

Harrison

IN THE COURT OF PROTECTION

CASE NO: 1288879T

AND IN THE MATTER OF GA

Before: Her Honour Judge Pemberton

B E T W E E N:

AA

Applicant

-and-

GA

(by her litigation friend, the Official Solicitor)

-and-

An NHS Clinical Commissioning Group

Respondents

Hearing: 8-10 December 2020

Miss Deborah Shield (instructed by Switalskis Solicitors) for the Applicant

Mr Benjamin Harrison (instructed by Cartwright King Solicitors) for the First Respondent

Mr Parishil Patel QC (instructed by Browne Jacobson) for the Second Respondent

Date:- 18 December 2020

JUDGMENT

1. This hearing has been listed to determine the challenge to the standard authorisation authorising the deprivation of liberty of GA at her current placement, "Placement A", with a plan for her to move to an alternative specialist residential placement, "Placement B".
2. The standard authorisation came into force on 10 January 2020 pursuant to Schedule A1 of the Mental Capacity Act 2005. The authorisation was initially due to expire on 8 June but has been extended by my orders of 30 June and 11 November and is now due to expire on 17 December.
3. At the pre-trial review of this matter, the parties agreed the issue which requires the court's determination is whether it is in GA's best interests for her to (1) move to reside and receive a package of care and support at Placement B (a specialist residential placement) or (2) for her to return to live with her mother, and brother, MA, at the family home with no professional input from the CCG.
4. In order to determine GA's best interests I have considered all of the documents in the bundle filed, running to some 2000 pages and I have heard oral evidence from TS the care manager for the CCG, GA's mother, AA and her brother, MA.
5. GA is a young woman who is 22 years old. She has a diagnosis of severe learning disability, Autism Spectrum Disorder, ADHD, epilepsy, and severe communication difficulties. GA is non-verbal and communicates through behavioural gestures.
6. I have not had the opportunity of meeting with GA but it is apparent from the photos I've seen and the reports that I have read that she is able to demonstrate her feelings and likes and dislikes. I have read reports of her smiling, giggling and enjoying interactions with others and also of her at times expressing frustration and exasperation and occasionally lashing out.
7. On 17 April 2019, Dr DN prepared a capacity report pursuant to section 49 of the Mental Capacity Act 2005 which concluded that GA was not able to understand, retain, or weigh up in basic terms the decisions about her residence or the level and nature of care she requires. She had no apparent ability to understand questions about her residence or care needs.
8. On the 10 December 2019, and with the consent and agreement of all parties, I made declarations, pursuant to section 15 of the Mental Capacity Act 2005, that GA lacks capacity to:

- i. conduct these proceedings.
- ii. make decisions as to her residence; and
- iii. make decisions as to her care and support.

Background

9. Until November 2019 GA was cared for in her family home, primarily by her mother but with assistance from her adult siblings. Also living in the family home were her younger siblings who are aged 13, nine and six.
10. Proceedings in relation to GA have a long and protracted history. They were initially brought on 26 March 2016 and were stayed in October of that year. The stay was lifted in March 2018 and in June 2018 the CCG was substituted as the applicant in place of the City Council.
11. In September 2019, at a round table meeting, the CCG informed all parties of its proposal for GA to be placed in a residential unit. The CCG's case was that significant concerns had arisen over the past 12 months that GA's needs were not being met in the family home. In addition, some child protection concerns in respect of the younger siblings had arisen which had caused children's services to become involved with the family and for the children to be recorded as being at risk of significant harm due to physical outbursts from GA including physical assaults towards staff, her mother and siblings (I accept that GA did not intend to hurt anyone).
12. A Domiciliary Care Agency had been commissioned by the CCG to provide GA with domiciliary support in the family home but they had withdrawn that service in July 2019, concerned at an inability to sustain the service. Since that time, an alternative care agency had been providing services for GA outside of the family home for several hours each Saturday and Sunday. During the week, GA was attending a day care service between 9:30 and 4:00 PM each day. She had had a recent period of respite care at a residential unit.
13. The proposal of the CCG was for a period of assessment in a residential care unit with a long-term goal of supporting GA to move into a supported living service.
14. In early October, the CCG became concerned at the risk of GA being removed from the jurisdiction and an ex parte order was made on 10 October 2019 prohibiting her removal and requiring the surrender of travel

documents. At a further hearing on 16 October, an order was made which provided for GA to return to her mother's care following surrender of travel documentation and the matter was listed for two days on 19 November for the court to determine the CCG's application for GA to move into residential care.

