Neutral Citation Number: [2024] EWCOP 11

Case No: 13577100

IN THE COURT OF PROTECTION

Date: 23 February 2024

Before:

MR JUSTICE POOLE

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Between:

Re: CLF (Capacity: Sexual Relations and Contraception)

SUNDERLAND CITY COUNCIL **Applicant**

- and –

(1) CLF (By her Litigation Friend, the Official Solicitor)
(2) NJF (A protected party by her Litigation Friend, the Official Solicitor)
(3) JT
Click here to enter text. **Respondents**

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Sam Karim KC (instructed by EMG Solicitors Ltd) for **the Applicant**
Joseph O'Brien KC (instructed by BHP Law via the Official Solicitor) for **the First Respondent**
Richard Copnall (instructed by David Gray Solicitors via the Official Solicitor) for **the Second Respondent**
The Third Respondent in person attending remotely

Hearing dates: 6 February 2024

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This judgment was delivered in public but a transparency order is in force. 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 OR the parties] must be strictly preserved. All persons, including representatives of the media and legal bloggers, must ensure that this condition is strictly complied with. Failure to do so may be a contempt of court.

Mr Justice Poole:

Introduction

1. This judgment concerns the mental capacity of CLF to make a variety of decisions for herself. The Applicant is the Local Authority responsible for CLF's placement and her care. The Second Respondent is CLF's mother, who herself lacks mental capacity to conduct proceedings and who is also represented by her litigation friend, the Official Solicitor. The Third Respondent is CLF's grandmother with whom CLF has lived in the past. CLF met with me remotely from her placement prior to the hearing and a note of our meeting was later circulated to the parties by BHP Law. CLF's capacity to make decisions about the following matters falls to be determined:

    i) The conduct of these proceedings
    ii) Residence
    iii) Care
    iv) Contact with Others
    v) Use of the internet and social media
    vi) Engagement in sexual relations
    vii) The use of contraception.

    I heard oral evidence from KD, a senior social worker with the Applicant Local Authority, and from Dr Lisa Rippon, Consultant Developmental Psychiatrist. By the time of closing submissions the parties were agreed that CLF lacks capacity to conduct the proceedings and to make decisions about her care, contact with others, and the use of the internet and social media. Mr Karim KC on behalf of the Local Authority submitted that CLF lacks capacity to make decisions about residence but Mr O'Brien KC for CLF submitted that whilst she lacks capacity to make decisions about her residence in a general sense, she has capacity when presented with concrete choices about where to live, provided that the care arrangements in those places have been determined for her and meet her needs. All parties agreed that CLF lacks capacity to make decisions about the use of contraception but Mr O'Brien KC submitted that any declaration to that effect should be made on an interim basis only because CLF may gain capacity in that area of decision making after focused educational work. As to capacity to engage in sexual relations, the Local Authority and First Respondent agreed that she has capacity, but Mr Copnall submitted that she does not. JT largely aligned herself with the submissions made by Mr Copnall.
2. Given the measure of agreement between the parties, and the very helpful and considered evidence of Dr Rippon, I need not dwell on the issues of CLF's capacity to conduct the litigation and to make decisions about care, contact with others, and the use of the internet and social media. I accept the expert evidence and the agreed positions of the parties on those areas of decision making and shall make the final declarations sought.

Background

3. CLF has been known to the Applicant Local Authority's Children's Services since early childhood. . Her mother suffered recurrent bouts of mental illness. In August 2008 a Residence Order was made in favour of JT but the relationship between CLF and her grandmother was very difficult as CLF responded violently when JT attempted to set

boundaries in relation to her use of social media. In February 2020 CLF was made subject to a child protection plan and shortly afterwards she was moved from JT's care to a placement. Proceedings in the Court of Protection were issued in March 2020 and interim declarations of lack of capacity and best interests were made. The Official Solicitor accepted an invitation to act as litigation friend for CLF.

4. CLF has moved from placement to placement since these proceedings began. She has also spent time back at JT's home. She has absconded on a number of occasions. She has also had relations with men, often after initial contact on the internet, that have placed her at risk. The evidence produced to me, including through the statements of KD, shows that during the last nine months or so, the following incidents and developments have occurred:

