Neutral Citation Number: [2023] EWCOP 30

Case No: COP13810531

IN THE COURT OF PROTECTION
IN THE MATTER OF MENTAL CAPACITY ACT 2005 IN THE MATTER OF TW

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 18/07/2023

Before :

MISS KATIE GOLLOP KC
SITTING AS A DEPUTY HIGH COURT JUDGE

- -

Between :

	TW (BY HIS LITIGATION FRIEND, THE OFFICIAL SOLICITOR)	**Applicant**
	- and -	
	MIDDLESBROUGH COUNCIL	**Respondent**

- -
- -

Mr Simon Garlick (instructed by **BHP Law)** for the **Applicant**
Mr Adrian Francis (instructed by **Middlesbrough Council)** for the **respondent**

Hearing dates 20th and 21st June 2023

- -

Approved Judgment

This judgment was handed down remotely at 10.30am on 18th July 2023 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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MISS KATIE GOLLOP KC

This judgment was delivered in private. The judge has given leave for this version of the judgment to be published on condition that (irrespective of what is contained in the judgment) in any published version of the judgment the anonymity of the children and members of their family must be strictly preserved. All persons, including representatives of the media, must ensure that this condition is strictly complied with. Failure to do so will be a contempt of court.

Miss Katie Gollop:

1. This application, made in August 2021, concerns a man now in his mid fifties who I shall call Tony. The issue for the court to determine was whether Tony has, or does not have, capacity to make decisions about which of two places of residence to live at, his care, and his use of the internet and social media. At the end of a hearing lasting one and a half days, the parties agreed that he lacks capacity in relation to all of these matters. I concurred and made declarations and interim orders accordingly. As the evidence suggested that there may be some unhelpful differences of approach to the diagnosis of Learning Disability amongst healthcare professionals, and the case concerns the effect of deprivation on mental development in the context of profound deafness, I was asked to provide a written judgment which I now do.

2. For many years, professionals concerned with Tony's best interests have supported him on the basis that he has a mild Learning Disability. That diagnosis was called into question by expert evidence provided by Dr O'Rourke, consultant clinical psychologist, in May 2022 after she undertook psychometric testing and identified that Tony's IQ is in the low average range, meaning that he does not meet one of the three mandatory diagnostic criteria. She was equally clear in her conclusion that his inability to understand information relevant to the matters in issue, and to comprehend the consequences of his decisions, means that in relation to the relevant matters, he functions as if he has a Learning Disability.

3. By the time this application came before the court in June 2023, the parties had had the benefit of MacDonald J's decision in *North Bristol NHS Trust v R* [2023] EWCOP 5 for some months. Paragraph 47 of that judgment explains why a formal diagnosis of a mental health condition or brain injury is not a necessary prerequisite to a finding that a person lacks capacity to make a decision about a matter, within the framework of the Mental Capacity Act 2005:

> "*…the wording of s.2(1) itself does not require a formal diagnosis before the court can be satisfied that whether any inability of R to make a decision in relation to the matter in issue is because of an impairment of, or a disturbance, in the functioning of the mind or brain. The words "impairment*

> *of, or a disturbance in" are not further defined elsewhere in the Act. In these circumstances, there is no basis for interpreting the statutory language as requiring the words "impairment of, or disturbance in" to be tied to a specific diagnosis. Indeed, it would be undesirable to do so. To introduce such a requirement would constrain the application of the Act to an undesirable degree, having regard to the complexity of the mind and brain, to the range of factors that may act to impair their functioning and, most importantly, to the intricacies of the causal nexus between a lack of ability to take a decision and the impairment in question. In PC v City of York Council McFarlane LJ (as he then was) cautioned against using s.2(1) as a means "simply to collect the mental health element" of the test for capacity and thereby risk a loss or prominence of the requirement of a causative nexus created by the words "because of" in s.2(1). Reading s.2(1) as requiring a formal diagnosis would in my judgment significantly increase that risk.*"

4. One might then question why the application was pursued. The answer is that the lack of a formal diagnosis of Learning Disability was actively causing Tony problems in his everyday life. Tony has a long history of using the internet to access images of child sexual abuse. (I am grateful to the Official Solicitor for alerting me to the fact that it is not appropriate to refer to "child pornography", and that this is the preferred and appropriate term.) The latest discovery of such behaviour was in November 2019 when police were involved and removed three internet enabled devices. Tony's care was transferred to the Council's Forensic Disability Service and its Forensic Social Care Team in around February 2021.