15. The hearing in November was then adjourned and listed before me in December and determined by me on 10 December 2019 after a two-day contested hearing. I decided that it was in GA's best interests to move to Placement A which was a specialist residential facility. A full functional, sensory and communication assessment was to be undertaken. The period of assessment was supported by all parties at the time other than AA.
16. The case was returned to court on 12 February 2020 on an urgent basis when it became apparent that GA had been overmedicated on her prescribed Risperidone. This was of course an extremely worrying and upsetting incident for AA and the family. GA suffered symptoms of lethargy, hand tremors and confusion. She was taken to A&E as a precaution, but I understand was discharged without admission or treatment. Other concerns were raised by the family and by GA's IMCA (AK). I directed that there should be various investigations and updates but that the period of assessment at Placement A should continue.
17. The position was considered again on 21 April when I directed that the period of assessment should continue. By the time of the next hearing on 30 June, the period of assessment had largely been completed and the recommendation of the multidisciplinary team was that GA should move to a small residential home for adults with similar needs or to a supported living placement with support from staff with expertise in working with adults with learning disabilities, autism and complex needs.
18. AA maintained that her daughter should return to the family home and put forward an alternative care plan for the family to care for GA with some domiciliary support.
19. The matter came before me once more for pre-trial review on 11 November at which point the CCG confirmed its position that its plan was for GA to transition to a small residential unit (Placement B). The CCG confirmed that it did not propose to commission any domiciliary care or support in the event that GA was cared for by her family as they did not consider that the entire package of care met her assessed needs.
20. The City Council had completed its assessment in respect of the younger children who were no longer deemed to be at risk given that GA was no longer in the family home and no party proposed that GA and her siblings should be cared for together. The City Council was discharged as a party at this hearing.

Legal framework

21. All parties agreed that the law to be applied is as set out in the very helpful skeleton argument prepared by Mr. Harrison on behalf of GA and set out in the following paragraphs.
22. These are section 21A proceedings. The court's primary task is to determine whether or not GA meets the qualifying requirements in Schedule A1 to the Mental Capacity Act 2005: *DP v London Borough of Hillingdon* [2020] EWCOP 45. However, once an application is made pursuant to section 21A of the 2005 Act the court has broad powers to make declarations pursuant to section 15 as to whether P lacks capacity to make any decisions, and once such a declaration is made, the court has wide powers pursuant to sections 16 and 17 of the 2005 Act to make decisions on P's behalf concerning their personal welfare (*CC v KK* [2012] EWHC 2136 (COP); *PH v A Local Authority* [2011] EWHC (Fam)).
23. Section 16(3) of the Mental Capacity Act 2005 provides that the court's powers to make decisions on behalf of those who lack capacity are subject to sections 1 and 4 of the 2005 Act. There is no dispute in this case that GA lacks capacity to (i) conduct these proceedings, (ii) make decisions as to where she should reside, and (iii) make decisions as to the care and support she should receive.
24. Section 1(5) and (6) provide that a decision made under the 2005 Act for or on behalf of a person who lacks capacity must be done, or made, in their best interests. Further, before 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.
25. Section 4 deals with best interests: -
 - (1) In determining for the purposes of this Act what is in a person's best interests, the person making the determination must not make it merely on the basis of—
 - a) the 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 what might be in his best interests.
 - (2) The person making the determination must consider all the relevant circumstances and, in particular, take the following steps.
 - (3) He must consider—
 - a) whether it is likely that the person will at some time have capacity in relation to the matter in question, and

b) if it appears likely that he will, when that is likely to be.

(4) He must, so far as reasonably practicable, permit and encourage the person to participate, or to improve his ability to participate, as fully as possible in any act done for him and any decision affecting him.

...

(6) He must consider, so far as is reasonably ascertainable—

- a) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity),
- b) the beliefs and values that would be likely to influence his decision if he had capacity, and
- c) the other factors that he would be likely to consider if he were able to do so.

(7) He must take into account, if it is practicable and appropriate to consult them, the views of—

- a) anyone named by the person as someone to be consulted on the matter in question or on matters of that kind,
- b) anyone engaged in caring for the person or interested in his welfare,
- c) any donee of a lasting power of attorney granted by the person, and
- d) any deputy appointed for the person by the court,

as to what would be in the person's best interests and, in particular, as to the matters mentioned in subsection (6).

...

(11)“Relevant circumstances” are those—

- a) of which the person making the determination is aware, and
- b) which it would be reasonable to regard as relevant.

26. I have also considered the four authorities which Mr Harrison refers me to, to assist in determining GA's best interests and I think it is helpful to set out here the principles from those authorities.

