Neutral Citation Number: [2020] EWCOP 58

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 18/11/2020

Before :

Mr Justice Poole

- -

Between :

AMDC	**Applicant**
- and –	
(1) AG	
(3) CI	**Respondent**

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- -

Brett Davies (instructed by Elizabeth Machin, Senior Solicitor **AMDC**) for the **Applicant**
Joseph O'Brien (instructed by **Switalskis Solicitors**) for the **First Respondent**
Ben McCormack (instructed by **Cartwright King Solicitors**) for the **Third Respondent**

Hearing dates: 26-28 October 2020

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APPROVED JUDGMENT

This judgment was delivered in public. An order is in place that prevents the publication or communication of material or information that identifies or is likely to identify AG, any member of her family, the applicant local authority, and the place where AG lives. The identification of CI would be likely to identify AG and where she lives. 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 patient and members of their family, and the local authority 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.

Mr Justice Poole:

Introduction

1. The person who is the subject of this application is AG, a 68-year-old woman who currently resides at the E Care Home ("ECH"). The issues for me to determine at the final hearing which began on 26 October 2020 are whether, as the applicant contends, AG lacks capacity to make decisions as to:

    a. The conduct of litigation.
    b. Her place of residence.
    c. Her care and support.
    d. Her contact with other people.
    e. Management of her property and affairs including termination of her tenancy.
    f. Engagement in sexual relations.
    g. Marriage.

2. The applicant local authority is responsible for meeting AG's eligible care and support needs under Care Act 2014 and commissions her placement at ECH. It is represented by Mr Davies. AG is the first respondent. Her accredited legal representative is Alison Kaye of Switalskis Solicitors, and she is represented by Mr O'Brien. Her son BH was the second respondent but he has previously been discharged as a party. He attended the hearing as an observer. The other remaining respondent is CI, another resident at the care home with whom AG has formed an attachment. He is represented by Mr McCormack.

3. On the second day of the final hearing of this application, following the conclusion of the oral evidence of Dr Quinn, Consultant Forensic Psychiatrist, an expert instructed jointly by all the parties, the applicant informed the court that it did not consider that it could adduce sufficient evidence in relation to capacity to found declarations under section 15 Mental Capacity Act 2005. The applicant has not conceded that AG has capacity in relation to any of the decisions but rather that it could not rely on Dr Quinn's evidence to prove that she lacks capacity, and there was insufficient other evidence to do so. There had been no assessments of capacity since January 2020 other than those conducted by Dr Quinn, and those other assessments did not address AG's capacity in relation to all of decisions in question. Dr Quinn's opinions were therefore crucial to the determinations of capacity that the court is being invited to make.

4. All parties readily agreed that although further delay in determining capacity was very regrettable, it was necessary for instructions to be given to a fresh expert to report to the court. This is not a case in which the application could simply be dismissed for lack of evidence. As Baker J, as he then was, said in *Cheshire West and Cheshire Council v P* [2011] EWCOP 1330 at [52]:

    > "The processes of the Court of Protection are essentially inquisitorial rather than adversarial. In other words, the ambit of the litigation is determined, not by the parties, but by the court, because the function of the court is not to determine in a disinterested way a dispute brought to it by the parties, but rather, to engage in a process of assessing whether an adult is lacking in capacity, and if so, making decisions about his welfare that are in his best interests."

When ordering an adjournment of this case I was satisfied, in accordance with s. 48 of the Mental Capacity Act 2005, that, notwithstanding the concerns about the expert opinion evidence, the evidence as a whole established that there was reason to believe that AG lacks capacity to make the decisions under consideration and that it was in her best interests to make interim orders and directions. Accordingly, on 28 October 2020 I authorised the continued deprivation of AG's liberty with her residence and care being in accordance with a safeguarding plan dated 20 May 2020. A resumed hearing was fixed in January 2021 with directions for the receipt of evidence from a new expert psychiatrist. These interim orders deprive AG of her liberty and interfere with her Article 8 rights. Amongst other restrictions, the ongoing regime which I have authorised to continue until the final determination of this case effectively prevents AG from engaging in sexual intercourse, from leaving ECH and from choosing her care arrangements. Because of the impact of an adjournment on AG, and to assist the newly instructed expert, I was invited to and agreed to give this interim judgment.