   i) In April 2023, CLF reported that she had sex with a male in some woods. Screenshots showed that she had received text messages from unknown males arranging for her to have sex.
   ii) On 8 May 2023, CLF left her placement and was reported missing. She returned later that evening together with a male whom she had met online.
   iii) At the same time, CLF had a boyfriend, R, who also has a learning disability and whose capacity to decide to engage in sexual relations has been questioned, through whom CLF appeared to be engaging with "unknown males".
   iv) At that time, CLF refused to comply with the internet and social media plan which required her to hand over her mobile telephone. However, concerns over sexualised contact with other men reduced and she was in a stable relationship.
   v) By September 2023 staff were reporting an escalation in CLF's behaviour. In the five weeks to 17 September 2023 CLF was reported missing from her home on seven occasions. Complaints were received from neighbours about her creating noise. CLF was reported to have pushed a neighbour during an altercation.
   vi) On 12 September 2023, CLF reported that her contraceptive implant had been removed and JT reported that she believed that CLF and her boyfriend were engaging in sex.
   vii) On 19 September 2023, CLF had barricaded herself in her room and was "actively self-harming". This followed a call from her ex-partner, R.
   viii) CLF began a new relationship with D about whom very little is known.
   ix) In November 2023 CLF absconded from her placement on a number of occasions and engaged in sexual relations. On 11 November 2023 she engaged in unprotected sex and required the 'morning-after pill'. On 13 November she was seen to enter a car which had arrived at her placement. The driver told staff that he had met CLF two hours previously on Tinder.
   x) On 15 November 2023 another male arrived by car at the placement and CLF entered the car which was then driven off.
   xi) On the evening of 16 November 2023, CLF absconded and was later found at a night club in Newcastle. She was arrested for kicking and punching a police officer but released without charge. CLF reported that she was seeing a male, DM, but he reported that CLF had stalked him all day.
   xii) On 21 November 2023 CLF and another man, S, whom she referred to as her boyfriend, left the placement. Staff followed the protocol and reported CLF missing. She was returned to the placement 90 minutes later. It is reported that S has learning disabilities.

xiii) There have been ongoing incidents in relation to CLF threatening to self-harm, absconding from the placement, and staying overnight at a Travelodge with an ex-partner, DM. CLF later disclosed that she had had sexual intercourse with DM. This is the subject of an ongoing police investigation.

xiv) On 14 December 2023, CLF was proposing to meet a male called AY who was an alleged sex offender. Following information provided by carers to her, CLF said that she would no longer meet him. However, further information from the police has revealed that CLF had come into contact with AY on a dating website and was referring to him as her boyfriend.

xv) On 21 December 2023, CLF absconded from her placement and was noted to be at an hotel in Newcastle-upon-Tyne. The police refused to intervene and staff attended the following morning. It appears that CLF had been with her ex-boyfriend.

xvi) On 31 December 2023, CLF reported to the police that she had been raped by someone she had met on Snapchat. CLF named the man to the police and this is the subject of an ongoing police investigation.

xvii) Between 17 November 2023 and 9 January 2024, CLF refused to take her medication on 11 occasions.

5. Very recently CLF was moved to an assessment unit. This is a more restrictive environment than CLF had when in supported living accommodation She has settled in very well and has one to one support at all times. Assessment will usually take about twelve weeks and this is not a long term placement. KD told the court that her visits to CLF usually trigger some form of dysregulation because of the nature of the discussions that she has to have with her. CLF will put her hands over her head and shut down, alternatively she will go into another room, scream, slam the door, and sometimes damage property. Clear and consistent boundaries and a lot of activities, work well to minimise these episodes. KD was able to point to a "formulation meeting" in May 2023 at which an attempt was made to identify the triggers for CLF's bouts of dysregulated behaviour when her thoughts and emotions would overwhelm her. She could not identify any follow up work or further meetings at which any care or management plan was developed. It is very difficult to engage CLF in any such planning.

6. When I met CLF, she appeared to be happy and relaxed. She smiled and had a couple of questions for me. We agreed that I would write to her to inform her of my decisions.

Expert Evidence

7. Dr Rippon has interviewed CLF on three occasions: in March 2021, August 2023, and December 2023. She had tried to speak with CLF on two earlier occasions but CLF had refused to see her. She told the court that CLF had a Learning Disability, Autism Spectrum Disorder, Attention Deficit Hyperactivity Disorder, and probably an Emotionally Unstable Personality Disorder, but that last diagnosis has not been formally made following psychological assessment.

8. Dr Rippon has been clear that CLF lacks capacity to conduct these proceedings. She referred in her report to the relevant case law and applied the tests appropriately. No party has disputed her conclusion.

9. In her report following the August 2023 interview, Dr Rippon considered capacity to make decisions about residence by reference to the relevant information identified by Theis J in *LBX v K & Ors* [2013] EWHC 3230 (Fam). She concluded that CLF did have capacity in this area – she had an understanding of the information and could weigh and use the information in order to explain the benefits of a potential new placement compared to where she was then living. However, in relation to care – again applying *LBX v K* (above) – whilst CLF could describe the care she received, she could not understand why it was needed. She "over-estimated" her ability to keep herself safe without support. She could not weigh or use the relevant information and therefore lacked capacity in this area.

10. Questions were put to Dr Rippon following her first report in 2023 and she re-visited CLF. One question concerned the consistency of her conclusions as to capacity to make decisions about residence and capacity to make decisions about care. She concluded in this second report:

> "At interview, CLF could describe where she is living including the address, what is available in the local area, the support she receives from staff and she understands that she is living there permanently rather than visiting. At the time of my interview, CLF told me that she has not been made aware of any other residences which are available to her and she is happy remaining in her current provision. Without a concrete alternative, it was difficult to get CLF to compare and contrast her current residence with another potential placement. As I will outline later in my report, I believe that she continues to lack capacity to make decisions around her care and support needs. If CLF was given the option of looking at two residences with the same type of support, she would be able to weigh-up the positives and negatives of both and would have capacity in this area. However, I do not believe that CLF would have capacity to decide to move into an environment with a level of support which did not meet her needs. In my opinion, the difficulties which CLF has with this are secondary to her Learning Disability and Autism Spectrum."