5. Prior to Dr O'Rourke's May 2022 report, preparations had been underway for Tony to move from Placement 1, where he had lived since January 2019, to Placement 2. Placement 2 is a five bedded residential care home exclusively for male adults at risk of coming into contact with the criminal justice system as a result of their offending behaviour. Tony had visited Placement 2 on a number of occasions and expressed a desire to move there. However, Placement 2's registration with the Care Quality Commission requires that its service is accessible only by male residents with Learning Disability.

6. Since being advised of Dr O'Rourke's conclusion in May 2022, and at the start of the hearing in June 2023, Placement 2's position was that it would not be able to accept Tony as a client unless he had a formal diagnosis. Accordingly, his transition to Placement 2 had had to be put on hold, and the respondent Council had been paying to keep his place there open for over a year pending the court's determination of this application. Further, Tony's continued access to the Forensic Disability Service was in jeopardy because there was doubt about whether it could properly be said that he has a mental health disability at all.

7. At the start of the hearing, the respondent's position was that Tony *does* meet the criteria for a formal diagnosis of Learning Disability, though its evidential basis for that position was unclear. The Official Solicitor, acting on Tony's behalf, wished to listen to Dr O'Rourke's oral evidence before taking a view. There was a collaborative process of exploring the relevant criteria, and mapping them on to Tony's life history and current presentation. At the end of that, Dr O'Rourke was asked whether she would endorse a formulation that in the context of having an IQ on the fourteenth centile, Tony has a longstanding impairment of the mind or brain, acquired before his eighteenth birthday as a result of prolonged deprivation of communication, education and life experience, which is best termed "a functional learning disability". She said that she would. The respondent made enquiries of Placement 2 which confirmed that that formulation would suffice to enable them to offer Tony a place (subject to regularisation of registration requirements with the CQC).

About Tony

8. Tony was born with cerebral palsy which, as was apparent during my brief meeting with him, affects the movements of his head, trunk and hands in particular. He was also born profoundly deaf. In 2017 he fractured his spine and he has been a wheelchair user since then.

9. He deploys a variety of methods of communication including British Sign Language, some Makaton, and other signs of his own devising which he supplements with occasional written notes. Cerebral palsy makes fingerspelling effortful and tiring.

However, he does not find direct use of BSL problematic. In addition, he has some useful speech sounds and lip patterns. It follows that he has some communication with hearing people generally, but opportunities for exchange of information and development of understanding are better with someone who has some BSL qualifications, and optimal with a person such as Dr O'Rourke, who is BSL fluent. Dr O'Rourke was at pains to explain that BSL is not English converted into signs, it is its own separate language with its own idioms.

10. Information about his early years, education and life in various different residential settings was very helpfully gathered and set out in a witness statement by his care manager. There are some gaps but a clear picture emerges. Tony was placed in the care of the local authority by his parents when a small baby, little is known about his family: his father is thought to have died and there is no information about his mother or brothers.

11. Between birth and the age of 20 years, he went to nurseries and schools as far apart as Leeds, Sussex, Kent and Clwyd, Wales. Though he was taught a form of signing, all of these establishments were for hearing children because priority was given to meeting his physical rather than his communication needs. It follows that Tony grew up with no exposure at all to his deaf peers. The records paint a picture of a child who bit people when angry, who could be uncontrollably aggressive, and who sometimes wept profusely. He was thought to be emotionally deprived and angry when unable to communicate. He was also able to make educational gains with reading, writing and numeracy, and he enjoyed group work and being a helper. A foster carer looking after him at age 16 years reported that if his demands were not met he would try to run away, and he once threatened her with a knife when she was unable to buy a piece of computer equipment he wanted.

