Neutral Citation Number: [2018] EWCOP 34

Case No: COP13012043

IN THE COURT OF PROTECTION

IN THE MATTER OF **THE MENTAL CAPACITY ACT 2005**

COVERDALE HOUSE
LEEDS
Judgment handed down at the
Newcastle Combined Court Centre

Date: 21/11/2018

Before:

THE HONOURABLE MR JUSTICE COBB

- -

Between:

A North East Local Authority	**Applicant**
- and -	
AC	**Respondents**
(by her Litigation Friend)	
BC	

- -
- -

Ms Jacqueline Thomas (instructed by **Local Authority Solicitor**) for the Applicant (Local Authority)
Mr Joe O'Brien (instructed by **Switalskis, Solicitors**) for AC, by her litigation friend Mrs BC in person

Hearing dates: 8-11, 15-18 October 2018

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Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

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THE HONOURABLE MR JUSTICE COBB

This judgment was delivered in private. The judge has given leave for this version of the judgment to be published on condition that (irrespective of what is contained in the judgment) in any published version of the judgment the anonymity of AC and BC and members of their family must be strictly preserved; this is likely to require anonymisation of the residential care units and professionals. 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.

The Honourable Mr Justice Cobb:

Contents of the Judgment:

Introduction

1. Miss AC (who I shall refer to as 'AC') was born in March 1969 and is now 49 years old. She has complex health needs, with a lifelong and significant learning disability; she has no formal speech; she suffers from epilepsy and has restricted mobility. She is doubly incontinent. She communicates by gesture, vocalisation, body language and facial expression. She currently resides at Placement 2 where she has been since February 2018.

~~2.~~ By application dated 20 January 2017, a North Eastern Clinical Commissioning Group (the CCG) sought the direction of the Court of Protection in relation to AC's deprivation of liberty and arrangements for her care. On 21 February 2018, given the then imminent changes in the funding arrangements for her services, the local authority was substituted as applicant. Mrs. BC (who I shall refer to as 'BC'), AC's sister, is the second respondent.

3. This court has already made final declarations (on 16 November 2017) that AC lacks capacity to litigate and make decisions in relation to her care and treatment. Interim declarations are currently in place to the effect that AC lacks capacity to make decisions about contact with others.

4. The application now before the court requires me to determine AC's future placement, and (subject to my view on AC's capacity to make decisions about contact) contact with others. These decisions will be governed by what is in her best interests. Given the specific options before the court, it is acknowledged by all parties that future care provision will inevitably be informed by conclusions reached about her recent past care. In that regard the Local Authority has presented to the court a schedule of proposed facts on which they ask me to make findings. These pertain to the care provided to AC by BC in her home up to November 2017 (and to a limited extent thereafter). This schedule has been the focus of the enquiry at this hearing, although inevitably the evidence has taken in a wider panorama. I must also of course consider the care offered to AC in the last 12 months, most recently at Placement 2.

5. The Local Authority maintains that AC's best interests will be served by her remaining in residential care; their initial position was that AC should remain at Placement 2, but part-way through the hearing they indicated that they would want to undertake a wider review the options for AC's future placement, and ultimately invited me to adjourn the case so that they could consider the respective merits of (a) AC remaining at Placement 2, or (b) AC moving to another placement, including a unit known as BD or a new resource (scheduled to open in February 2019) at LM.

6. The Litigation Friend of AC is LF1. He is employed by an Advocacy service, and has instructed solicitors and counsel. He opposes AC's return to the care of BC and contends that AC should remain in residential care or supported living; he wishes the Local Authority to research options and return to court when detailed information is to hand. He has advised that he has a range of concerns about AC remaining at Placement 2.

7. BC seeks the return of AC to her care with a package of support which would initially be provided by friends, neighbours and family, and subsequently by professional carers. At one point in the hearing, she offered to vacate her home for a period to allow AC back into the home, while her friends (F1 and F2, present at this hearing to support BC) care for AC. This option was abandoned before the end of the hearing.

8. BC has represented herself in this hearing. This has obviously been challenging for her. At an earlier stage of the proceedings, she filed a document containing this statement:

> "I admit I am nervous and intimidated in such surroundings [i.e. court] and procedures, and I am emotional at the false allegations and consequences of the same, of being separated from my sister, and in order to speak at all, I have to focus and hold back the tears".

I accept that as a sincere reflection of the daunting nature of the task she faced. There is a huge amount of documentation for her to digest. The trial bundles alone exceed 3000 pages; that said, she had plainly mastered the information well. The subject

matter of the dispute and the outcome is one (which she herself reflects above) in which she has a significant emotional investment. She presented her case with skill, and was respectful to the court throughout the hearing (and earlier hearings). I allowed her to have her two friends (F1 and F2) in court with her to support her. Although relations between BC and the Local Authority witnesses has been at best strained (at worse, hostile: see below), she was able, for the most part, to question them without displaying obvious ill-feeling. Only once did I consider that BC was actually threatening of a witness at court through the way she addressed her[1], and I intervened.

9. The trial bundles contained a *huge* volume of written material[2]. I regret, in hindsight, that I did nothing in the final throes of case managing the applications to rein in the volume and content of the written material presented to me, some of which dates back 13 or more years. On re-reading the materials for the purposes of this Judgment, I felt a sense of rising despair at the failure of the advocates to marshal the documents into better order for the trial bundle; little if any thought appears to have been given to the proportionality of the filing of written evidence, and/or the structure of the bundles which have been unwieldy and extremely difficult to navigate. There is a lesson there to be learned for us all.

10. I was invited by the parties, particularly BC to view some video-recordings, and listen to audio-recordings; altogether I spent about 1.5 hours in that exercise during the hearing. I found it useful. Less useful was reviewing BC's 'transcripts' of the recordings, which were demonstrably inaccurate and incomplete.

11. I read the statements of many witnesses, some of whom were not required to attend for cross-examination[3]; insofar as the evidence of any of the witnesses whose statements had been read were not accepted, I have obviously given their evidence limited weight. I received oral evidence from altogether 19 witnesses[4], including, of course, BC herself.

12. I have not attempted in this judgment to cover every point of detail raised and traversed in the documents, nor all the arguments advanced nor points of contention raised. BC has been fastidious (I refer to it below [105] as 'near-obsessive') in commenting on and invariably challenging points advanced, and alleged facts asserted, in documents generated by the professional bodies over a number of years. I have sought to concentrate on those aspects of the evidence on which there was greatest focus in this enquiry, which most directly affect my decision, and to give sufficient evidence-based explanation for my decision.

Post-hearing events

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[1] To care professional 1 (CP1), when cross-examining her: "I have got recordings – so you had better be careful what you say"

[2] A fair amount of the documentation from BC was in closely written manuscript; this is an observation not a criticism. Inevitably documents take longer to read when written in manuscript, and the photocopying is often less satisfactory. This has contributed to the difficulties for all parties in marshalling the relevant information for the hearing.

[3] Including, notably, the numerous statements from BC's main supporters F1 and F2

[4] Community Nurse 2(CN2), CP2, CP3, CP4, CP5, Community Matron 1(CM1), SW3, CN1, Commissioning Manager 1 (CMan1), CP1, CP6, CMan4, Dr.1, SW4, SW2, Dr. 2, SW1; on behalf of BC, F5, CP7, and BC herself.

13. I mention at this stage that I have been made aware, through regular e-mails to my clerk principally from BC, but also from the local authority, that since the hearing there have been developments in relation to AC and her care, including a period of hospitalisation. I note that there has been a change of key social worker, and a proposal for a meeting to discuss contact issues. A COP9 has been issued by BC, in which she re-states her claim to have AC home with her. Whilst I have noted the contents of this correspondence, I have decided that I should not consider those communications in addressing the issues in this judgment; no party has suggested that I should. The events described in those communications may, of course, feature evidentially in the next hearing.

Applicable principles of the law

14. Subject to what I have said about the volume of paper filed in the case (see [9] above) in steering this case to this fact-finding and 'best interests' hearing, I have had firmly in mind the overriding objective set out in *rule 3* to the *Court of Protection Rules 2007* – observing the obligation to deal with the case "justly", "expeditiously and fairly" (*rule 3(3)(a)*), and ensuring that AC's interests and position are properly considered. I have sought to deal with this case in a way which is proportionate to the nature, importance and complexity of the issues. In this regard, I have made every allowance for the fact that BC is unrepresented; I am satisfied that she has had every chance fully and actively to participate in the process, and she has indeed done so. While all parties have at times, in their questioning, strayed into wider reaches of the panorama referred to earlier (territory which was not specifically germane to my enquiry), I have sought throughout, and in this judgment, to focus only on those "issues [which] need full investigation" ignoring those "which do not" (*rule 5(2) CoPR 2007*); particularly given the length of these proceedings I am conscious of the need to deal "with as many aspects of the case as the court can on the same occasion" (ibid.).