11. In oral evidence Dr Rippon confirmed that if care was a "given", meaning that it was provided at a sufficient level to meet her needs whatever residence was available to CLF, she could make a choice about other aspects of the available accommodation.

12. In her first report of 2023 Dr Rippon had suggested that CLF had capacity to make decisions about contact with family members but not with people with whom she was unfamiliar. In her later report she changed her opinion. It is to her credit that having dug deeper into the issue she was prepared to change her mind and to explain why she had changed her mind. Her final conclusion is that CLF does not understand the relevant information and cannot weigh the positives and negatives of having contact with others, including her mother. This was secondary, she believed, to CLF's Learning Disability and Autism Spectrum Disorder.

13. In her interview in August 2023, Dr Rippon asked CLF about sexual intercourse. CLF volunteered that "If you don't use contraception you might get pregnant. You can also get diseases." She was able to name two such diseases and gave a basic description of what might happen if she caught one. She was able to explain the need for consent to sexual relations. I note that CLF has reported an alleged rape. There may be a concern as to whether the report was accurate, but it supports the conclusion that she understands the concept of consent and recognises that sexual intercourse without consent is a criminal offence.

14. In her second report from 2023, Dr Rippon advised:

> "During my interview, CLF could describe the physical act of sexual intercourse and she could once again explain sexually transmitted infections and their potential risks. She also understood that both partners must consent to sex, that she can withdraw consent and there were times when a person could not give consent - for example, if they were drunk or unconscious. It is my view that CLF understood the relevant information, could use and weigh information, retain information and communicate her decision. It is therefore my opinion that CLF has capacity to make decisions around sexual relations."

15. In that same report Dr Rippon considered the information relevant to decisions about the use of contraception set out by Bodey J in *A Local Authority v Mrs A and Mr A [*2010] EWHC 1549 (Fam). She advised:

> "At interview, CLF could name different forms of contraception, including condoms, implants, depo, oral contraceptive pill and coil and understood an explanation as to how these are used. However, in my opinion, CLF did not understand the side-effects and could not provide any benefits of using contraception. She continued to express the belief that, if she used some forms of contraception, she would not become pregnant, despite being told this was not the case. CLF believes that withdrawal is an effective form of contraception, despite being told that this was not the case. It is my view that CLF did not understand the relevant information and could not weigh-up the positives and negatives of using contraception. She appeared to struggle to retain the information which I provided to her but could communicate her decision. It is therefore my opinion that CLF lacks capacity in this area."

In her oral evidence Dr Rippon explained that CLF had a belief that using the withdrawal method to avoid pregnancy was guaranteed to be effective. She did not understand the risks of pregnancy from this method. This was not a question of CLF making an unwise decision, but rather that she could not understand and weigh or use information relevant to decisions about contraception. Furthermore, CLF believed that contraceptive medication made you infertile so that you could never conceive a child after using them. I note evidence that CLF has previously had a contraceptive implant which she reported had been removed. I understand her belief about infertility relates to medication. According to Dr Rippon, this belief too is due to her inability to

understand relevant information. In each case her functional inabilities were due to her Learning Disability and Autism Spectrum Disorder.

16. In her interview in August 2023, CLF told Dr Rippon about a recent sexual experience. This account demonstrates the cause for concern about her capacity and her best interests in relation to sexual relations and contraception:

> "… she had left the placement without staff the previous Friday and Monday. CLF said 'I went into town but with my ex. We did stuff. I was a bit drunk. He had a hotel and he didn't want to be on his own'. She told me that they had unprotected sex, but her ex-boyfriend had 'pulled out' before he ejaculated. I asked CLF what she thought the risks of this were and initially she said 'Get pregnant, diseases' (including HIV) but, later in the interview, she told me that she did not think she could get pregnant. I explained that withdrawing is not a safe form of contraception."

17. Dr Rippon accepted in cross-examination that if CLF cannot understand that the withdrawal method is a form of unprotected sex which could give rise to pregnancy, she does not understand that intercourse can lead to pregnancy. One of the pieces of information relevant to decision-making about engaging in sexual relations.

18. Dr Rippon advised the court that direct, focused, educational work with CLF on the issues of contraception, could lead to her gaining sufficient understanding to have capacity to make decisions about the use of contraception. This would not be long term work requiring months of input, but a shorter-term programme of education.

Legal Framework

19. The Court of Protection applies the tests of capacity laid down in ss2 and 3 of the Mental Capacity Act 2005 (MCA 2005) and the principles in s1 of that Act. MCA 2005 s2(1) provides a single test for capacity which falls to be interpreted by applying the remaining provisions of ss2 and 3.

20. Assessments of capacity are decision specific and are made under the MCA 2005 Act and not for the purposes of the criminal law. The principles in MCA 2005 s1 are:

> "1(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.
> (5) An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
> (6) Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as

effectively achieved in a way that is less restrictive of the person's rights and freedom of action."