12. It was not until age 20 years that Tony went to live at a facility for deaf people. He was described as lacking an identity and he developed a fascination with hospitals and a fantastical belief that he had medical and forensic knowledge. In his thirties, he went to college and learned computer skills. He would leave the placement and go out in search of his family and then be escorted back by the police. Strange behaviours persisted (he bought a high visibility jacket and attempted to direct the traffic and to

work as a security guard at a hospital) as did aggression towards others. He was thought to have a short attention span and to lack capacity to live independently. Testing of intellectual and adaptive functioning was undertaken and the conclusion was that overall, he did not have a learning disability. In 2011 he moved into his own flat supported by carers who came in every day and that arrangement worked well for just under three years.

13. In 2014, staff reported to the police that Tony had been accessing images of child sexual abuse and his devices were seized. He assaulted his social worker by biting her, he signed that he needed help with his mental health, and he made desperate attempts to get access to a computer. He was assessed by a now retired consultant clinical neuropsychologist known to, and well respected by, Dr O'Rourke. The consultant found that Tony's scores for general functioning were at the top of the range of abilities associated with a mild learning disability but he scored much lower in relation to concentration and memory skills. He was noted to demonstrate resourcefulness in relation to executive functioning but the contradictory test results suggested that although he had some good problem solving skills, Tony would struggle to deploy them in real life situations.

14. Both before and after his spinal injury in 2017, Tony persisted in accessing images of child sexual abuse despite completing internet safety training. In 2021, a group of professionals from the Adult Learning Disability team, including an interpreter and a social worker who knew him well and who was able to sign, completed an assessment of his capacity to use the internet. The group agreed that he was unable to understand and weigh up the consequences of looking at such images and took the view that functionally he had a learning disability. The police were involved and a COP9 application form states that Tony was served with a Sexual Risks Order and that there were court hearings.

15. At around this time, Tony indicated that he wanted to "bite" and also "sack" his social worker who withdrew from working with him. He was allowed to use a computer so long as he was supervised whilst doing so and he responded to that limitation by saying that he would prefer not to use a computer at all. Contact was made with Placement 2 and after some visits, Tony indicated that he wanted to go and live there.

It was within this context that he brought these proceedings challenging the standard authorisation of his deprivation of liberty at Placement 1, his care and restrictions on his internet use, and the court gave the parties permission jointly to instruct Dr O'Rourke to opine on capacity.

Dr O'Rourke's Evidence

16. Dr O'Rourke is a consultant clinical psychologist who has worked predominantly in the field of mental health and deafness since 1989. She has extensive experience of forensic services, for example as the Manager of Deaf Services at Rampton Hospital and as the head of psychology at a medium secure unit. She is also fluent in BSL and a Qualified Sign Language Interpreter, and her doctoral thesis concerns deaf people in the criminal justice system. She is a national, if not international expert in her field, and she gave evidence with very considerable authority.

17. She made her assessment of Tony's capacity in accordance with the 2015 Guidance on the Assessment and Diagnosis of Intellectual Disabilities in Adulthood published by the British Psychological Society ("the BPS Guidance"). Of note is the fact that the BPS Guidance deprecates the use of screening tools, and reliance on just one part of the assessment process. Further, it recommends that "*a judgement as to whether or not an individual has an intellectual disability should only be made when all three components of the assessment are carried out by an appropriately qualified professional, who is able to justify their opinion in accordance with this guidance. This would reduce confusion for individuals, families and services."* The appropriately qualified professional will be a psychologist.

18. The three criteria necessary to an assessment of learning disability are:

    a) a significant impairment of intellectual functioning; and
    b) a significant impairment of adaptive behaviour (social functioning); with
    c) both impairments arising before adulthood.

Significant means more than two standard deviations below the population mean which is 100. Intellectual functioning refers to a Full-scale IQ score and therefore the relevant threshold of this criterion is 70. Adaptive behaviour refers to a score on a standard measure of Conceptual, Social, Practical or General adaptive behaviour skills. "Before adulthood" means prior to age 18 years.