27. The first is from the case of *Aintree University Hospitals NHS Foundation Trust v James and others* [2013] UKSC 67 in which Baroness Hale noted that the 2005 Act gives limited guidance about best interests and noted that every case is different. She stated at paragraph 39 that:

‘The most that can be said, therefore, is that in considering the best interests of this particular patient at this particular time, decision-makers must look at his welfare in the widest sense, not just medical but social and psychological they must try and put themselves in the place of the individual patient and ask what his attitude to the treatment is or would be likely to be; and they

must consult others who are looking after him or interested in his welfare, in particular for their view of what his attitude would be.'

28. Munby J, as he then was, provided further helpful guidance in the case of *ITW v Z, M and Various Charities* [2009] EWHC 2525 (Fam) as to the application of the statutory scheme at paragraph 32. The guidance was threefold:

'i) The first is that the statute lays down no hierarchy as between the various factors which have to be borne in mind, beyond the overarching principle that what is determinative is the judicial evaluation of what is in P's "best interests".

ii) The second is that the weight to be attached to the various factors will, inevitably, differ depending upon the individual circumstances of the particular case. A feature or factor which in one case may carry great, possibly even preponderant, weight may in another, superficially similar, case carry much less, or even very little, weight.

*iii) The third, following on from the others, is that there may, in the particular case, be one or more features or factors which, as Thorpe LJ has frequently put it, are of "magnetic importance" in influencing or even determining the outcome: see, for example, *Crossley v Crossley* [2007] EWCA Civ 1491, [2008] 1 FLR 1467, at para [15] (contrasting "the peripheral factors in the case" with the "factor of magnetic importance") and *White v White* [1999] Fam 304 (affirmed, [2001] 1 AC 596) where at page 314 he said "Although there is no ranking of the criteria to be found in the statute, there is as it were a magnetism that draws the individual case to attach to one, two, or several factors as having decisive influence on its determination."...'*

29. Peter Jackson J noted in *Cases A & B (Court of Protection: Delay and Costs)* [2014] EWCOP 48 at paragraph 14:-

"People with mental capacity do not expect perfect solutions in life, and the requirement in Section 1(5) of the 2005 Act that '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' calls for a sensible decision, not the pursuit of perfection"

30. Finally, there is no presumption in favour of family life in the best interests analysis and it is only after applying the section 4 'checklist' that a judge should ask whether the conclusions amount to a violation of Article 8 ECHR rights and if so, if this is necessary and proportionate. No additional starting point should be added to the exercise, and family life will not always 'trump' private life: *K v LBX and Others* [2012] EWCA Civ 79 .

Application of the law to the evidence in this case

31. I accept that an indication of GA's wishes and feelings is that when GA is with her family, she has on occasions indicated wanting to leave the placement with them at the end of their visits. Her relationship with her family and the mutual love they have for each other is a significant factor which would support GA returning home. However, there is no objective evidence to support the family's submission that separation from her family has had a significantly detrimental impact on GA's emotional well-being.
32. I have taken into account the legitimate concerns that the family have raised in respect of some of the errors in the care provided to GA, the most serious being in respect of the Risperidone overdose and the failure to properly supervise GA and a male resident which resulted in an inappropriate encounter. I accept that such mistakes may happen in the proposed placement at Placement B.
33. GA's family are able to provide her with love and commitment, with familiarity, with a cultural and religious lifestyle in accordance with her background. I have no doubt at all that if she were returned to the care of her mother with the support of MA and other family members that they would love her and care for her to the very best of their ability. I have considered very carefully the plans put forward by the family. I note that they have put a great deal of thought and preparation into these plans.
34. However, this must be balanced against the potential of very clear difficulties that they would have in anticipating and meeting her needs on a 24-hour a day basis, seven days a week. It is apparent from the documents before me that they have struggled at times to fully meet GA's needs. The family's plan relies heavily on the availability of the Day Care Centre and weekend support which the CCG is not prepared to commission in the event that GA returned home. I note that whilst being cared for by her family, the family were provided with a considerable amount of additional support through the day care and domiciliary care services, which would no longer be available. Even with this level of support concerns were increasing in respect of the family's ability to properly manage GA's needs and behaviour.
35. As referred to earlier in this judgment, the CCG have held concerns for a number of years in respect of the care and treatment provided to GA in the family home. Having read AA's proposals and read and heard her and MA's evidence, I am not persuaded that those concerns have been addressed and I find it highly likely that similar or even greater concerns, given the lack of additional support that the family would have, would arise in the future.
36. There is a clear discrepancy between the professional assessments in terms of GA's needs and how best to

meet these, (examples being in respect of stimulation and engagement) and the family's understanding of those needs.