21. MCA 2005 s2(1) provides that:

> "2(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.
> (5) No power which a person ("D") may exercise under this Act—
> (a) in relation to a person who lacks capacity, or
> (b) where D reasonably thinks that a person lacks capacity, is exercisable in relation to a person under 16."

MCA 2005 s3 states:

> "(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."

22. The burden is on the Applicant to establish a lack of capacity in relation to any area of decision-making. The "material time" to which MCA 2005 s2(1) refers is the specific time when the decision has to be made. In *A Local Authority v JB* [2021] UKSC 52, [2022] 3 All ER 697, Lord Stephens held that there is a sequence in which questions must be considered. The court must identify "the correct formulation of "the matter" in respect of which it must evaluate whether "P is unable to make a decision for himself" ([68] of *JB*), and the information relevant to the decision, which will include the reasonably foreseeable consequences of making or not making the decision (MCA 2005, s3(4)). Having done so, the first question is whether P is unable to make a decision for himself in relation to the matter. If so, the second question is whether that inability is 'because of' an impairment of, or a disturbance in the functioning of, the mind or brain.

23. The Supreme Court's decision in *A Local Authority v JB* [2021] UKSC 52, [2022] 3 All ER 697 ("JB"), and the Court of Appeal judgment of Baker LJ in the same case, [2020] EWCA Civ 735, [2021] 1 All ER 1103, lay down a definitive guide for assessing capacity to make decisions about engaging in sexual relations. Theis J's judgment in *LBX v K* [2013] EWHC 3230 (Fam) provides guidance as to the information relevant to decisions about residence, care, and contact with others. In *A Local Authority v Mrs A and Mr A* [2010] EWHC 1549 (Fam) Bodey J considered the proper approach to determining whether a woman has capacity to make decisions about the use of contraception.

24. I considered the Supreme Court's judgment in *JB* in *Re PN (Capacity: Sexual Relations and Disclosure)* [2023] EWCOP 344 and again even more recently in *Re EE (Capacity: Contraception and Conception)* [2024] EWCOP 5.

25. In relation to decision-making about sexual relations, *JB* establishes that the correct formulation is whether P has capacity to make decisions to engage in sexual relations, not whether P has capacity to consent to sexual relations. At [84] Lord Stephens approved the formulation of the information relevant to a decision to engage in sexual relations given in the Court of Appeal by Baker LJ at paragraph [100] of his judgment:

> "… the information relevant to the decision [to engage in sexual relations] may include the following:
> (1) the sexual nature and character of the act of sexual intercourse, including the mechanics of the act;
> (2) the fact that the other person must have the capacity to consent to the sexual activity and must in fact consent before and throughout the sexual activity;
> (3) the fact that P can say yes or no to having sexual relations and is able to decide whether to give or withhold consent;
> (4) that a reasonably foreseeable consequence of sexual intercourse between a man and woman is that the woman will become pregnant;
> (5) that there are health risks involved, particularly the acquisition of sexually transmitted and transmissible infections, and that the risk of sexually transmitted infection can be reduced by the taking of precautions such as the use of a condom."

26. Baker LJ did not purport to give an exclusive or exhaustive list and, as I set out in *PN* (above), my reading of the judgment of Lord Stephens in the Supreme Court is that not all of the information listed by Baker LJ will be relevant in every case. Furthermore, in any particular case there may be additional relevant information that is not within Baker LJ's list. Lord Stephens held at [70]:

> "I consider, and the Court of Appeal in this case held at para 48, that the court must identify the information relevant to the decision "within the specific factual context of the case": see also *York City Council v C* at para 39."

And at [73]:

> "The information relevant to the decision includes information about the "reasonably foreseeable consequences" of a decision, or of failing to make a decision: section 3(4). These consequences are not limited to the "reasonably foreseeable consequences" for P, but can extend to consequences for others. This again illustrates that the information relevant to the decision must be identified within the factual context of each case."

27. Hence, in respect of decisions about engaging in sexual relations, the "specific factual context of the case" will dictate whether:
a. The decision is or is not person-specific: the decision for P might be whether to engage in sexual relations with a specific person or people, or whether to engage in sexual relations more generally.
b. All, or only some, of the information listed by Baker LJ will be relevant. For example, if P is male and wishes to engage in sexual relations only with other males, then there is no risk of pregnancy.
c. The court should consider if any additional information is relevant, for example in a case where there would be a reasonably foreseeable, high risk of "serious or grave consequences" of the decision, see para. 4.19 of the MCA 2005 Code of Practice referred to at [74] of *JB*:

> "'Relevant information must include what the likely consequences of a decision would be (the possible effects of deciding one way or another) … But a person might need more detailed information or access to advice, depending on the decision that needs to be made. If a decision could have serious or grave consequences, it is even more important that a person understands the information relevant to that decision.'"

I pause to note that insofar as the Code of Practice is inconsistent with the MCA 2005, I must apply the statutory provisions.

28. However, although the specific factual context is important, Lord Stephens warned against setting the bar for capacity too high by stretching the "reasonably foreseeable consequences" too far:

> "[75] … there should 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 s 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 *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."