19. The BPS Guidance deals specifically (at paragraph 4.6) with the fact that IQ and adaptive behaviour are not highly correlated (the document uses the term "intellectual disability" rather than learning disability):

> "*This is reflected in the fact that of the just over 2.5 per cent (approximately) of the population whose IQs are believed to be under 70, just a quarter to a third are known to Intellectual Disability Services; this implies that many people with this level of cognitive ability are nevertheless able to function adequately in their everyday lives and so do not fulfil the criterion of a 'significant impairment of adaptive behaviour'. Conversely, there are many people whose adaptive behaviour is impaired but whose IQs are above 70, who are known to services as 'vulnerable adults', and who fulfil the criteria for certain other conditions, such as autistic spectrum disorder, personality disorder, etc. (It is generally true that people who are referred to services have deficits in their adaptive behaviour; indeed this usually is the reason why they need help and are referred in the first place.)*"

20. Dr O'Rourke first saw Tony in early February 2022. Some Covid restrictions were still in place and they were separated by a screen which made comprehensive psychometric testing impossible. When she re-visited him in May, she assessed using the Wechsler Adult Intelligence Scale fourth edition (WAIS-IV). Tony's ability to complete one test was adversely affected by his physical disability and he was given more time. She conducted a long interview with Tony and she also spoke to his Team Leader and the care manager who had provided the witness statement with information about his early years, care and placements, and who had been part of the group assessing him in 2021. Dr O'Rourke's conclusions on capacity to make decisions about residence, care and use of the internet were that:

a) Tony's nonverbal skills were within the normal range;
b) however his acquisition of knowledge and skills was poor as a result of deafness leading to lack of access to information and learning;
c) that lack of access is not unusual among deaf people but it had been exacerbated in Tony's case as a result of him being in schools for hearing children in his formative years and thus without access to effective communication with his peers;
d) consequently, he had poor understanding of matters that would be understood by most individuals with his nonverbal skills
e) that inconsistency was explained by educational and experiential deprivation, not organic impairment;
f) the fact that his intellectual potential was within the normal range raised the question of whether the diagnostic test of the MCA was met.

21. In July 2022, Dr O'Rourke provided answers to questions put by the parties. By this time, she had had access to additional records and the 2014 WAIS scores. She explained that on proper analysis of the 2014 test results, and when she administered the updated tests in 2022, he scored in the low average range for IQ, on the fourteenth centile, and therefore did not meet the criteria in the BPS Guidance for a diagnosis of Learning Disability. She elaborated on this: "*The fact that he can learn computer skills, adapt his signing to meet my needs, understand humour and answer questions involving 'why?', all support the notion that he does not have a learning disability. However, there are clear deficits in understanding of more abstract and complex matters and impairments in adaptive functioning, most notably a lack of insight into his own needs and matters concerning risk.*" She went on to say that "*this discrepancy and his very obvious difficulties in adaptive functioning are a result of lack of access to formal and incidental learning, lack of opportunity and impoverished linguistic environments which did not afford him the opportunity to develop."*

22. As I have noted above, Dr O'Rourke's opinion was tested in court when she gave oral evidence. She was robust in defending and explaining her assessment of Tony's IQ and

there was no serious challenge to that. She explained that most hearing people in the same IQ range will have capacity to make decisions on the matters in focus and that had Tony attended a residential school for deaf children, his level of understanding would not be where it is now. However, institutionalisation, combined with deprivation of communication, peer relationships, and opportunities to learn give and take and conflict resolution skills, meant that his learning was "*both absent and skewed*". His understanding was limited because his experience of life has been so limited.