15. The applicable law is uncontentious.

16. In a fact-finding hearing in the Court of Protection, as in other civil litigation, the burden of proof lies with the party who makes the allegation, in this case it is the local authority. It is not for BC to prove anything.

17. The standard of proof is the ordinary civil standard, the balance of probabilities. As Lord Hoffman described this test in *Re B (Care Proceedings: Standard of Proof)* [2008] UKHL 35 at §2:

> "If a legal rule requires a fact to be proved (a 'fact in issue'), a judge or jury must decide whether or not it happened. There is no room for a finding that it might have happened. The law operates a binary system in which the only values are 0 and 1. The fact either happened or it did not. If the tribunal is left in doubt, the doubt is resolved by a rule that one party or the other carries the burden of proof. If the party who bears the burden of proof fails to discharge it, a value of 0 is returned and the fact is treated as not having happened. If he does discharge it, a value of 1 is returned and the fact is treated as having happened".

18. Accordingly, only if I find that it is more likely than not that an allegation is made out as the local authority contend, will it be treated hereafter within these proceedings as the basis on which further decisions (about AC's residence and contact in particular) and assessments are made.

19. Findings of fact in these cases must of course be based on evidence, including inferences that can properly be drawn from the evidence, but not on suspicion or speculation. The evidence is to be taken as a whole; in this case, there are multiple strands of material to weave together to create the factual tapestry.

20. The importance of establishing a secure factual platform for future planning was described (in the context of *Children Act 1989* proceedings) in *Re W* [2008] EWHC 1188 (Fam) where McFarlane J (as he then was) held at [72]:

> "It is important that the planning in the future for these children, particularly C, is based upon as correct a view of what happened to R as possible. It is not in the children's interests, or in the interests of justice, or in the interests of the two adults, for the finding to be based on an erroneous basis. It is also in the interests of all of the children that are before this court for the mother's role to be fully understood and investigated."

It seems to me that the principles outlined above can be appropriately transported from the Family Division to the Court of Protection.

21. Hearsay evidence is plainly admissible in proceedings of this kind, as McFarlane J made clear in *LB Enfield v SA* [2010] 1 FLR 1836. While ruling (at [29-30]) that proceedings in the Court of Protection under the *MCA 2005* must fall within the wide definition of 'civil proceedings' under *section 11 of the CEA 1995*, he went on to conclude ([36]) that:

> "COPR 2007, r 95(d) gives the Court of Protection power to admit hearsay evidence which originates from a person who is not competent as a witness and which would otherwise be inadmissible under CEA 1995, s 5. Admissibility is one thing, and the weight to be attached to any particular piece of hearsay evidence will be a matter for specific evaluation in each individual case. Within that evaluation, the fact that the individual from whom the evidence originates is not a competent witness will no doubt be an important factor, just as it is, in a different context, when the family court has to evaluate what has been said by a very young child".

22. As I have indicated above, the court is presented with quite a range of options as to AC's future placement. The Local Authority and the Litigation Friend speak with one voice in contending that I can and should at this stage rule out the option of AC's return home, even though they both contend that I should adjourn the proceedings for further evidence to be garnered in relation to residential care/supported living. This approach brought to mind the guidance from *In re B-S (Children) (Adoption Order: Leave to Oppose)* [2013] EWCA Civ 1146, [2014] 1 WLR 563, [2014] 1 FLR 1035 in

the family jurisdiction. In that case, the court described court being required to conduct:

> "… a balancing exercise in which each option is evaluated to the degree of detail necessary to analyse and weigh its own internal positives and negatives and each option is then compared, side by side, against the competing option or options".

23. I raised the question with counsel whether the court could legitimately rule out one possible outcome/option, before reaching a firm conclusion on best interests. In seeking an answer to that question, I referred counsel to the case of *North Yorkshire CC v B* [2008] 1 FLR 1645. In that case, Black J (as she then was) said this at [18]:

> "If the evidence is available, I see nothing wrong in the court determining in advance of the local authority presenting its final care plan and the court considering 'disposal' that a particular individual is not going to be in a position to care for a child safely in the sort of timescale that the child needs. I do not agree … that that is an unusual course in these courts. It is not at all uncommon for a parent or another individual to be ruled out after a fact-finding hearing". (emphasis by underlining added).

And at [20]:

> "Here the evidence has all been collected on the future prospects with regard to the mother in preparation for this hearing. It is not in any way going to be rendered uncertain by the continuing assessments of the paternal family. The court should, therefore, consider that evidence with a view to determining whether a clear route exists with regard to the mother now. She is not taken by surprise by that course. That is in fact what was expected of this hearing, and would have been carried out in any event, were it not for more recent developments".

24. Miss Thomas in turn referred me to *Re R* [2014] EWCA Civ 1625. In that case, McFarlane LJ and Sir James Munby P highlighted the "fundamental" importance of the court concerning itself in the final analysis only with 'realistic' options (see [59] of *Re R*). Sir James Munby P explained:

> "*Re B-S* does not require the further forensic pursuit of options which, having been properly evaluated, typically at an early stage in the proceedings, can legitimately be discarded as not being realistic. *Re B-S* does not require that every conceivable option on the spectrum … has to be canvassed and bottomed out with reasons in the evidence and judgment in every single case. Full consideration is required only with respect to those options which are "realistically possible"".

25. Sir James Munby P made the further point at [65] of *Re R* that:

> "This process of identifying options which can properly be discarded at an early stage in the proceedings itself demands an appropriate degree of rigour, in particular if there is dispute as to whether or not a particular option is or is not realistic."

26. And at [67] of *Re R* he made this important point:

> "If, in this way, an aunt or a grandparent can be ruled out before the final hearing as not providing a realistic option, there can in principle be no reason why, in an appropriate case, one or other or even both parents should not likewise be ruled out before the final hearing as not providing a realistic option. *Re B-S* requires focus on the realistic options and if, on the evidence, the parent(s) are not a realistic option, then the court can at an early hearing, if appropriate having heard oral evidence, come to that conclusion and rule them out. *North Yorkshire County Council v B* [2008] 1 FLR 1645 is still good law. So the possibility exists, though judges should be appropriately cautious, especially if invited to rule out both parents before the final hearing or, what amounts to the same thing, ruling out before the final hearing the only parent who is putting themself forward as a carer"

27. Finally, I should add that in considering the issues in this case I have had regard to the *European Convention on Human Rights*, and in particular *Article 8* which is a right enjoyed by BC and AC and protects their mutual "right to respect for [their] private and family life" and "[their] home". I have also considered in this case the *United Nations Convention on the Rights of Persons with Disability ('UNCRPD')*[5]. This has as its first principle the promotion and protection of respect for the inherent dignity of all persons with disabilities[6]. I have been particularly conscious in this case of the obligation expressed in *Article 22*, namely:

> "No person with disabilities, regardless of place of residence or living arrangements, shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home or correspondence or other types of communication or to unlawful attacks on his or her honour and reputation. Persons with disabilities have the right to the protection of the law against such interference or attacks".

28. The UNCRPD remains currently an undomesticated international instrument, and therefore of no *direct* effect (see Lord Bingham in *A v Secretary of State for the Home Department* [2005] UKHL 71; [2006] 2 AC 221 at [27]). It nonetheless provides the

[5] Signed by UK in 2007, ratified in 2009

[6] Persons with Disabilities within the UNCRPD are those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

framework to address the rights of persons with disabilities; by ratifying a Convention (as the UK has done) this jurisdiction has undertaken that wherever possible its laws will conform to the norms and values that the Convention enshrines: *AH v West London MHT* [2011] UKUT 74 (AAC); [16][7]. I am satisfied that I should interpret the domestic law in a way which is consistent with this convention.

The background history

29. In this section of the judgment I rehearse the relevant background history. Where relevant and convenient I make findings; in doing so, I apply the principles of law which I have set out above.

30. Before turning to that history and the schedule of findings, it is important that I should record that BC cared for AC for 12 or so years at her home, taking over from her mother, when her mother became too old/unwell to continue. BC's and AC's mother then passed away, and BC became the sole carer. I accept, on the evidence which I have heard, that BC loves her sister, AC, very much and that this love is mutual. Some of the professionals from whom I have heard evidence have commented on this[8].

31. The evidence laid before me largely focused on the period from early 2016 to the present. For the majority of that period, (indeed until November 2017), AC's care was provided at home by BC, supported by a care package (including Agency 1) of 56 hours per week, initially provided by the local authority; BC received a direct payment for 12 hours of that care. BC is a nurse, although no longer registered. In reality, BC was a key component of the package.