37. MA who is a key part of the support package has his own family and undoubtedly his commitment to them is likely to disrupt his ability to provide support to his mother in caring for GA.
38. I am not sure how realistic the plan of the family, that the younger siblings will be cared for elsewhere, is. I anticipate that there will be times when AA is needed to assist in the care of her younger children, and she will no doubt wish to maintain the loving relationship that she has with them. The plan that has been prepared by the family does not in my view properly recognise AA's caring commitments for her younger children.
39. The plan relies on AA effectively being the primary carer for GA for 24-hours a day. Whilst MA will be on hand to offer support and assistance, he is unable to undertake any personal care for GA (although he did tell me he would be able to undertake this "in an emergency"). Given the assessment of GA's care needs and her need for constant focused behavioural management and stimulation, this is an impossible task for one individual even with extensive support from family members.
40. In addition to GA's personal care needs, TS refers to her assessed needs as being for a structured activity schedule, to be based on social and play rather than goal based, providing time for;
- High/Low sensory stimulation (visual/physical/smell/hearing/noise)
 - Activities requiring time for self-regulation
 - Cause & effect activity
 - Intensive interaction
- and the need for the Staff team to understand and facilitate rapid change/turnover in activities.
41. Dr B is the psychiatrist who has prepared several reports as part of multidisciplinary assessment. He has confirmed in an email update sent to the parties and the court on 10 November 2020 that, in his view, GA requires 24-hour care and support throughout the day:-
- 'GA requires a high level of support and supervision throughout the day to maintain her safety when engaging within day to day tasks. She has little danger awareness and within her current environment kitchen facilities are locked to ensure her safety. She will often throw items with little awareness of danger to self, others, or property. Throwing items does not appear to be in aggression but rather a play based,

cause and effect seeking response for her. She requires support with her antiepileptic medication (potentially lifesaving) and with her complex sensory processing which in turn result in functional difficulties. She also needs support throughout the night to encourage a good sleep hygiene and monitor potential seizure activity. GA has Behavioural Dysphagia and this means that she is at risk of choking and aspiration by overfilling her mouth with food and drink, eating and drinking at a fast pace, vocalising with food and drink in her mouth and walking with food and drink in her mouth.'

42. Later in the same email he summarises the recommendations from the Multi-disciplinary team: -

'We remain of the view that a family home would struggle to meet the recommended environmental features and, furthermore, a family cannot possibly provide the level of attention and interactions described above, what would lead to an increase in the frequency and intensity of problem behaviours. This would in turn result in increased risks to both herself and to family members, particularly children. It is very likely that her medication would be increased if her environmental and relational needs were not met appropriately at the family home. A specialist home is able to provide a highly structured environment and teams of experienced staff who can provide the level of intensive interaction she requires whereas this would be exhausting and unattainable for a family unit.'

43. The evidence is overwhelming that the level of care needed is such care that would only be available from a professional team (not an individual). As Dr B indicates, during her time at Placement A, GA's dosage of Risperidone has reduced significantly, with her behaviour managed through careful structure and planning rather than medication, and the plan is that this medication can be ceased entirely. In all probability, in order to manage GA's behaviour in the home, the family are likely to require Risperidone to be reintroduced or increased. This would not in my judgment be in GA's best interests.

44. Having considered all of the evidence and assessments in this case, I accept the professional assessments and conclusions in respect of GA's needs and the ability of the family to meet those needs in the family home. I am satisfied that the care and support that she needs, in order to offer her consistency, stability and predictability can only be provided through a team of professional care. I am therefore satisfied that the proposed placement in Placement B is the one which is in GA's best interests.

45. I recognise that this is an interference with the article 8 rights of both GA and her family. I am satisfied that such interference is both necessary and proportionate.

46. I am also satisfied that the CCG have given appropriate consideration to the importance of regular and enjoyable contact for GA with her family and that once the current health restrictions are reduced, the plan

for contact properly enables GA to maintain and enjoy a relationship with her family and the ability to celebrate important occasions.

47. It was suggested on behalf of AA that there should be an adjournment for placement of GA at Placement B or at home to take place on a trial basis. I'm not persuaded that that is either proportionate or necessary and in fact conclude that this would be contrary to GA's best interests as it is likely to be confusing and disruptive for her.

48. I am however persuaded that the transition should be overseen by the court thus ensuring that GA and her mother remain represented within these proceedings and to liaise with the court in respect of a further hearing to take place following a period of settling in for GA.

That is my judgment.

HHJ Pemberton

17 December 2020