5. The hearing is part heard. The evidence is not complete and it would be wrong for me now to make any findings, including any findings in relation to Dr Quinn's conclusions. My short review of his expert evidence is confined to that which is necessary to explain the need for the adjournment and to help to prevent any further delay beyond January 2021. Insofar as I make any criticisms of Dr Quinn's evidence, it should be noted that Dr Quinn was questioned at length about these concerns at the hearing and had ample opportunity to respond to the concerns raised.

Background

6. At her request I spoke to AG in the presence of her ALR prior to the hearing. The meeting was recorded and a note of the discussion made and circulated to the parties. AG has married four times, has four children, 11 grandchildren and 18 great grandchildren. She was living alone in a bungalow as a local authority tenant prior to moving to the ECH on 2 July 2019 on an emergency respite basis. She continues to reside there nearly 17 months later. AG has a diagnosis of frontal lobe dementia and suffered episodes of confusion, aggression, and behavioural changes that the applicant contends affected her safety in the community. It is alleged that she had become a frequent caller to the ambulance service and attender at A&E without requiring medical treatment and that on one day alone in December 2018 she called for an ambulance on 16 occasions. It is contended that even with intensive support from Age UK from 2016 until the summer of 2019, AG could not manage to live safely on her own in the community - she frequently ran out of money, she had been found naked outside her bungalow on one occasion, smashed neighbours' plant pots, and several times she lost her keys, handbag, passport, bank cards or money. A further incident on 2 July 2019 resulted in her admission to ECH. AG herself does not accept that she needed admission to ECH.

7. Having suffered a stroke which has left him as a wheelchair user but cognitively intact, CI moved to ECH in or about November 2019. AG and CI formed an attachment and AG was found sharing intimacy with CI on several occasions. CI revealed to his social worker that he and AG had taken their relationship "to the next level" and wanted to marry and live together. AG was referred to AMDC on 18 December 2019 and AG's social worker assessed AG as lacking capacity to consent to sexual relations. After that

assessment, further events are recorded in which AG and CI were found together in CI's bed.

8. The case first came before the court on 13 January 2020 when a Transparency Order was made that remains in force. At subsequent hearings interim orders were made and directions given, including for the joint instruction of an expert witness, Dr Quinn, Consultant Forensic Psychiatrist.

Expert Evidence

9. Dr Quinn saw AG in person on 11 February and reported on 24 February 2020. He saw her again on 22 May 2020, reporting on 1 June 2020. On 17 August 2020, Dr Quinn answered the parties' questions and responded to a fresh witness statement from the allocated social worker. On 29 September 2020 he visited AG once more at the ECH and produced his final report dated 21 October 2020. This last report was seen by the parties only one working day before the hearing began on Monday 26 October. Detailed letters of instruction complying with the Practice Direction were sent to Dr Quinn prior to each assessment which set out the relevant information for each decision.

10. All parties had concerns with aspects of Dr Quinn's written evidence but had had very little time before the hearing to consider his final report. Inevitably therefore, the extent of their concerns did not emerge fully until he had been questioned in court. During his oral evidence the expert himself expressed his own "disquiet" about some of his evidence in this case.

11. The Court is very grateful that Dr Quinn visited AG in her care home on three occasions, including during the Covid-19 pandemic. He is an expert who has experience of assisting the courts in relation to capacity issues and who Counsel informed me has been a very helpful expert witness to the Court of Protection in a number of other cases. This was clearly a case which troubled him. His ultimate conclusion was that AG lacks capacity to make any of the decisions under consideration. What concerned the parties was the process leading to that the conclusion and the lack of clear explanation as to how it had been reached.

12. Dr Quinn stated at paragraph 10.2 of his first report that he had been asked to assess capacity to:

> "a. Conduct proceedings.
>
> b. Make decisions about her residence and care.
>
> c. Consent to sexual relations.
>
> d. Make decisions in relation to contact with others.
>
> e. Make decisions about her property and affairs to include terminating her tenancy."

Dr Quinn concluded his report with the following summary:

> "There is an impairment of her disturbance in the functioning of her mind or brain as arises from the presence of dementia. She lacks capacity to make a decision in relation to the matters in question."

13. There is currently no dispute in this case, on the evidence to date, that AG has frontal lobe dementia and that the "diagnostic element" of the test for incapacity is satisfied. The parties do not agree that the "functional element" is satisfied or that the presumption of capacity is rebutted.