32. I pick up the narrative in or about April 2016, for it was then that the CCG assessed AC as eligible for full NHS continuing care funding, and at that time responsibility for the package of care transferred to them. From an early stage of their involvement it is apparent that BC was not satisfied with the package of care offered (although the package was said to be more extensive than AC's actual needs required) and she complained strongly about the care staff; the care agency accordingly gave notice. At that stage there were assessed to be "low levels of risk in relation to safeguarding issues"[9]. A second agency, care agency 2, took over the package in June 2016 and continued in this role until July 2016. BC disputed the care plan put in place by Care agency 2 as she felt that it provided inadequate night care. In spite of these difficulties 'on the ground', it was nonetheless felt that BC cared for AC to a satisfactory standard. I heard evidence from CP7 (a carer from Care agency 2, called by BC) who worked in BC's home for three months in May-July 2016; she told me that she had "never witnessed any action or behaviour by [BC] or any other which would appear to put AC at risk… [BC] always had her sister's best interests at heart".

33. Concern was raised by the CCG in the early part of their direct involvement about BC's bowel care management; the concern was not so much that the management was causing AC permanent physical damage, but that extensive and invasive procedures were being performed routinely by BC who was untrained in bowel management. AC

[7] See Morris J in *R(Davey) v Oxfordshire CC & others* [2017] EWHC 354 (Admin)
[8] CP6, a health care assistant, confirmed in oral evidence that in her view BC "does care for AC very, very, deeply": cross-examination.
[9] Statement of SP

was, it appears from the evidence, receiving frequent digital examinations from BC, without (it was felt) a proper basis. Over the next 18-24 months (and continuing) this issue of appropriate bowel care became a significant 'battle ground' between BC and the professionals engaged by the CCG and the local authority.

34. On 18 July 2016, specific safeguarding concerns were raised by Care agency 2 that BC was physically and emotionally abusing AC; it was said that BC had slapped and shouted at AC. A safeguarding alert was issued to the Local Authority who investigated the complaint under *section 42* of the *Care Act 2014*. BC denied the allegations, but the safeguarding enquiry substantiated the allegations of physical abuse (by slapping), neglect (by BC's non-engagement with professionals) and emotional abuse. Allegations around invasive bowel management proved inconclusive. BC disputed, and continues to dispute, the outcome of the safeguarding enquiry, and I do not go behind those findings. The relationship between BC and the care agency, Care agency 2, inevitably broke down; the CCG attempted to provide support through domiciliary visits, but the attempts were unsuccessful.

35. In August 2016, Dr. 2, a specialist colorectal clinician reviewed AC in clinic; Dr. 2 has been a colorectal surgeon at Hospital 1 for nearly 20 years, and has known AC for at least the last five. A letter following that review reflected no concern about BC's interaction with AC (which of course is accepted by BC, and offered some reassurance given the safeguarding concerns); his *caveat* was that he felt that "the family were a little bit resistant to potential changes in her management"[10], a view which, on all the evidence which *I* have read and heard, I find understates the position considerably. CM1, present in the meeting, reported that Dr. 2 had advised BC that she must co-operate with the continence team who needed to observe what was happening in the home. This did not, regrettably, feature in the report of the clinic appointment. The letter did refer however to the fact that BC was performing "*daily*" rectal examinations of her sister (sometimes with irrigation or an enema); BC refutes the accuracy of this recorded information, but (in spite of the care with which she challenged other witnesses) she did not challenge this when Dr. 2 gave evidence before me. In fact, BC had apparently (though this was not verified in the evidence) told the social workers that she was examining AC rectally two or three (or possibly even four) times per day.

36. The safeguarding investigation prompted enquiries to be made of Dr. 3, the consultant neurologist responsible for AC's epilepsy management; the recorded conversation with him (located in the medical notes) reveals that he had no concerns about the care provided by BC based on his interactions with them in neurology clinic though he could not comment on the occasions when it was felt that BC had omitted AC's epilepsy medications.

37. The safeguarding co-ordinator at this time, in a letter to Dr. 2 (21.9.2016), confirmed that "separating [BC and AC] would be a very last resort and after all efforts to work with [BC] in ensuring care and treatment is being delivered in [AC]'s best interests have been exhausted."

38. On 27 September 2016 CN1, the lead Continence Nurse at the CCG, visited BC and AC at her home to discuss, specifically, bowel care management; she was there for 2

[10] E-mail 24.8.18

hours 40 minutes. I have listened to an audio recording of part of this visit and have seen BC's notes of the visit. The audio recording is revealing; to my ear, it reveals BC to be passively aggressive towards CN1. CN1 (who was a good clear witness) told me that she found it "very difficult to find out what was going on; she [BC] kept going off on a tangent"[11]. This observation entirely chimed with my own experience of BC when she was asked to focus on the issues in the case. CN1 told me that she was very shocked and concerned about the manner in which BC gave AC a *per rectum* examination during the visit, in a manner which she described as "highly inappropriate"[12]. BC believed that she had been asked to perform this, though CN1 disputes this (I discuss this further below).

39. CN1 left the home, she told me, without any clear understanding of the colorectal care which BC was giving to AC, and concerned that the care regime (if indeed there was such a regime) would not be easily be communicable to a third party. She was further concerned that BC had an unstructured (my word not hers) and wholly reactive approach to bowel care, which had even involved discussions of a 'stoma' – a remedy only appropriate if no other treatment is working, and not indicated here. While I understand CN1's concerns about the stoma, it is right to point out in fairness to BC, that when Dr. 2 later in the hearing gave evidence he indicated (in cross-examination by BC) that he "had no reasons to be concerned about your [BC's] care of AC. I offered, if it became difficult, for her to have a colostomy, but given AC's behavioural issues, you did not think that this would be the best option for her"[13].

40. It is right also to balance the accounts above with the overview offered by CMan2, Head of Integrated and Continuing Healthcare at the CCG, who visited in 2016/2017, who described AC as being cared for well by BC.

41. The dispute developed (or more accurately continued) between BC and the CCG about the provision of care; BC stated that she required *nursing staff* to attend her home to assist in the care, whereas the CCG believed that the majority of the care could be provided by *care workers*. BC, I am satisfied, was difficult over agreeing health assessments and care plans sent to her by CM2 (Community Matron, who had taken over from CM1 in that role in October 2016 following a breakdown in that earlier relationship), and (I find) refused to co-operate over the drafting of the detailed arrangements; BC was openly critical of CM2 at court (both at the hearing before me, and at earlier hearings); however, on my finding, BC actively obstructed the community matron to do her job by withholding information and co-operation. The personal or professional discord which festered between BC and CM2 over an extended period had implications for AC's care; it could not be said with confidence that the medication chart and epilepsy protocol were accurate given the fact that BC withheld key information from KC. The relationship between BC and the district nurses team became highly conflictual: she accused them of being "unreliable" and "shirking responsibilities".

42. On 3 November 2016, a safeguarding review was held, at which BC was present. The notes of the meeting suggest that it was a testy meeting; BC was reported to have

[11] Evidence in chief
[12] Evidence in chief
[13] This is confirmed by Dr. 2's letter of 20 December 2016: "she might benefit from a stoma but I understand [BC]'s concerns"

repeatedly interrupted the discussion, preventing professionals from speaking; for a period, BC left the room. The note of the meeting reads:

> "throughout the meeting BC frequently interrupted other participants, including the chair, preventing others from completing their sentences, despite repeated requests from the chair to allow others to speak without interruption. BC made frequent allegations of poor care and misconduct against a wide range of professionals and agencies including some individuals present. Despite requests from the chair, BC frequently attempted to steer the discussion towards her allegations of historic abuse by others, rather than addressing the current safeguarding concerns and protection plan relating to BC's care of AC".

I reproduce that note in full, because it conveniently encapsulates the flavour of much of what I heard about BC's conduct throughout the period under scrutiny.

43. In March 2017, CMan3, the head of the CCG's healthcare, and who had been the sole point of contact between BC and the CCG withdrew from any further involvement following a conversation in which she described BC as being "very angry" and making "derogatory" comments. BC in evidence was unrepentant when asked about CMan3's reaction to this call ("that's her choice"). Further argument broke out over the provision of a mattress for AC in 2017 – and in a letter to HHJ Hunt in 2017, BC accused the nurses of refusing to admit their mistakes. The CCG struggled to identify a suitable company to provide the nursing care, and when the proceedings were issued (in January 2017) BC was protesting that she was unable or unwilling to work with the brokerage company.

44. Given the increasingly difficult relationships between BC and the professionals, and the lack of clarity about AC's true health and care needs, in July 2017, the CCG asked the court to authorise an assessment of AC. The CCG was concerned that the assessments which by that time had been completed had relied overly-heavily on information from BC, and that there was insufficient objective evidence in relation to the management of epilepsy and bowel care; it felt itself in something of a Catch-22 situation: a care plan was needed to govern the package of support and assessment, but the assessment was needed in order to devise the care plan. HHJ Lynch, sitting as a nominated judge of the Court of Protection, heard evidence at the hearing in July 2017; she considered a large quantity of the relevant documentation and concluded that there would be a material benefit in there being a proper objective assessment. She delivered a judgment acknowledging that BC would find it difficult to receive assessors in her home 24 hours per day, 7 days per week, but nonetheless considered that this would be the most appropriate method of assessment in AC's best interests. The judge felt that AC would be distressed to be removed from her home, and that this should be avoided if possible. The assessment was scheduled to take 6 weeks, with a 24-hour package of support in place. BC continued to take the view at that time that she believed that the assessment would have to be conducted by *nursing staff* not *carers*.