23. She said he had learned words such as "court" and "prison" but had no understanding of what they mean in reality. In relation to images of child sexual abuse, he has learned to say, if asked directly, that it is wrong, has acquired the knowledge that people will be cross with him if he looks at it and will take the internet away, and has adapted to that by hiding devices when he can. However, he has no understanding of the potential criminal justice consequences of accessing such images, how they are harmful to the children involved, why people get cross with him for looking at them, or why society deems the images unacceptable. He is unable to understand why his behaviour in this regard puts himself or others at risk. She recommended that work be done with him to help him to gain some insight into these matters and considered that Placement 2 is the right environment for him. However, she thought that it would take "years" before there was a chance of him gaining capacity in relation to use of the internet, and even then she was not optimistic because of the level of impaired or absent development.

24. Notwithstanding her very considerable expertise, the court was told that two other clinicians rejected Dr O'Rourke's opinion that Tony cannot properly be diagnosed with a Learning Disability. The respondent Council reported that in June 2021, within the Deprivation of Liberty Safeguards process, a GP had assessed him as having a mild Learning Disability. During the hearing, the Council asked the GP if she wished to revise her view in the light of Dr O'Rourke's reports. It reported that the GP had responded by saying that having read the expert evidence, she was "entrenched" in her view. However, when requested to say so in writing, the GP sent an e mail in which she expressed no view at all, and advised that it was not within her expertise to make a diagnosis of Learning Disability.

25. It happened that the hearing took place just before the expiry of the standard authorisation of Tony's deprivation of liberty at Placement 1. The respondent arranged for him to be assessed in that regard by a psychiatrist, Dr G, whilst Dr O'Rourke was giving evidence, and Dr G was provided with her reports and asked to consider them. The hearing was then told (no documents were available) that like the GP, Dr G had also diagnosed mild Learning Disability. No explanation was available as to how he reached that diagnosis when he had not himself administered the WAIS-IV tests.

26. The reported diagnoses of the GP and psychiatrist, in the face of Dr O'Rourke's assessment of IQ, are important because they illustrate the confusion identified by the BPS Guidance, and the pertinence of the recommendations it makes with regard to the need for assessment of Learning Disability to be made by a trained psychologist in accordance with the Guidance. When Dr O' Rourke was asked how she thought it was that a GP and a psychiatrist disagreed with her expert opinion, she said that in her experience most (though not all) psychiatrists are not trained to administer the WAIS tests, and may not be fully cognisant with them or fully appreciate their significance.

27. It may be that some healthcare professionals assume an IQ below 70 where the adaptive behaviour criterion is clearly met. Alternatively, there may be a linguistic issue. The term "learning disability" may be being used as a descriptor of functional incapacitous decision making, without an intention to connote a formal diagnosis. Whatever the explanation, the present case demonstrates there will be occasions when P's welfare is compromised if there is confusion about whether all three criteria are met, and a lack of robust evidence supporting any diagnosis. Further, if the practice of referring to a person provided with adult social care as having "mild learning disability" where that person's IQ is properly assessed as being over 70 is widespread, that practice may undermine the validity of the diagnosis. It may mean that the potential of people who have the capability to gain capacity is not being maximised, or that their strengths and weaknesses are not being analysed in the way envisaged by the BPS Guidance (see paragraph 5.7) with deleterious effect. It may perhaps be helpful if healthcare professionals recording that a person has a learning disability (with or without capital letters) go on to state whether that assessment is "within BPS Guidance" or "outside BPS Guidance".

The Law

28. The relevant sections of the Mental Capacity Act 2005 provide that:

> "**1 The principles**
>
> …
>
> (2) A person must be assumed to have capacity unless it is established that he lacks capacity.
>
> (3) 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.
>
> (4) A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
>
> …
>
> **2 People who lack capacity**
>
> (1) For the purposes of this Act, 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.
>
> (2) It does not matter whether the impairment or disturbance is permanent or temporary.
>
> (3) A lack of capacity cannot be established merely by reference to—
>
> (a) a person's age or appearance, or
>
> (b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about his capacity.
>
> (4) In proceedings under this Act or any other enactment, any question whether a person lacks capacity within the meaning of this Act must be decided on the balance of probabilities.
>
> …
>
> **3 Inability to make decisions**
>
> (1) For the purposes of section 2, a person is unable to make a decision for himself if he is unable—
>
> (a) to understand the information relevant to the decision,
>
> (b) to retain that information,
>
> (c) to use or weigh that information as part of the process of making the decision, or