It is well established that the person is not required to understand, retain, weigh or use, and communicate every nuance of the relevant information but only the salient parts, see for example *CC v KK* [2012] EWCOP 2136 per Baker J.

29. This balance between the need to identify relevant information within the specific factual context of the case and setting "practical limits" to what needs to be envisaged as reasonably foreseeable consequences of a decision, or not making a decision, surely applies to all areas of decision-making in relation to which capacity is being assessed. In achieving that balance the court should be mindful of the practical implications of determinations of capacity - *Re B (By her Litigation Friend the Official Solicitor) v A Local Authority* [2019] EWCA Civ 913.

30. In, *LBX* (above) at [43] Theis J held that information relevant to decisions about residence included:

> "(1) what the two options are, including information about what they are, what sort of property they are and what sort of facilities they have;
> (2) 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);
> (3) the difference between living somewhere and visiting it;
> (4) what activities L would be able to do if he lived in each place;
> (5) whether and how he would be able to see his family and friends if he lived in each place;
> (6) 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 has to comply with the relevant lists of "do's and "don'ts, otherwise he will not be able to remain living at the placement;
> (7) who he would be living with at each placement;
> (8) 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

> (9) the risk that his father might not want to see him if L chooses to live in the new placement."

31. In *Re B* (above), the Court of Appeal considered the compatibility of determinations of capacity in relation to decisions about residence, care, and contact with others made at first instance by Cobb J. At [63] to [65] the Court of Appeal held:

> "[63] At the heart of the Local Authority's appeal against Cobb J's decision that B has capacity to make decisions in relation to residence is the criticism that the Judge failed to take into account information which, in accordance with the MCA s.3(1) and (4), it was necessary for B to be able to understand, to retain and to use or weigh as part of the process of making a decision, including the reasonably foreseeable consequences of deciding one way or another or failing to make the decision. The Local Authority says that the Judge's conclusion on B's capacity to make decisions on residence, in particular whether to move to Mr C's property or to remain at her parents' home or to move into residential care, was fundamentally flawed in (1) failing to take into account relevant information relating to the consequences of each of those decisions, and (2) producing a situation in which there was an irreconcilable conflict with his conclusion on B's incapacity to make other decisions, and so (3) making the Local Authority's care for and treatment of B practically impossible. Mr Lock submitted that the Judge's flawed conclusion followed from his approach in analysing B's capacity in respect of different decisions as self-contained "silos" without regard to the overlap between them. "
> [64] We agree with the Local Authority. The point is simply made. We have already drawn attention to the provision in section 3(4) of the MCA that information relevant to a decision includes information about the reasonably foreseeable consequences of deciding one way or another, and to paragraph 4.16 of Chapter 4 of the Code of Practice, which provides that relevant information includes the likely effects of deciding one way or another or making no decision at all. The Judge stated (at [27] and [28]), however, that the implications of living with a particular person (here, Mr C), and the risks which this posed, were more appropriately considered under decisions on "care" and contact than residence. He further stated that the evidence showed that B did understand in broad terms the care she would receive if she lived with Mr C in contrast to living at home or in residential care, even though he concluded elsewhere in his judgment that B did not have capacity to make decisions about her care. In the circumstances, having observed (at [27]) that Dr Rippon accepted that B had a "basic understanding" in respect of all of the nine areas covered by Theis J's test, the Judge was able to reach his conclusion (in [28]) that the Local Authority had

> failed to discharge the burden of proving that B did not have capacity.
> [65] Turning specifically to B's capacity to decide whether or not to move to live with Mr C, Cobb J's decision (in [32]-[33]) to make a final declaration under the MCA s.15 that B did not have capacity to make a decision as to the persons with whom she has contact was plainly relevant. That conflicted directly with the Judge's conclusion that B had capacity to decide to move to live with Mr C. The point is reinforced by the fact that Cobb J had already granted an interim injunction prohibiting Mr C from having any contact with B. Permitting B to move to live with Mr C would presumably have placed both him and B in contempt of court for breach of the injunction. The question whether B was able to understand those consequences and to use or weigh them in a decision about whether to reside with Mr C was not explored in the judgment."

32. In *A Local Authority v Mrs A and Mr A* (above), Bodey J rejected the Local Authority's submission that the information relevant to a decision whether or not to use contraception included foresight of the consequences of bringing up a child. He warned against blurring the line between capacity and best interests:

> "[A] wider test would create a real risk of blurring the line between capacity and best interests. If part of the test were to involve whether the woman concerned understood enough about the practical realities of parenthood, then one would inevitably be in the realms of a degree of subjectivity, into which a paternalistic approach could easily creep. What exactly would the woman have to be able to envisage about parenthood, who would decide, and just how accurate would her expectations have to be? Butler-Sloss LJ put it this way *in Re B (consent to treatment: capacity)* 2002 1FLR1090:
> "… if there are difficulties in deciding whether the patient has sufficient mental capacity, particularly if the refusal may have grave consequences for the patient, it is most important that those considering the issue should not confuse the question of mental capacity with the nature of the decision made by the patient, however grave the consequences. The view of the patient may reflect a difference in values rather than an absence of competence and the assessment of capacity should be approached with this firmly in mind. The doctors must not allow their emotional reaction to or strong disagreement with the decision of the patient to cloud their judgment in answering the primary question whether the patient has the mental capacity to make the decision."
> This translates into the statutory embargo in S.1(4) against finding incapacity on the basis that a given decision would be 'unwise'."