45. Having ruled that the assessment should take place in the home (about this she was "quite clear"), HHJ Lynch nonetheless indicated (understandably, in my view) that this assessment would require BC's full co-operation, "both in allowing the carers in and enabling them to do what is required of them, and it will require the carers to act professionally in carrying out their observations". She concluded: "I very much hope that … all the people involved in AC's life can work together to make assessment in her home possible".

46. The commencement-date for the assessment was 12 October 2017. The assessment was to be conducted by Care agency 3, commissioned by the CCG. In the event, the assessment did not progress beyond the 12 October. There is a dispute as to the precise reasons for this. The Local Authority maintain that BC effectively closed down the assessment by her conduct towards the assessors. The witnesses from whom I have heard evidence referred to BC as "obstructive", confrontational, "aggressive", and "intimidating". BC maintains that the care workers who came to her home had a preconceived bias against her and took the first opportunity to find fault in the smallest thing; they in turn allege that she interrogated them and was rude to them. One of the care workers, CN2 (continence nurse specialist, supervised by CN1) complained that at one point BC shoulder-barged her, pushing her out of the way ("she was definitely not in a great emotional state. It was very intentional…".). Having heard CN2 and BC give evidence on this issue, I can indicate at this stage that I accept CN2's account. I also, materially, accept the care workers accounts of BC's conduct on this day.

47. Indeed, when the nurses left the home on 12 October, I noted that BC was captured on camera saying: "I am not having her [AC] messed about with because it suits them. I feel they want to dictate to me. They want to tell me, but a lot of serious harm has happened to [AC] but they don't know that, they're not interested".

48. On 18 October, the CCG restored the application to the Court of Protection on the basis that the plan for assessment had broken down; the CCG indicated that it was not prepared to continue or restart the assessment in BC's home. The Community Matron and district nurses were specifically asked if they would return to her home for further assessment if BC made assurances or gave guarantees about her behaviour. They stated clearly that they felt that no amount of assurances or guarantees from BC would make that difference and that they were not prepared to return to care for or assess AC in that environment. The CCG's application was placed before the court on 16 November 2017. As an alternative to the home assessment, the CCG proposed assessment at a residential unit namely Placement 1 – a proposal which was adopted by HHJ Lynch in the face of opposition from BC. No restrictions were placed on BC's contact with AC save for those which were relevant to all visitors of the residents.

49. It was in those circumstances that, on 20 November, AC moved into residential care at Placement 1 for assessment. To her credit, BC co-operated with the arrangements for AC's move, and the parties achieved AC's smooth transition to her temporary home. The deprivation of liberty at the placement was covered by standard authorisations (as indeed it has been throughout the period since November 2017). The assessments commenced, and a good appraisal of her care needs was established, for the first time.

50. CM2 told me that when AC settled at Placement 1 her care needs and clinical input was much less than the professionals had been led (by BC) to believe it would be[14].

51. Early on in the placement, difficulties arose through BC's alleged conduct towards staff and the other residents. On 1 December there was an argument between staff members and BC; it appears that voices were raised, and residents became upset. CMan1 told me that "some of the residents had been traumatised for days thereafter"[15]. I am satisfied on all that I have heard (and given the wider context of evidence) that the Local Authority evidence on this point is likely to be right. On 7 December, the manager at Placement 1 notified the CCG that Placement 1 would no longer tolerate visits by BC onto the unit. The issue was put before the court. On 18 December, HHJ Lynch ordered that contact between BC and AC should in the circumstances take place away from Placement 1 on Saturdays for no more than 3 hours; it was directed that BC was not to perform any invasive procedures on AC while at contact.

52. Over Christmas and New Year 2017, F3 visited Placement 1 while assisting BC take up the contact; she reported to this court a range of concerns about AC's care and the state of the placement. Witness statements in similar vein were supplied by BC from F4 and F5. F1 and F2 also reported their concerns about AC in this period. BC then made an application to the court for AC's immediate return home; she alleged that AC was being neglected at Placement 1, was being institutionalised, and that she was withdrawn. BC threatened to take the issue to the local press. The views expressed by BC were not consistent with the evidence filed by the CCG, which indicated that AC was enjoying life at Placement 1, and that the standard of care was good. Materially, LF1 (AC's litigation friend) visited AC in Placement 1 and found AC to be "very well cared for… she appears calmer and more settled". I accept LF1's account.

53. In January 2018, Ms SW1 became the allocated social worker for AC. By that stage AC's health and care needs had been fully assessed in the placement, and a Bowel Assessment report (16 January 2018) was produced, naming four specific recommendations for future bowel care. A similar report was prepared addressing the management of her epilepsy (EN1: 12 January 2018); a Physiotherapy report (12 January 18) and Occupational Health report (8 January 2018) completed the suite of investigations. The assessments confirmed that AC's mobility was improving, she appeared to be establishing a regular bowel pattern, and she was participating in activities in the unit. The CCG in the circumstances opposed AC's return home, when the matter was next before the court; their view was confirmed by the emerging picture of BC's rigid attitudes and lack of co-operation with professionals.

54. In late January 2018, Placement 1 gave notice that it was not willing to continue to offer care to AC beyond 6 February. This was a result of continued reported behaviours by BC towards the staff there, which they viewed as vexatious and disruptive to their service. The matter was put before the court on 5 February, by which time Placement 2 had been identified as a suitable alternative resource. On the following day (6 February), AC moved to Placement 2; this is a 12-bed residential and nursing placement.

[14] Cross examination by Mr. O'Brien.
[15] Cross examination by Mr O'Brien

55. In line with placement policy at Placement 2, BC was given free opportunity to visit BC at any time of the day. However, this freedom was short lived, and in my judgment, quickly abused. As a result of allegedly hostile and unpleasant behaviour of BC towards the care staff on the first few visits (9, 10 and 11 February), placement 2 suspended their offer to BC to visit AC in the home; it confirmed that its staff would no longer be prepared to have direct contact with her. The matter was once again placed before the court (21 February), at which hearing the court directed that BC's contact with AC was to continue at the sensory room at placement 2. This was soon, and mutually, felt not to be an acceptable arrangement.

56. On 28 February BC raised a number of issues about BC's care at placement 2 with the safeguarding team; she alleged that AC was being neglected in many domains of her life. This prompted a *section 42* investigation. The investigation concluded with no safeguarding issues having been identified.

57. At the next hearing (21 March: DJ Murphy) contact was then directed to take place in the community for 2 hours, not at BC's home; the contact arrangement was governed by a contract of expectations.

58. On 2 March 2018, the funding responsibility for AC transferred from the CCG to the Local Authority (as I mentioned in [2] above); the CCG resolved that AC was no longer eligible for funding. On 11 May 2018, the CCG was discharged as a party to the proceedings.

59. A great deal of suspicion was generated on both sides. It led to repeated situations when urine and faeces samples from AC were being taken (F3) at BC's home and submitted for examination. It was also a matter of concern that Dr. 2 had sanctioned an endoscopy for AC – on the basis of a history given by BC.

60. On 6 March, LF1, AC's litigation friend, visited AC. He was disappointed by what he found; he sensed that AC was "very unhappy and withdrawn" compared to her earlier presentation at Placement 1 (where she had been "relaxed, calm, affectionate"). His report of the visit concluded with the words "it was upsetting to see the dramatic change in AC". On 31 March, F4, a friend of BC's and former carer of AC, visited AC at placement 2. I have read her statement. Her experience was similar to that of LF1. She considered that AC was not "thriving in this environment… she is becoming increasingly withdrawn and unhappy". This undoubtedly fuelled BC's anxieties about the placement.

61. On 13 April 2018, BC took her sister out for contact. SW1, supervising the handover, reported that BC was agitated, hostile, rude, loud and unreasonable at the handover; she was argumentative and was questioning of AC's care. I accept that account. Then in breach, or purported breach, of the contract of expectations (see [57] above) that BC was not to take AC back to her home, and for contact to take place in the community, BC conveyed AC back to her house, and they sat for the duration of contact in the garden of the property. When later challenged about the breach, or purported breach, BC protested that this was not a breach of the agreement as AC had not entered the house itself. She maintained that position at the hearing before me. Contact was suspended for a period. I pause here to indicate that I consider that BC did breach the contract of expectations in bringing AC to her garden at her home; this was bringing her 'home' even if AC did not cross the threshold.

62. Supervised contact was offered on 11 May; a few contacts in the community took place supervised by F3 (a friend of BC). Otherwise BC did not take up this offer of contact. A hearing was set up for 11 and 12 June before me in order for me to review the contact arrangements, and give case management directions. Regrettably this hearing had to be vacated.