14. Dr Quinn saw AG again on 22 May 2020 with a view to answering questions about his initial report, and to assess capacity to make other decisions, namely marriage and issuing a divorce petition. Another thorough letter of instruction made it quite clear that the parties also wanted him to provide more detail and explanation for his views on capacity. The letter opened with this request:

> "please set out the relevant information given to AG for **each decision assessed** and her ability to understand, retain use and weigh that information as set out in the test for capacity in the MCA 2005." [emphasis in the original].

15. Dr Quinn concluded in his report of 1 June 2020 that AG did have capacity to make decisions about issuing divorce petition and marrying. He has not subsequently revisited the issue of capacity to make those decisions and told me that, notwithstanding that he found AG's condition had significantly deteriorated when he saw her again at the end of September 2020, he maintained his views on capacity to issue divorce proceedings and to marry because he had not re-addressed them at the September assessment. This did not sit well with his final assessment that AG lacks capacity to engage in sexual relations.

16. Dr Quinn considered capacity to consent to sexual relations at some length in his June report. He noted at paragraph 3:

> "Having re-visited the case again on 22nd May 2020 the author explored with her the area of capacity to consent to sexual relations including the mechanics of the act, pregnancy, sexually transmitted infections and the issue of consent. Those matters were discussed with her in blunt basic terms. She did not demonstrate any deficit in registering, retaining the information and weighing up the pros and cons of consent to sexual relations the author can advise those instructing that at the time of that examination on 22nd May 2020 she did not lack capacity. However, and the author would advise caution moving forward with this, that issue can change at any time with [AG]."

Indeed, he added the following caveat at the end of paragraph 3 of that report:

> "… whether the picture of dementia changes i.e. deteriorates even further is difficult for the author to comment on. It is as the court will see, a fluctuating picture."

At paragraph 6 he wrote,

> "Her ability to make the assessed decision as a consequence of her dementia will likely fluctuate as (that which has already been seen) it is a fluctuating picture and not present on a continuous basis. It is likely only at those times when she is either confused and or disinhibited that her capacity to weigh up information presented to her to come to make the assessed decisions would be impaired."

And at paragraph 8(b):

> "The disinhibited behaviour does not render her unable to understand, retain or use information but [to] … weigh that information up prior to coming to a decision."

17. Dr Quinn said in oral evidence that he had at that time concluded that AG had fluctuating capacity in relation to *all* the decisions under consideration (save for decisions to issue a divorce petition and to marry). He emphasised that he had in mind the impact on AG's ability to use or weigh information as a result of periods of disinhibition. Although his June report does flag up the possibility of AG's dementia deteriorating, his assessment focused on "a fluctuating picture" rather than an expectation of loss of capacity due to an overall deterioration.

18. The parties then asked Dr Quinn to consider the impact of the Court of Appeal decision in *A Local Authority v JB (Rev 2)* [2020] EWCA 735 by addressing the question of whether AG had capacity to make decisions about engaging in sexual relations (a different question from that of capacity to consent to sexual relations). The parties also provided Dr Quinn with a further witness statement from the allocated social worker dated 6 July 2020.

19. In his short report of 17 August 2020, Dr Quinn briefly reviewed the further statement and concluded:

> "By way of final comment it is now probable (from when examined on 2 May 2020) the clinical picture has now changed i.e. there has been a more obvious global deterioration as would leave the author to conclude (contrary to that which appears 1st in the report dated 1st June 2020 – point 6) that the picture is likely a continuous one i.e. she is impaired probably on a continuous basis and not a fluctuating one."

The reference to "point 6" was to paragraph 6 which is set out above.

20. The parties prudently invited the court to direct that Dr Quinn should assess AG once more in person. He did so in late September. Dr Quinn began his most recent report by noting that, initially at least, AG did not recall meeting him previously. He remarked that,

> "The change, i.e. deterioration in her presentation, was evident from when previously examined by the author. Having

> explained the nature and purpose of the examination on several occasions in basic language she could not understand this."

He reported that he attempted to explore issues of capacity concerning the areas of decision-making under consideration, but "her responses lacked any meaningful detail." For example, questioning about financial arrangements prompted the response "no idea". As to sexual relations, AG simply said that she and CI would look after one another and she would not tolerate any further enquiry. Dr Quinn concluded firmly:

> "4.3 Having met with her face to face on 29th September 2020 her superficiality, fatuous presentation and irritability when the author attempted to probe beneath the surface likely arise because of the further decline in her cognitive functioning.
>
> 4.4 The author is not now satisfied that [AG] has capacity to;
>
> 4.4.1 Make decisions about her residence.
>
> 4.4.2 Make decisions about her care and support.
>
> 4.4.3 Make decisions in relation to contact with others.
>
> 4.4.4 Make decisions about her property and affairs to include terminating her tenancy and;
>
> 4.4.5 Engage in sexual relations."

