion nor does it reflect the significant areas of agreement between the two experts. To my mind, what Dr Todd is emphasising is Y's inability to plan or to convert an expression of motivation into practice in the way that she was able to do so before the accident and which is behaviour which Dr Todd considers, within mainstream opinion, as consistent with brain damage. He has been taken to F's statement and has interrogated it, as

indeed I have, in the context of his central proposition. There is also, as I understand it, a consensus view that Y's mother is unlikely to be an entirely reliable chronicler of events. Her apparent resistance to therapeutic support for Y, historically, has properly been deprecated. Later, Ms Butler-Cole makes the following submission:

> *"Dr Todd relied heavily on the lack of meaningful activity or routine. His view was that watching Netflix, seeing family, playing the piano and so on was not good enough. There had to be not just 'community access' but this had to be regular and routine. There needed to be participation in a course or vocational programme. At the time he assessed [Y] she had just left almost a year in a rehabilitation unit, and had only been in her own property for a matter of weeks. There is no evidence that her staff have tried hard to support her to participate in a course or other programme and that she has been unable to manage it. She does now do more activities (for example going to the gym – see the Gym Support Plan) but her rehabilitation plan of 7 January 2023 does not even include finding courses or programmes for her to participate in as a goal There is a real issue about staffing in any event – staff had been completing written records dishonestly and inconsistently and a new team leader was introduced around February 2023 to address problems with the care provision."*

Again, I think Ms Butler-Cole is not doing justice to the central point that Dr Todd is making, which is broader than "lack of meaningful activity or routine" and predicated on his perception of a qualitatively different post-injury behaviour that Dr Grace does not see, other than perhaps, in times of heightened arousal. Dr Grace considers that Y's difficulties are, as I understand her opinion, predominately caused by her anxiety and fail to meet the diagnostic test of capacity.

45. Executive dysfunction and frontal lobe paradox is, as Ms Butler-Cole correctly submits, not to be regarded as synonymous with the functional test for mental capacity. The former derives from clinical practice, the latter is the test prescribed by MCA. Neither is 'insight' to be viewed as equating to or synonymous with capacity. To elide those two would be to derogate from personal autonomy, every adult from time-to-time lacks insight into an issue or indeed into themselves. I do not consider that Dr Todd falls into these rudimentary errors. It must be emphasised that severe traumatic brain injury has been identified neuroradiologically in this case and that this is not challenged. Dr Todd considers that Y has cognitive, emotional and behavioural manifestations which are not confined to periods of heightened arousal but are pervasive and reductive of capacity for problem solving. These, he considers are frequently associated with frontal lobe damage. Again, whilst recognising the variability of these behaviours, I do not understand this central premise to be in dispute. The consequence, Dr Todd contends, is to impair the ability to think consequentially and ultimately, to be able satisfactorily to understand, retain or weigh information in order to make a decision about care needs and accommodation. To my mind, that establishes both the functional and diagnostic test. Moreover, for the reasons I have already explained, I consider that the accounts given by F very much reinforce Dr Todd's views and do not sit as comfortably with those expressed by Dr Grace. It is Dr Todd's opinion which unifies most of (though by no means all) the features of what is undoubtedly a complex evidential matrix.

46. I do not consider the case is "delicately balanced" in the way that phrase is frequently used. The decision is essentially binary. It requires me to determine which of two carefully analysed opinions I consider likely to be accurate. I have come to the clear view that Dr Todd's opinion is to be preferred and for the reasons I have already stated. This is not, in any way, to reject all that Dr Grace has said. On the contrary, as I have highlighted, there is much common ground between the two professionals. I am particularly alert to her entirely proper warning that a dissociation

between knowing or understanding and a failure to follow through or convert to action, is not, axiomatically, pathological. It would be reductive of Dr Todd's opinion however, to characterise it in that way.

47. The presumption of capacity is the central tenet of the MCA. It is a powerful safeguard of civil liberty. It requires to be rebutted on cogent evidence, nothing else will ever do. The principle was well embodied in the case law that preceded the MCA. It is both a guard against the power of the state and a gateway to State support where needed. It is woven into the professional DNA of practitioners and Judges in this important and evolving sphere of the law. I feel confident that every Judge, evaluating a question of capacity, approaches the test with a resolve to find that an individual has capacity and arrives at a contrary conclusion only when the evidence demands it. Having concluded that Y lacks capacity to make decisions relating to her care and accommodation, it is important always to remember that the MCA constructs an ongoing obligation to promote capacity, in effect, to build a pathway to capacity where there is a prospect of it. There is evidence that Y is making progress cognitively and more broadly. That evidence, at present, has a degree of fragility which causes me to draw back from any more confident assertion. What it indicates, however, is the importance of the obligation to provide a scaffolding of support for Y in order that she is availed of the very best opportunity to reassert her autonomy in these two very important spheres of decision taking. It may well be that in the months to come, the landscape might change and require my decision to be revisited. I suspect, though I may be entirely wrong, that some of Dr Grace's reservations may also reflect my own sense from the evidence that Y's situation remains an evolving one.