> (d) to communicate his decision (whether by talking, using sign language or any other means).
>
> (2) A person is not to be regarded as unable to understand the information relevant to a decision if he is able to understand an explanation of it given to him in a way that is appropriate to his circumstances (using simple language, visual aids or any other means).
>
> (3) The fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him from being regarded as able to make the decision.
>
> (4) The information relevant to a decision includes information about the reasonably foreseeable consequences of—
>
> (a) deciding one way or another, or
>
> (b) failing to make the decision."

29. I refer, gratefully, to the comprehensive summary of the key principles relevant to capacity set out by Macdonald J in paragraph 41 of *North Bristol NHS Trust v R*. In *A Local Authority v JB* [2023] UKSC 52, the Supreme Court explained the correct approach to any assessment of whether P lacks capacity to make a decision. Paragraph 65 tells us that:

> "*The core determinative provision within the statutory scheme for the assessment of whether P lacks capacity is section 2(1). The remaining provisions of sections 2 and 3, including the specific elements within the decision-making process set out in section 3(1), are statutory descriptions and explanations which support the core provision in section 2(1). Those additional provisions do not establish a series of additional, freestanding tests of capacity. Section 2(1) is the single test, albeit that it falls to be interpreted by applying the more detailed description given around it in sections 2 and 3: see the judgment of McFarlane LJ in York City Council v C at paras 56 and 58-60.*"

Conclusion

30. I am satisfied that on a balance of probabilities, Tony lacks capacity to decide: whether to live at Placement 1 or Placement 2, who should care for him and the type of care and support he receives, and what use to make of the internet and social media. In relation to each decision, the inability exists by reason of an impairment in the functioning of his mind or brain. The impairment, which operates as a functional learning disability, is the result of stunted mental development, occurring before the age of 18 years, as a result of prolonged deprivation of communication, education, social learning and life experience, in combination with institutionalisation. That impairment renders Tony unable to understand why accessing images of child sexual abuse is wrong, the potential consequences for him if the police are involved, and the harm caused to children directly and to wider society indirectly by his actions when he is allowed unrestricted, unsupervised internet access.

31. This inability to understand why he must not access such images underpins his lack of capacity in relation to residence and care. Tony has decided he wants to live at Placement 2, not because of the opportunities it offers him to gain insight into, and step away from this behaviour but because he thinks that if he moves there, there is a chance he will get his devices back. He lives in hope of that happening because he is unable to understand why his internet access has to be restricted. As to his care, he rejects high quality support from professionals he gets on with, and who like and understand him, when those professionals prevent him from going online unsupervised. He is unable to understand that no support worker will allow this and wrongly believes that if he shops around for long enough, unfettered internet access will be restored.

32. I have made final declarations that Tony lacks capacity in relation to these three matters, and that he lacks capacity to litigate these proceedings. I have also authorised a resumption of his transition to Placement 2, pending final determination of his best interests in relation to residence, care, support, and use of the internet and social media.

33. In addition, I have made interim orders which permit support workers to supervise Tony's access to the internet and social media, and prevent him from accessing images of child sexual abuse, or any other material they consider may be illegal or which may make those viewing or possessing the images liable to criminal prosecution. I declined to accede to the Official Solicitor's application to bring what were described as "crime

adjacent" images of children within the ambit of that interim order. I was told that in the past, when Tony has access to a device with software that prevents him from accessing images of child sexual abuse, he may seek out pictures or video of, for example, children in swimming costumes in a paddling pool. It appeared to me that viewing or possession of such images may not be unlawful, that such a measure could be unduly restrictive, and in any event may be difficult to justify in circumstances where Tony is currently choosing not to use a screen at all whilst supervised. This is a matter that is properly ventilated and determined at the final best interests hearing, where a proposed Care Plan is likely to be available.