21. The Mental Capacity Act 2005 provides

> **"1 The principles**
>
> The following principles apply for the purposes of this Act.
>
> (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...."
>
> **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."

22. The Vice President Mr Justice Hayden in *London Borough of Tower Hamlets v PB* [2020] EWCOP 34 gave helpful guidance as to the general approach to be taken by the court when determining an issue of capacity:

> "51.i. The obligation of this Court to protect P is not confined to physical, emotional or medical welfare, it extends in all cases and at all times to the protection of P's autonomy;
>
> ii. The healthy and moral human instinct to protect vulnerable people from unwise, indeed, potentially catastrophic decisions must never be permitted to eclipse their fundamental right to take their own decisions where they have the capacity to do so. Misguided paternalism has no place in the Court of Protection;
>
> iii. Whatever factual similarities may arise in the case law, the Court will always be concerned to evaluate the particular decision faced by the individual (P) in every case. The framework of the Mental Capacity Act 2005 establishes a uniquely fact sensitive jurisdiction;

iv. The presumption of capacity is the paramount principle in the MCA. It can only be displaced by cogent and well-reasoned analysis;

v. The criteria for assessing capacity should be established on a realistic evaluation of what is required to understand the ambit of a particular decision by the individual in focus. The bar should never be set unnecessarily high. The criteria by which capacity is evaluated on any particular issue should not be confined within artificial or conceptual silos but applied in a way which is sensitive to the particular circumstances of the case and the individual involved, see London Borough of Tower Hamlets v NB (consent to sex) [2019] EWCOP 27. The professional instinct to achieve that which is objectively in P's best interests should never influence the formulation of the criteria on which capacity is assessed;

vi. It follows from the above that the weight to be given to P's expressed wishes and feelings will inevitably vary from case to case.

23. To set the bar too high could be unfair, unnecessary and discriminatory against the mentally disabled: *Sheffield City Council v E* [2004] EWHC 2808, para. 144 per Munby J, as applied by Baker J. in *PH v A Local Authority* [2011] EWHC 1704]. A linked principle is that the person must understand the salient information but not necessarily all the peripheral detail: *LBC v RYJ* [2010] EWHC 2665.

24. As noted, I am told that Dr Quinn has given helpful evidence to the Court of Protection and other courts on many previous occasions. Unfortunately in this case his evidence left the parties, the court, and even Dr Quinn himself, with some “disquiet”. I emphasise that I have no misgivings about Dr Quinn’s professionalism or expertise. No party has questioned his conduct. The concerns expressed by the parties and shared by the court arise from the series of written reports in this case. Those concerns were raised with him in questioning at the hearing. They include:

    a. Paragraph 4.16 of the Code of Practice states, “ It is important not to assess someone’s understanding before they have been given relevant information about a decision. Every effort must be made to provide information in a way that is most appropriate to help the person understand”. The expert’s reports did not provide sufficient evidence either that AG had been given the relevant information in relation to each decision, or of the discussions the expert had had with P about the relevant information.

    b. It is not a criticism of an expert that at different times they have reached different conclusions about a person’s capacity. Capacity can change and new evidence may come to light. However, in this case significantly different conclusions had been reached at different times without clear explanations of why the conclusions had changed or how the evidence as a whole fitted together. Further, the change in opinion between the June report and the August letter had

followed the receipt of a single further statement and without any further face to face assessment.

c. The expert's final conclusion had been reached on a broad-brush basis rather than by reference to each decision under consideration.

d. A lack of information to show how AG had been assisted to engage when the expert had "hit a brick wall" in his attempts to have a discussion with her at his final interview. The lack of information left doubt as to whether AG was incapable of understanding the purpose of the interview, whether she had been given adequate support to engage, or whether she had simply chosen not to talk to the expert.

e. A lack of a cogent explanation for why the presumption of capacity had been displaced in relation to the decisions under consideration. Conclusions were stated but not clearly explained.