63. On 12 June 2018, BC issued an application maintaining her concern about AC's presentation, health and well-being at placement 2. She again sought AC's immediate return home. HHJ Lynch adjourned the matter to me to consider at a case management hearing; I did so on 24 July. At that hearing, in London, I declined to accede to the application through a summary process.

64. On 11 August 2018 there was an incident in the placement. A worker manhandled AC to the edge of the bed when AC refused to sit up; AC was then further manhandled to a shower chair when she would not stand to transfer. While showering, AC scratched or nipped the care worker who "in retaliation … turned the shower head and pointed it into AC's face, spraying her directly in the face" (email 15.8.18). The worker who sprayed the shower in AC's face was initially suspended. I now understand that the worker has been disciplined, and dismissed[16]. SW1, the key social worker aptly described this as a "horrible" incident[17]; I agree, and share HHJ Lynch's view ([10] of her 5 September 2018 judgment) that this gave rise to a "serious safeguarding incident". In an e-mail from SW2 (Team Manager at the CTLD), he said that the incident "is not serious in nature but does warrant a visit". This response did not faithfully reflect the gravity of the incident.

65. The Local Authority advised BC of the incident on 15 August; she in turn again immediately applied for AC to return home.

66. On 23 August 2018, AC was admitted to hospital. She had suffered a fall from her bed at placement 2 on the previous day, causing an abrasion to her head. It was said that carers were assisting her to stand, but she overbalanced and fell bumping her head; appropriate medical attention was sought. She was reported to be subdued after the incident but eating and drinking well; BC attributed this to "neglect and possibly abuse" of AC. She expressed herself "gravely concerned" about these events at the placement. The safeguarding investigation reporter referred to the fact that BC "would not tell me what alternative action should have been taken"; when cross examined, she confirmed to me "I am not going to tell you what they should have done. I am clear about that".

67. On 24 August, AC was unwell; she vomited, and a small amount of blood may have been detected in her vomit[18]. In the early hours of the following morning, she was conveyed to hospital where she remained for a number of days until the court could determine whether she should return to placement 2. She was initially diagnosed with sepsis, and anti-biotics were prescribed; this diagnosis was not confirmed on further examination and the anti-biotics were discontinued. Dr.1 assessed that AC had suffered from a "minor infection" for which she received "prompt and appropriate treatment". The medical records for this admission reveal that the "family" (i.e. BC)

[16] Per SW4: Cross examination by Mr O'Brien
[17] Evidence in chief
[18] Dr1's letter 18 September 2018

appears (according to Dr. 1) to have introduced the possibility of constipation as a cause for her ailment. Dr. 1 was of the view that there was no objective evidence to support this.

68. On 30 August 2018, a complaint was made that BC had been "rude" and "hostile" at the hospital. BC denied that she had been "aggressive", or hostile as alleged. While it seems in keeping with other behaviours described and complained of, I am not able to make a finding on this incident one way or another.

69. BC's application for AC's immediate return home was put before HHJ Lynch over two days – 3 and 5 September. Judge Lynch refused the application, but said this in her judgment:

> "One has to say that this is one of those cases where there is no obvious best interest decision for [AC] … I do have concerns about the unit [placement 2] on the very limited information I have, but I am satisfied at the present time that is the best of the options available to me today".

70. In that hearing it became apparent that AC's litigation friend was dissatisfied with the Local Authority's response to the safeguarding concern and took the view that the Local Authority had failed to deal with the need to consider the range of alternative options for AC in a timely way. While continuing the standard authorisation, HHJ Lynch added a range of conditions to ensure the safeguards available. It was apparent to me during the cross-examination of the key social worker, SW1 that compliance with the conditions has been patchy at best.

71. Currently SW1 told me that AC sees about 27 professionals on a routine basis (social care, hydrotherapy, day service [she has been attending weekly], district nurses, continence nurse, physiotherapist and others); she has been attending a weekly 'Beat it' music session too. None of those whom she has seen in those environments have reported to have raised concerns about AC. Indeed, the registered manager of Placement 2 described AC in September as "very bright", and "the best I have seen her in a while".

72. I am pleased to note that the parties engaged in mediation, particularly in order to resurrect contact; I have seen the mediation agreement reached on 26 July 2018. This agreement has not, sadly, led to much actual change in the contact arrangements. Mediation has again been proposed.

Positions of the parties

The position of the Local Authority

73. By the conclusion of the hearing, the Local Authority were proposing an adjournment of the final best interests' decision, inviting me nonetheless to rule out the option of AC returning home into the care of BC in view of the findings which (they maintained) I should make. In that regard, the Local Authority asserted that the allegations set out in the Schedule of Findings (to which I turn in the next main section of the judgment) were proven on the balance of probabilities, and that it was

unrealistic to consider that AC could ever be safely cared for by her sister, and that there was no available package of care to support BC.

74. The Local Authority have set out their case in the proposed Schedule of Findings. It seeks the findings in three areas. It attaches greatest importance to the difficulties encountered in BC's engagement with professionals.

75. **Engagement with Professionals**: As to this, the local authority maintains that there is an overwhelming wealth of evidence of the difficulties in the relationship between BC and professionals – the Local Authority, the local NHS Trust and the CCG. It accepts that this is not a black/white picture, in that it acknowledges that BC has had a reasonable relationship with the GPs and Dr. 2, the medical consultant. It is said that the difficulties encountered by professionals here has been unique and unprecedented. The local authority disputes any evidence of a "vendetta", as complained of BC (see [96] below), but point to the corroboration offered by the consistent account of obstructive and hostile behaviour of BC towards multiple professionals. Ms Thomas maintains that there is no scope for attributing these difficulties to clashes of individual personalities; she argues that BC has shown a marked lack of insight and reflection, and this affects BC's ability to change. The local authority assert that the difficulties have become more and more entrenched, with BC making increasingly exorbitant allegations, including most recently an assertion of 'grooming' of AC by male staff at Placement 2 ("this appalling placement"[19]), notwithstanding, it is said, the absence of any cogent or coherent evidence of this[20]. Ms Thomas maintains that it is difficult to see a way forward if AC were to return home.

76. **Bowel care**: There are two main concerns in this regard: (1) inappropriate and undignified bowel care of AC by BC, and (2) the lack of any reliable plan for and history of bowel care while AC was in the care of her sister. It is said that the bowel care involved far too frequent *per rectum* examinations (daily or more) and performed with little thought for AC's comfort or dignity (illustrated by the examination on 27 September 16). It is further argued that despite efforts to establish a clear picture of this intimate form of care, the continence team and carers were unable to do so; a proposed plan was 'disputed' by BC. The authority maintains that a bowel care plan has been devised and implemented at placement 2 and that this is working (in this regard I rely on the evidence of CP2).

77. Aside from the dignity issues, the Local Authority do not seek to prove that the bowel care was necessarily wrong or that it caused damage, but they are concerned about the lack of clarity, and reliable reporting. They are worried that BC's stance on a bowel care programme has been reactive when it should have been proactive. The Local Authority have no confidence that the current plan would be maintained were AC to return to the care of her sister.

78. **Physical harm**: It is said that BC physically harmed on 12 October by 'yanking' her out of a chair. The Local Authority accept that BC's CCTV video-footage does not show this act, but they contend that CP4 from Care agency 3 (who described the incident) was a clear witness and confirmed that she had witnessed this act: CP4

[19] BC position statement #41
[20] BC refers to three unrelated pieces of non-specific evidence: the presence of thrush, a "hand-shaped bruise" on the leg, and the presence of a male in a locked room with AC, for no apparent purpose.

replied to a question from BC on this issue: "you marched in and yanked her. I am not wrong (about this)"[21]. She added "it was quite frightening, there were loud voices. [BC] was shouting; it was the first time I had seen someone acting like this"[22].

79. On the same day (12 October 2017), BC shoulder-barged one of the carers CN2 (see above). BC disputes this, but the Local Authority maintain that CN2 was not making this up. I have already indicated above that I accept CN2's account (see [46] above). The Local Authority refer to the fact that the CCG viewed the 12 October as a turning point in their involvement.

80. **Best interests**: It is submitted by the Local Authority that it would not be in AC's interests for her to return to her home to live with BC, and that this option should be ruled out at this stage. SW2 (social work team manager) told me that three conditions would need to be assuredly fulfilled before AC could return home; (a) there would need to be full and sincere agreement from BC as to the care plan, (b) there would need to be carers available to work with BC and AC, and (c) there would need to be district nurses available. He asserted that it was unrealistic to consider that a care plan could be delivered without professional support (even if it were agreed). Quite apart from the lack of confidence in BC's ability to adhere to a professional care plan, and given the history, it is a hard fact that no professional has been identified to undertake this piece of work. The Local Authority point to the fact that, given the history, co-operation by BC with the care plan or with professionals is very unlikely to be sustained.