He went on to hold:

> "63. Contrary to my initial view as to the very wide ambit of the words "the reasonably foreseeable consequences" of deciding one way or another on contraception, I have concluded that the Official Solicitor's submissions on this are correct. Although in theory the 'reasonably foreseeable consequences' of not taking contraception involve possible conception, a birth and the parenting of a child, there should be some limit in practice on what needs to be envisaged, if only for public policy reasons. I accept the submission that it is unrealistic to require consideration of a woman's ability to foresee the realities of parenthood, or to expect her to be able to envisage the fact-specific demands of caring for a particular child not yet conceived (let alone born) with unpredictable levels of third-party support. I do not think such matters are reasonably foreseeable: or, to borrow an expression from elsewhere, I think they are too remote from the medical issue of contraception. To apply the wider test would be to 'set the bar too high' and would risk a move away from personal autonomy in the direction of social engineering. Further, if one were to admit of a requirement to be able to foresee things beyond a child's birth, then drawing a line on into the child's life would be nigh impossible.
> 64. So in my judgment, the test for capacity should be so applied as to ascertain the woman's ability to understand and weigh up the immediate medical issues surrounding contraceptive treatment ("the proximate medical issues" - per Mr O'Brien), including:
> (i) the reason for contraception and what it does (which includes the likelihood of pregnancy if it is not in use during sexual intercourse);
> (ii) the types available and how each is used;
> (iii) the advantages and disadvantages of each type;
> (iv) the possible side-effects of each and how they can be dealt with;
> (v) how easily each type can be changed; and
> (vi) the generally accepted effectiveness of each.
> I do not consider that questions need be asked as to the woman's understanding of what bringing up a child would be like in practice; nor any opinion attempted as to how she would be likely to get on; nor whether any child would be likely to be removed from her care."

33. In *Mental Health Trust and ors v DD (No.2)* [2014] EWCOP 13, Cobb J added to the list of relevant information set out by Bodey J in *A Local Authority v Mrs A and Mr A* (above) by including information about medical risks to which P would be exposed upon becoming pregnant. He observed that Bodey J's list was not exhaustive or exclusive and that any significant medical risks associated with P's pregnancy would be sufficiently proximate to be included in the relevant information. In the case he was

dealing with, those risks were certainly "serious and grave" since they included significant risks of fatal complications.

Analysis and Conclusions

34. Having regard to MCA 2005 ss1 to 3, the guidance from the judgments set out above, and the evidence before me, including the helpful expert opinion evidence of Dr Rippon, I have no hesitation in finding, as the parties have agreed, that CLF lacks capacity to conduct this litigation, and to make decisions about her care, contact with others (including her family), and the use of social media and the internet. It is unnecessary for me to give detailed reasons for those determinations – I adopt the reasoning provided in Dr Rippon's reports.

35. The determinations of capacity that require detailed analysis are those relating to decisions about residence, engagement in sexual relations, and the use of contraception.

Residence

36. Dr Rippon's evidence as set out at paragraphs [10] and [11] of this judgment is that CLF is able to make a decision as between two options for her residence but only if adequate care was arranged at each one. CLF does not have capacity to make decisions about her care but, as I understand Dr Rippon's evidence, she can describe her care – she understands what care is and what kind of care she is receiving. Hence, she could not make a decision about residence if it involved an assessment of the appropriate level of care in each place available for her. But if the provision of care was decided for her, she would be able to understand, retain, and weigh or use the other information relevant to a decision about residence – see *LBX* at [43] (above). Mr Karim KC for the Local Authority submitted that the court should not accept the distinction that Dr Rippon had adopted but should apply *LBX*, avoid the trap identified in *Re B*, and find that CLF lacks capacity to make decisions about residence. Mr O'Brien KC, for the Official Solicitor for CLF, submitted that the danger of considering decision-making in silos, as identified in *Re B*, was that it may result in a situation that would be "practically impossible" for the Local Authority to implement – *Re B* at [63] (above). Here, it would not be practically impossible for the Local Authority to make decisions about the care provision CLF requires, make arrangements for that to be put in place at residence A and residence B, and then allow CLF to make a choice about which residence to live in. Where possible, her autonomy should be respected and protected.