25. It is fair to say that Dr Quinn responded very properly to questioning at the hearing and he did not seek to gloss over the concerns raised or his own disquiet.

26. It might be helpful to provide some indications of how experts' reports on capacity in a case such as this can best assist the court. In doing so, I have no wish to be prescriptive about the form and content of reports - the Court of Protection Rules r15 and the Practice Direction 15A should of course be followed by all experts and those instructing them. Nor shall I comment on the way an expert should interview or assess P – those are matters for the expert's professional judgment. The inquiry into capacity will vary considerably from case to case, and experts must always be sensitive to what is required for the individual assessment in which they are engaged. I am also mindful of the very recently published final report of the President's *Working Group on Medical Experts in the Family Courts*, in which Mr Justice Williams and his working group highlight the pressures on expert witnesses that surely apply also to those giving evidence in the Court of Protection – the rates of remuneration, the lack of support and training, the court processes and perceived criticism by lawyers, judiciary and the press. It is with due care therefore that I provide the following comments which are intended merely to assist experts when writing reports in cases such as the present one. The Working Group recommends constructive feedback to encourage good practice.

27. Expert evidence under COPR r15 is by no means the only way in which capacity assessments are provided to the court Indeed r15.3(2) provides

"The court may give permission to file or adduce expert evidence … only if satisfied that the evidence –
(a) Is necessary to assist the court to resolve the issues in the proceedings; and
(b) Cannot otherwise be provided either –
(i) by a rule 1.2 representative; or
(j) in a report under section 49 of the Act."

Some section 49 reports are written by psychiatrists who might, in other cases, provide an expert report under r.15. An assessment of capacity is no less important when carried out under s. 49 or by a social worker or Best Interests Assessor. What follows might be

of assistance to all assessors, but it is specifically directed to r15 expert witnesses because that is the form of evidence under consideration in this case.

28. When providing written reports to the court on P's capacity, it will benefit the court if the expert bears in mind the following:

    a. An expert report on capacity is not a clinical assessment but should seek to assist the court to determine certain identified issues. The expert should therefore pay close regard to (i) the terms of the Mental Capacity Act and Code of Practice, and (ii) the letter of instruction.

    b. The letter of instruction should, as it did in this case, identify the decisions under consideration, the relevant information for each decision, the need to consider the diagnostic and functional elements of capacity, and the causal relationship between any impairment and the inability to decide. It will assist the court if the expert structures their report accordingly. If an expert witness is unsure what decisions they are being asked to consider, what the relevant information is in respect to those decisions, or any other matter relevant to the making of their report, they should ask for clarification.

    c. It is important that the parties and the court can see from their reports that the expert has understood and applied the presumption of capacity and the other fundamental principles set out at section 1 of the MCA 2005.

    d. In cases where the expert assesses capacity in relation to more than one decision,

        i. broad-brush conclusions are unlikely to be as helpful as specific conclusions as to the capacity to make each decision;
        ii. experts should ensure that their opinions in relation to each decision are consistent and coherent.

    e. An expert report should not only state the expert's opinions, but also explain the basis of each opinion. The court is unlikely to give weight to an opinion unless it knows on what evidence it was based, and what reasoning led to it being formed.

    f. If an expert changes their opinion on capacity following re-assessment or otherwise, they ought to provide a full explanation of why their conclusion has changed.

    g. The interview with P need not be fully transcribed in the body of the report (although it might be provided in an appendix), but if the expert relies on a particular exchange or something said by P during interview, then at least an account of what was said should be included.

    h. If on assessment P does not engage with the expert, then the expert is not required mechanically to ask P about each and every piece of relevant information if to do so would be obviously futile or even aggravating. However, the report should record what attempts were made to assist P to engage and what alternative strategies were used. If an expert hits a "brick wall" with P then they

might want to liaise with others to formulate alternative strategies to engage P. The expert might consider what further bespoke education or support can be given to P to promote P's capacity *or* P's engagement in the decisions which may have to be taken on their behalf. Failure to take steps to assist P to engage and to support her in her decision-making would be contrary to the fundamental principles of the Mental Capacity Act 2005 ss 1(3) and 3(2).

29. The newly instructed expert in this case may or may not reach the same conclusions as Dr Quinn, but it will be important that the parties and the court can see from their report that the fundamental principles of the MCA 2005 have been followed, that proper steps have been taken to support AG's decision-making and participation in the assessment, and that the conclusions reached are adequately explained.