81. The Local Authority accept that there should then be a review of other options, to which, they now concede, there has been insufficient attention given thus far. Accordingly, the Local Authority seeks an adjournment. In relation to the future options, the Local Authority concedes that it has only seriously pursued placement 2 up to the point of this hearing. But for the incidents in August 2018, they had been content with the placement 2 care. The Local authority accept that the events occurring in August 2018 at placement 2 are distressing and serious events, and as a consequence, they say that they are committed to looking more widely at supported living arrangements in the area. This process has started, but has not yet been completed; there is much to investigate including the nature and contractual obligations of any tenancy agreement, and the financial ramifications and the distribution / allocation of state benefits. At the time the last statement was drafted the social worker had not been aware of BD, a 4-bed house with three other (currently male) residents which has emerged as a possible alternative home for her.

82. **Contact**: The Local Authority maintain that AC does not have the capacity to make decisions about contact; they rely on the evidence of SW3 (see below) to demonstrate this. The Local Authority is keen that BC should see AC, and this has been their position throughout. They maintain that it has been necessary to limit the contact since the occasion on 13 April 2018 when BC took AC to the garden of her home contrary to the agreement (see [61] above). In those circumstances, supervised contact has been offered. The contact has never commenced, in spite of being on offer. It is now proposed that BC could see AC unsupervised in the community;

[21] Cross examination by BC
[22] Cross examination by Mr. O'Brien

sadly, BC does not want to take this up. At the time of drafting this judgment, it is not therefore known how contact will be facilitated.

83. In terms of future management of the case, SW2 has agreed to be the point of contact for BC, subject to executive decisions about whether he can continue to case-work the case.

The position of BC

84. BC's case is that she would like AC to return to her home (the home is an adapted bungalow in a small estate), with a package of care initially provided by family and friends, and subsequently by professional carers. She submits that this would be the best outcome for AC who could then "re-build her life and confidence, and know that she is safe in her room at night"[23]. She maintains that she had provided high standards of care in the past; she asserts with some justification that she is a good advocate for AC and is well able to argue for her needs. She felt that her nursing skills were still good, and claimed that she understood AC better than anyone. BC refers to the physical suitability of the home, and feels that AC would remember it, and would recall strong positive associations with it. She argues that AC should be back into her community and her family.

85. **The allegations**: She said that she felt "attacked" by the safeguarding enquiry undertaken in 2016; she wanted me to know that she is not an "unkind" person but acknowledges that she has limited or no tolerance for anyone who is "not honest or open".

86. BC takes issue with the contention that she is responsible for the breakdown of professional relationships, and refers to her good rapport with the colorectal expert Dr. 2. She invites me to distinguish between what she refers to her as her tenacity (an undoubted trait of hers) and challenging conduct (the Local Authority's interpretation). She is much exercised by what she describes as poor recording on the part of the professionals, and misquoting of inter-agency conversations.

87. She asserts that CN1 and Dr. 2 have different approaches to bowel care, and that she prefers the view of Dr. 2. BC felt that the professionals had all taken a 'party line' and had contaminated each other's views, and that this reduces the value of their evidence.

88. **Best interests**: She argues that AC should return home; she would want to follow the current bowel care plan, and would want to be able to record what is happening for her. She would want to maintain the CCTV in AC's bedroom to monitor night time seizures. She draws attention to the fact that the house is set up for AC's needs. She feels able to rely on the support of friends and family: F1 and F2, F4, neighbours, F5, brothers (although neither of her brothers are prepared to meet with social services, BC advised me), and F3. They would assist her in the care of AC until carers could be introduced. She would not wish to work (or even "engage") with CN1 or CM2 again[24]. She maintains that she could do the bowel care. She is concerned that contact between AC and family/friends is going to be difficult if AC remains in

[23] BC Position Statement #43
[24] Cross examination Ms Thomas

residential care: she will lose more and more contact with people who love her. She told me that if AC remains in residential care, this may jeopardise BC's use of a Local Authority-funded mobility vehicle, which will be difficult to replace.

89. She rejects the proposal for residential care going forward: she fairly points to the evidence that AC has been abused while in residential care, and further asserts that AC's needs in many respects have been neglected. BC believes that were it not for her attention to AC's needs, even now, many things would not be "picked up". She believes that the Local Authority have lost sight of AC as a real individual, and that AC deserves to be treated as such.

90. **Contact**: BC disputes that AC does not have capacity to make decisions about contact. She told me[25] that from her personal knowledge of AC "I know who she needs around her"; she conceded however that if someone posed a risk to her "she would not be able to make that assessment"[26].

91. If it were to be demonstrated that AC lacks capacity in relation to contact (and the court accordingly assumes jurisdiction), then she would want contact with AC in the home now. If not, she asks how will contact actually be achieved? And how will transport be achieved if she does not have a mobility vehicle (see above)? She points out that Placement 2 does not want her to visit their premises, which rules out contact in AC's current placement. She felt that if AC is to remain in care, then she (BC) may leave the area and possibly return to the West Country.

The position of the Litigation Friend

92. **Capacity**: The Litigation Friend contends that AC does not have capacity to make decisions about contact. He maintains that the position is clear, having specific regard to the statement and oral evidence of SW3. Mr. O'Brien points to the concession made by BC in evidence that AC would not be able to use or weigh the evidence about the risks posed by strangers (see above) as confirmation (or strongly indicative) of a lack of capacity in this regard.

93. **Schedule of findings**: Mr. O'Brien described "a wealth of evidence" that BC's relationship with professionals is – and has been for some considerable time – extraordinarily poor; he submits (with justification, it seems to me) that BC has a long history of obstruction of professionals, and has demonstrated a stubborn reluctance properly to engage with them even for the benefit of AC. He points to the convincing accounts from a number of professional witnesses of their fear of BC, and their descriptions of being intimidated by her. He further points to the unusual fact that statutory bodies now refuse to permit their staff to go into BC's property, to deliver care to AC. He relies on the evidence of CMan1 and CM3 who refer to the fact that they can normally find routes and pathways to work with carers, but that it has not been possible here.

94. Mr. O'Brien points to the fact that BC does not accept the professional assessments on bowel care or epilepsy and does not accept that the plans of the nurses and carers meet AC's needs. He invites me to conclude that CP4 was consistent in how she

[25] Cross examination Mr. O'Brien
[26] Cross examination Mr. O'Brien

described the incident of 'yanking' and that she did this credibly and without exaggeration.

95. **Best interests**: Mr. O'Brien submits that BC has shown no insight into her behaviours notwithstanding her claims to have reflected over the areas of concern. He draws attention to the evidence that she sees no need to modify behaviour, or the way in which she interacts with professionals. He begs the rhetorical question, if she adopts the same approach to professionals in the future as she has in the past, how will that impact on the sustainability of a care package in the family home? He adds (per his opening position statement):

> "If the court was satisfied that it was not sustainable, then the Litigation Friend submits that it would not be in [AC's] best interests to return home to live and receive care there."

96. It is submitted that BC's complaint of a 'vendetta' and the evidentially-baseless allegation of 'grooming' (which she means in the sexual sense) has only served to aggravate her stance of non-acceptance, and lack of insight. He describes as "disastrous" BC's present position on professional intervention, and submits that it is no basis for a plan of care being delivered in the home; it is, he said, a "recipe for a care plan being subjected to the same problems as have been evident over the last 1-2 years, and AC would be the true loser".

97. Mr. O'Brien contends that AC's best interests would not be met (as he put it "through the prism of *section 4*") by living in an environment of disagreement, conflict and confrontation; there is a risk, argues Mr. O'Brien, that AC herself would become side-lined simply so that BC can prove a point to the professionals. He acknowledges the unusual strength of these submissions, but maintains them as appropriate on these facts. In light of the evidence, he invites me to rule at this stage that it would not be in AC's interests to return home now. He submits:

i) That any care provider, given the relevant information about the background history and about BC, will not engage with BC; professionals would be likely to take the view that the care package "exposes us to risk of complaint, risk of problems, a deviation from the package of care" and they will not be interested;

ii) It is not sustainable – in the short, medium or long-term given BC's poor recent (i.e. in the last 24-36 months) track record of co-operating with professionals. It is a best interests' decision in itself. BC is unwilling to reflect on her behaviour. She is unlikely to implement the bowel care plan / package;

iii) It would be neither proper, says Mr O'Brien, nor in AC's interests for the required level of care to be delivered by friends and family; it has to be delivered by professionals.

It follows that rehabilitation is not an achievable or *realistic* option for AC.

98. The Litigation Friend is frustrated by the actions (and/or inactions) of the Local Authority, and specifically by the delay in their identification of options for AC's future care. He urges greater focus in this urgent work; he referred to the fact that the last statement of the social worker was misleading in that the placements identified were in fact unsuitable. He urges the Local Authority to commit themselves to seeking to find alternatives to Placement 2. The Litigation Friend wants to see the most robust examination of alternative options for AC; the range of options needs to be properly probed.