37. There is a risk, in my judgement, in dissecting areas of decision-making such that it becomes practically impossible for those caring for P to implement the assessments of capacity made. It would make it difficult for a Local Authority to implement a care plan if it had been determined that P had capacity to make decisions on, for instance, eight aspects of her care, but not on five others. Furthermore, the process of assessing capacity might become unwieldy. However, in this instance, Dr Rippon's evidence is that CLF would have capacity to make decisions about her residence but for the element of choosing the right level of care within those places. I can see that if care decisions could be removed from decision-making about residence, then a declaration that CLF had capacity to make decisions about residence provided that the care arrangements for each available residential option were made for her, would not necessarily be incompatible with a declaration that she lacks capacity to make decisions about her

care. However, my concern is that the position is more complex than Dr Rippon has assumed. As well as compatibility with the declaration of incapacity to make decisions about care, I also have to consider compatibility with my finding that CLF lacks capacity to make decisions about contact with others and to use the internet and social media. When considering the practical implications of the declaration regarding residence decision-making sought on CLF 's behalf by the Official Solicitor, I do not see how a declaration of even conditional capacity to make decisions about residence, is compatible with declarations of incapacity that I make. What might seem an attractive solution in theory, could not be possibly to put into practice. Much of the information relevant to a decision about residence, even with a care package determined for her, will be relevant to care, contact with others and the use of th internet and social media. A choice about whether to live in house A or house B will involve information about access to activities and the community which entails questions about risk; about the neighbours and any risks of conflict with them, or harm from them; about the layout of the house or flat, the ability to monitor CLF within the accommodation, including her use of social media and the internet. Care is not simply a "given": the choice of residence will itself determine the level and kind of care required. Similarly, decisions about contact with others will be contingent upon where CLF lives. Whilst wishing to protect CLF's autonomy as much as is possible, I cannot see a way in which to divorce her decision-making about residence from other decision-making in relation to which it is agreed, and I have found, CLF lacks capacity.

38. Notwithstanding the conclusion reached by Dr Rippon, in my judgement, CLF lacks capacity to understand, and weigh or use the information relevant to decisions about residence. She does so because of her Learning Disability and Autism Spectrum Disorder. It does not follow that CLF may not take any part in decision-making. Clearly, her views about residence should be sought and she should be supported to be able to express her opinions and take into account relevant information.

Engagement in Sexual Relations

39. Dr Rippon has given clear and consistent evidence that CLF has capacity to engage in sexual relations. Mr Karim KC and Mr O'Brien KC invite the court to accept her evidence and make a finding of capacity accordingly. There was some concern during the hearing that when or because she is emotionally dysregulated CLF might lack capacity in this area, but it seems to me that there is simply no evidence that she engages in sex when emotionally dysregulated. She may abscond when emotionally dysregulated, and she may have sex with men after she has absconded, but there is no evidence that she becomes overwhelmed and dysregulated and in that state engages in sex when unable to make decisions for herself about whether to do so.

40. Mr Copnall submitted that CLF's belief that the withdrawal method was a wholly effective method of avoiding pregnancy, such that she engaged in unprotected sex, meant that she lacked capacity to decide to engage in sexual relations. She could not understand and weigh or use information relevant to decisions to engage in sexual relations, namely that pregnancy might result from sex. The difficulty with accepting this submission is that there is clear evidence from Dr Rippon that CLF does understand, and can weigh or use, information that pregnancy can result from sex. I also note her recent use of the "morning after" pill. CLF's understanding about the withdrawal method is relevant to her decision-making capacity in relation to

contraception, but it should not be conflated with her capacity to make decisions about engaging in sexual relations.

41. CLF clearly understands that sex may result in pregnancy. She understands and can weigh or use the other relevant information identified by Baker LJ and the Supreme Court in *JB* (above). On the basis of the evidence before me, including Dr Rippon's opinion evidence, I find that CLF has capacity to make decisions about engagement in sexual relations. As explained below, I find that she presently lacks capacity to make decisions about the use of contraception. I do not consider that these two findings are incompatible. The bar should not be set too high for capacity in relation to sex. There are practical limits on what should be envisaged by the individual concerned. There is a danger in imposing requirements on their decision-making that are higher than those attained by many capacitous people making the same decisions. A lack of understanding about a particular method of contraception or birth control, should not deprive a person of being found to have capacity to engage in sexual relations. It is unhelpful to break down decision-making in relation to a particular area, here sexual relations, into sub-divisions such as the decision to engage in sex whilst relying on the man withdrawing before ejaculation to avoid pregnancy. Firstly, that route will often lead to a result that is "practical impossible" to manage: how can anyone manage a situation in which a person has capacity to engage in sex using a condom but not have capacity to engage in sex using the withdrawal method? Secondly, many otherwise capacitous individuals might be found to lack capacity to make very specific decisions. Thirdly, and related to the second objection, the more one breaks down an area of decision-making into sub-divisions, the more complex the relevant information within that area becomes, and the more difficult it will be for people with a learning disability or other cognitive impairments, to avoid conclusions that they lack capacity. The MCA 2005 directs those assessing capacity to support people to make decisions for themselves. Framing decisions with ever more precision risks undermining that purpose of the Act.

42. I have had to consider the practical limitations identified by Lord Stephens in *JB* (above) in relation to decisions to engage in sexual relations in this case and in previous decisions referred to above. It is necessary, first, to consider the relevant information set out by Baker LJ and endorsed by the Supreme Court in *JB*. The specific factual context in any particular case may mean that one or more of the entries on that list may not be relevant and that, in rare cases, additional information might be relevant. There are, however, practical limits and the bar must not be set too high. Whilst, in my judgement, serious or grave consequences of pregnancy to which a woman would be particularly vulnerable, might be considered to be part of the relevant information, other consequences of pregnancy, such as common risks or complications of pregnancy will not be included. Nor will information about potential complications for the child after delivery, or about caring for a newborn or growing child. In each case it should be asked whether the decision-making about engagement in sexual relations is person-specific or general.

43. In the present case I conclude that CLF does have capacity to decide to engage in sexual relations. I do not consider that to be inconsistent with the finding that CLF lacks capacity to make decisions about contact with others. I have sought to explain why such findings are not inconsistent in the cases of *PN* and *EE* (above) and I adopt the same reasoning here. When decision making about sexual relations is general, not person-

specific, it is not necessarily inconsistent to find that P lacks capacity regarding contact, but has capacity regarding sex. Baker J contemplated the practical consequences of such a position in *A Local Authority v TZ (No. 2)* [2014] EWHC 973 (COP), rejecting the suggestion that a Deputy should be appointed for the purpose of decisions about contact with others:

> "[57] When delivering a plan to address TZ's lack of capacity to decide whether someone with whom he may wish to have sexual relations is safe, the principal focus should be on educating and empowering him to make these decisions. Any provisions in the plan directed at protecting him and restricting his contact should be seen as interim measures until the time when he acquires skills to make such decisions for himself.
> [58] To that end, the plan should contain the following features.
> [59] First, a named worker should be identified and tasked with the specific role of overseeing a programme of education and empowerment. That professional should be someone suitably trained and equipped in these matters. He or she should identify all resources available for the assessment of risk and educating persons with limited capacities to identify and assess risk. TZ should be supported in accessing these education programmes and ways should be identified to assess and check the development of his understanding of these issues. At present, this support is provided by GB, a learning disabilities nurse, who has been assisting TZ to develop his social and interpersonal skills. Evidence to date suggests that TZ does respond to education of this type. Dr X thought it might take 4 to 5 years for TZ to acquire capacity by these means, but the local authority believes that this may be unduly pessimistic.
> [60] Secondly, advice and assistance should be sought from LGBT groups, who are likely to have resources which TZ and his support workers will find helpful. It would be particularly helpful to identify someone within the lesbian and gay community who can provide TZ with peer support.
> [61] Thirdly, his support worker should devise a programme of social activities to which TZ can be introduced. This will involve visiting pubs, cafes, clubs and other venues, checking to see if the milieu is likely to be of interest to TZ, and one in which he is likely to be safe."

Care plans of that kind are now commonly known as TZ style care plans and one already exists in this case. Such a plan will allow for the practical implementation of the findings made as to capacity.

The Use of Contraception

44. I have regard to the relevant information identified by Bodey J in *A Local Authority v Mrs A and Mr A* (above). Dr Rippon's evidence is clear that CLF does not understand, and cannot weigh or use, information about different forms of contraception, their

effects, side-effects, and effectiveness. This is primarily because she understands that contraception involving medication or a device (not condoms) will render her permanently infertile. Dr Rippon has recorded:

> "However, at interview, she told me that she did not want to use contraception because she believed it would make her infertile. P also believed that it would stop her periods and she wanted to have periods so that she could tell her children what having them was like, so I told her that this was not the case. I then described different forms of contraception, their potential side- effects, explained that they were generally safe and told P that use of a condom also prevents sexually transmitted infections. However, she continued to tell me that she did not to use contraception because she wanted to have children in the future (perhaps when she was aged twenty-seven or twenty-eight years)."

45. Dr Rippon confirmed that CLF's inability to understand the relevant information was because of her Learning Disability and Autism Spectrum Disorder. In the circumstances, I conclude, as was accepted by all the parties, that CLF lacks capacity to make decisions about the use of contraception.

46. CLF also told Dr Rippon that she believed that the withdrawal method was wholly reliable to prevent her from becoming pregnant. I recognise the sensitivity of referring to the withdrawal method as a form of contraception. It might better be described as a form of birth control. I would not accept any argument that faith in the withdrawal method as a form of birth control was in itself proof of a lack of capacity to make decisions about the use of contraception (or birth control). It is practised by many millions of people. However, I accept that in CLF's case, she does not understand, and is unable to weigh or use, information about birth control, including the withdrawal method, because of her Learning Disability and Autism Spectrum Disorder. Even if I am wrong, she clearly lacks capacity in that area for the reasons referred to in the previous paragraph of this judgment.

47. Mr O'Brien KC submitted that the court should only make an interim declaration in relation to CLF's capacity to make decisions about the use of contraception. I agree. The evidence of Dr Rippon was that a focused educational programme could lead to CLF gaining capacity in this area.

Final Conclusion

48. For the reasons given I shall make final declarations that CLF lacks capacity to conduct these proceedings and to make decisions about her residence, care, contact with others, and the use of social media and the internet. I shall make an interim declaration only that she lacks capacity to make decisions about the use of contraception. She has capacity to make decisions about engaging in sexual relations. As agreed with CLF, I shall write to her to let her know of my decisions.