99. **Contact**: Mr. O'Brien acknowledges (rightly in my view, I may add) that it is in AC's best interests that she has contact with BC. He observes and regrets that BC appears to have set her face against contact otherwise than at her home; she will not accept other contact. This approach is not in AC's best interests, argues Mr. O'Brien. I am asked to make an order that it is in AC's best interests that BC and AC have contact; the order should reflect as a recital what the Local Authority propose. There needs to be a rebuilding of trust and confidence between BC and the Local Authority; she needs to demonstrate that she can comply with the court orders. Equally, the order must reflect some restrictions on BC's contact with AC in any residential setting in order not to jeopardise professional relationships with AC's care-givers.

100. **Interim position**: The Litigation Friend is very concerned that the supervisory body has not taken sufficiently seriously the conditions imposed by HHJ Lynch on the standard authorisation following the hearing in September. It is argued that these ought to be repeated in my order at this stage, and tidied up; there has been no 'joined up' approach by the supervisory body and the social work team. The Litigation Friend argues that the Local Authority should confirm a weekly liaison between the social worker and the supervisory body. The social worker needs to read the records, and provide the records to the Litigation friend, so that he can be part of the scrutiny. The Local Authority should agree, on the face of the order, to a regime which reflected the concerns of the Litigation Friend.

The Schedule of Findings: Review of evidence and conclusions

Context

101. Before looking at the specific schedule of findings, it may be helpful to set a context. It is relevant to note that BC's case is that the NHS Trust, the CCG and the Local Authority have for some time pursued, and are still pursuing, a "vendetta" (her word[27]) against her, and that this explains their case, and the evidence which I have heard. BC offered no real explanation for why these authorities would want to act in concert to pursue a 'vendetta' against her. I reject this argument. BC further maintains (though it could be said to be part and parcel of the complaint about a vendetta) that all the agencies and/or individual professionals who have been assigned to work with BC in the period from 2016 approached their work with a pre-conceived bias against her, having received slanted pre-assessment briefings and/or having been party to discussions about her. In short, she maintains, that she had acquired a reputation which 'preceded' her with all those who came to assess her.

[27] While cross-examined by Miss Thomas for the Local Authority

102. This latter point is, at least potentially, a reasonable one for her to make, as there plainly were briefings for, and discussions among, care agency employees about BC and her care of AC, and some of those discussions took place before care-workers and others met with BC. It is indeed possible that a slanted briefing or discussion may have an effect on the independence of a care-worker or someone tasked with assessing BC. While I am satisfied that it is important for professionals to share relevant and necessary information with those who work with families in this context, there is sometimes a fine line between providing that which is relevant and necessary, and that which is gratuitous and prejudicial. In certain circumstances it can be challenging to impart key information in an unbiased way. I recognise the risk that the unguarded sharing of prejudiced information may have the effect of contaminating the otherwise independent opinion of the recipient of the relevant communication. It is not easy to say that this has not happened here; there is a chance that it has.

103. BC further complains about the lack of professionalism of the care workers and nurses; she is specifically exercised about their deficient record keeping. She is concerned that unrecorded myths (my word) about her care of AC (and/or its deficiencies) have been allowed to percolate through the professional care-agency network in an unchecked way. She illustrated this, effectively it seemed to me, by reference to the repeated assertion that she provided liquid for AC via a teaspoon; it was well-known that AC did not like touching hot cups. The only reference I could find in the voluminous material to the minimal amounts of liquid taken by AC referenced her using a 'pot mug' and taking only 100mls at a time. Over the months of years of recent involvement, she has felt driven to raise numerous complaints against the actions of the professionals through official channels – the Local Authority Safeguarding Unit, the Local Authority Commissioning Services, the Local Authority Complaints section, Placement 2 Complaints Service (TP), Placement 2 Management, the Care Quality Commission, and the Police. These complaints have been investigated, and disposed of without (so far as I can tell, and save for the matters alluded to above concerning Placement 2 in 2018) any or any material findings against the agencies complained about.

104. In light of the criticisms raised before me at the hearing (and through the statements filed), I have re-read and reviewed the evidence of the Local Authority and health service witnesses for any indication of the characteristics complained of; I have specifically searched for signs that the professionals have acted inappropriately in concert or have pursued a campaign against BC. There is a high degree of consistency in the evidence of the professionals from the various agencies, who have provided evidence on behalf of the Local Authority, reflecting the position as they each saw it. There may be some validity in the complaint that record keeping has not been conscientiously observed as it might and/or that (save for the minor illustration above, or like issues of insignificance) rumours and chatter have been allowed to spread unchecked. Overall, however, I do not find that this has contaminated the approach of the professionals in the fulfilment of their roles or in their appraisal of the case.

105. BC gave lengthy evidence over two days. She is plainly a highly intelligent and articulate woman. I sensed a forceful and direct personality; she is (as Mr O'Brien described it, accurately in my view) a "stickler" for detail, and the disciplined preparation of her case has been accomplished with near-obsessive attention to detail.

BC has become angry by what she sees as an unjust interference by social services in her life and the care of AC. She does not find it easy to work with other professionals, particularly those she regards as having inferior qualifications or experience. I am satisfied that she has become increasingly obstructive and argumentative with the care workers and the health workers to the point now where her contempt for them is no longer hidden. I overheard her commenting to BB (when listening / watching the recordings from CCTV at Her home) "that's what I'm up against" which reinforced for me that the situation in which she was being visited by professionals in her home had become a highly combative, antagonistic, one.

106. This anger and defiance characterised and spilled out into her evidence. She was, I regret, not a satisfactory witness; she cavilled with counsel, and avoided answering many straightforward questions. She was preoccupied with detail, and I was satisfied therefore that when she did not answer the question in a straightforward way, it was because she could not do so without having to accept her failures or criticisms of inappropriate conduct.

107. BC was apparently unaware of the inherent hypocrisy in her case – she was fixated with the poor record keeping of the local authority, but had no good records of her own care of AC. She was adamant that AC's dignity was compromised in residential care, yet I find that she subjected AC to undignified procedures in front of strangers (including for instance the visit of CN1 on 27 September 2016). BC knows that AC disliked the camera (she made the point to AC on one of the clips I saw: "don't like the camera do you") but continued routinely to film AC often in intrusive close-up, and in her home recorded AC almost continuously with CCTV cameras positioned in AC's bedroom. I note that within an order dated 21 February 2017 (HHJ Hunt), it was detailed that "it is not in P's best interests to have care provided to her which is recorded either on CCTV or audio"; she allowed footage of her naked sister to be seen by relative strangers, including males.

108. With these contextual matters in mind, I turn to the specifics.

Bowel management

109. **(1) BC has used methods of bowel care management which have been considered by carers and nurses who have witnessed the care as inappropriate due to the impact on AC of a loss of her dignity**.

110. AC has had problems with constipation for more than 12 years. She has been treated in various ways, and with different medications. Most recently the treatment has included Bisacodyl (a stimulant laxative drug which works directly on the colon) once or twice per week, Peristeen anal irrigation system, Laxido sachets, and various forms of enema. The records reveal that other medications have been attempted over the years. AC also receives epilepsy medication (Gabapentin is one of the drugs administered historically, if not recently; also Epilim), and occasional pain relief (Paracetamol, Tramadol or Buprenophine). For the whole of the period up to November 2017 BC was responsible for the administration of the bowel care. Dr. 2 and Dr. 1 both have considerable experience of BC and AC, and in Dr. 2's case, in the management of colorectal problems. They both advised me that they were broadly satisfied with the bowel care offered by BC to AC. Unsurprisingly BC lays great

store by their evidence. I accept the views of these experts, but record that their opinions have to be seen in context:

i) Even though the doctors saw BC and AC reasonably regularly, these were for short consultations (even BC described Dr. 2 as so busy that she did not feel that she could trouble him to amend what she now says was a material inaccuracy in his report);

ii) They were invariably reliant on the history given to them by BC.

111. By contrast, the carers who visited BC and AC in the home, and who had greater exposure to the issues, expressed considerable concern about bowel care. CN1 is an experienced continence nurse who advised me that she sought to introduce a bowel care plan, because it was important to achieve clarity about BC's methods for bowel care. This would be relevant in the event that BC were suddenly to become unavailable to care for AC, and to ensure that it was done in the most appropriate way. The evidence reveals (and I accept) that BC was heavily resistant to this proposal; my sense is that she objected to professionals 'telling her what to do'. She took issue with advice offered by CN1, protesting that it was "not realistic" and was "disputed" ("P will not be trialled… P will go nowhere where she is caused unnecessary pain and discomfort"). She sought to challenge and undermine the authority and expertise of CN1, leaving her to declare "no trust or confidence" in the relationship.

112. CN1 told me that she felt that the frequency of BC's manual investigations was not in AC's interests, and overly invasive (in CoP terms, this treatment was not the 'least restrictive'). It had also been observed to be painful: there is evidence (CP5: 2.8.16: part of the safeguarding enquiry) that AC was "quite distressed" while BC was "routing around" with her fingers in AC's anus; CP3 reported that:

> "While BC has her fingers in AC she may scream as if it is uncomfortable. CP3 said BC will continue with bowel care even if AC is unsettled … BC may get annoyed with AC and snap verbally in a stern voice saying "you know I've got to do this". If AC is very distressed, BC will stop but will continue later in the day".

113. CN1 further expressed herself to be shocked on 27 September when BC performed the manual rectal examination of AC without any invitation to do so, pulling on the latex glove which she waved in front of AC's face before inserting her finger into AC's anus in front of the guests (I referred to this above at [38]). CN1 was of the view that it was important to try to reduce the number of bowel interventions and manual evacuations; she felt – and I shared this view – that BC did not acknowledge the need to do so, and did not acknowledge that AC's quality of life was being adversely affected by these regular intimate and invasive examinations.

114. Having heard all of the evidence, and with particular regard to the matters set out above, I find this allegation proved.

115. **(2) Since her assessment in January 2018, the level of intrusive bowel care management has been reduced significantly as set out in the commissioning care plan**;

116. The evidence reveals that BC was at one time administering *per rectum* examinations at least daily; this is what BC apparently told Dr. 2, and I accept that he has accurately recorded her account. The carers (including but not limited, I believe, to CP8) suggest that the *per rectum* examinations or evacuations could have been up to four times per day; I cannot find this as a fact specifically, but suspect that this *may* have been the case. The care staff at Placement 1 and Placement 2 have not needed to perform examinations or evacuations with anything like this frequency. I am satisfied that bowel care can now be managed in a way which is much less invasive and distressing to AC.

117. There is now a clear bowel care plan in place; there is now a predictable and clear regime of care, which can be managed in a predictably by the team of nurses. Even though this plan has not averted altogether occasional episodes of constipation, I am satisfied that it is in AC's best interest that this important aspect of her intimate health care is now achieved in a structured way.

118. This allegation is proved.

119. **(3) BC opposed the introduction of a written bowel care management plan, and since one has been introduced, has maintained that her methods are the most appropriate**;

120. It is clear from all the evidence which I have read and heard that BC was reluctant to agree the implementation of a bowel care plan when CN1 sought to introduce it. The safeguarding report of 2016 references BC as "declining to deal with" a care plan: "she claimed it was not her job to write a bowel care plan, and that she was the only person responsible for AC's bowel care." … "BC has consistently been reluctant to share information for a care plan to be written."[28] At that stage (2016), it was reported that:

> "It is unclear exactly what procedures BC is undertaking on AC. There is no bowel management plan, and at this time the continence nurse has been met with aggression and abuse when trying to arrange an appointment. the current bowel regime causes AC distress and restricts her contact with carers and day services." (Safeguarding Report: 2016).

121. A bowel care plan was recommended, and was presented to BC. BC later referred to the plan as "not a realistic care plan, with no nursing rationale" and "not a safe-practice care plan". In a letter to the Court dated 20 May 2017 (page 18) she wrote: "The bowel care plan is DISPUTED. P will not be "trialled"" (capitals in the original).

[28] Safeguarding report

122. In February 2018, shortly after AC's move to Placement 2, BC visited and sought to countermand the care plan insofar as it pertained to bowel management; she sought to direct workers how to care for AC. She also made, I am satisfied, derogatory comments to other residents.

123. I regret that many discussions since this time have confirmed that the bowel care plan has been rejected by BC; the evidence of CMan1 was to this effect. Further fruitless discussions at court caused the CCG to write to BC confirming that "you will not accept any assessment or management of AC's continence care based on the plan devised by CN1". I was unconvinced by BC's evidence before me that she was accepting of the plan.

Physical Harm

124. **(4) On 12 October 2017, BC physically yanked AC from her chair and put her on the bed without warning or reason.**

125. I have heard the evidence of CP4 about this. I have described it above. I felt that CP4 had no reason to invent or exaggerate this account. CP4 was cross-examined by BC directly about this incident; I accept the account which CP4 gave (which I have reproduced at [78] above in the description of the Local Authority's case).

126. I find on balance that this allegation is proved.

127. **(5) On 12 October 2017, BC required AC to stand by the side of the bed until she could no longer weight bear, describing it as exercise but in an inappropriate manner in the view of the carers' present.**

128. It was reported through the care workers (including CP4) that BC made AC stand by her bed "for exercise"; AC had no apparent awareness or appreciation of the purpose of this 'activity' (which she obviously found uncomfortable) until she allegedly slowly collapsed, and the staff had to assist her to sit back safely. The carers had a sense that BC was so furious with the involvement of the staff assessing BC and AC that she was "spilling all her anger out on [AC]" and man-handling her in her room in an aggressive way. She had spoken to AC in an aggressive way too".

129. I was not able fully to gain an understanding of this incident, and heard limited evidence about it. It is not suggested that what BC did was sadistic, and if it were so suggested I would reject this. I do not overall consider that the Local Authority have demonstrated to my satisfaction either the evidence to support the facts or the intention which lay behind the alleged activity.

Engagement with professionals

130. **(6) BC has refused to accept professional advice following the recommendations of the safeguarding enquiries in 2016 and 2017. The safeguarding concerns from the 2016 enquiry remain open to the authority.**

131. AC needs consistent full-time care; this cannot be provided by one person alone, a view which BC expressly accepts. AC needs a support network around her which includes professional carers. For the care to be safe and effective, there needs to be a

good degree of communication and co-operation between the carers and other professionals. As a result of long-standing and extreme hostility to care workers, the situation has now developed wherein professional care agencies are not prepared to send their employees into the home. There are no current care providers able to provide this care. BC will not communicate with AC's social worker.

132. BC has been described by the social work professionals as one of the most difficult individuals they have had to deal with, with limited if any insight into her failings (this was regrettably all too apparent in the way in which she presented her case). In my judgment she has adopted an unreasonable stance towards carers characterising her relationship with them as oppositional ('them' and 'us'); she has declared that she would not "be the scapegoat for incompetence by any professionals", but I do not find that this ac accurately reflects the position. In a letter to HH Peter Hunt in February 2017, she wrote off the safeguarding concerns as "disgruntled carers trouble-making"; in further correspondence to the judge she referred to the "long-winded manipulations of facts, unprofessional attitudes to cover-up [AC]'s very poor harmful care in the hands of the local authority and its associates". CMan1 (who I found to be a measured, and clear witness, who gave her evidence objectively and I thought fairly) was of the firm view that if AC returned to her home, BC would not comply with the care plan: in her statement of evidence, CMan1 observed that BC has "consistently asserted that her behaviour is reasonable" – an unpropitious stance given that attitudinal change is in my view required.

133. In a highly revealing and important section of her oral evidence[29], BC made the following significant points:

i) There has been no reliable assessment of AC's needs at Placement 1;

ii) The Local Authority's current care plans for AC are "dubious";

iii) "I do not believe that my behaviour has at any point been unacceptable. I say that *they* [the authority] are being unreasonable in their decision to withdraw services from the home";

iv) "I would not want to change my behaviour in any way. I am open and honest and direct";

v) She was resistant to any new care company solicited to work with AC in the home knowing anything of the background history;

vi) Male workers at Placement 2 "could be involved in grooming" AC;

vii) "I do think it is appropriate for the CCTV to be on in the house".

134. This section of the evidence reveals much about BC's unwillingness or inability to accept professional advice and/or to see the failings in the past.

135. This allegation is proved to my satisfaction.

[29] Cross examination Mr.O'Brien

136. **(7) Care providers have repeatedly cited BC's behaviour as the reason for the termination of care packages. The NHS Trust will not provide staff to support AC in BC's home. This pattern of behaviour restricts the pool of expertise that AC would be able to access were she to return to BC's care**.

137. This proposed finding speaks for itself, and on the evidence put before me I am obliged to accept its accuracy.

138. This finding was supported by various witnesses, including (but not limited to the following):

i) CN2 told me "we would not be prepared to put ourselves in that position again[30]" (i.e. in BC's home);

ii) CP2 told me that she would not be prepared to go back into the house[31], because of BC's intimidating manner; she said that she was unable to have a conversation with BC because BC was "hostile"[32], adding "it felt unsafe to be there. The manner in which you [CP2 was addressing BC in court, who was cross-examining] were projecting. You were very aggressive and hostile; the tone and language and body language". She told Mr O'Brien that BC would just "snap" at them, "I felt awful and belittled"[33];

iii) CM2 told me that she could not establish a working relationship with BC, and the arrangement became unworkable[34]; she felt that BC showed no signs of engaging[35], adding (materially) that in 25 years as a community matron she had never had such a difficult situation "never to this extent", and that it would be "impossible" for care to be delivered in the home;

iv) CN1 described BC as having been "incredibly difficult… I have had to put the phone down on her as she is so rude. The carers have found it a toxic environment… the staff (at Placement 1) were all terrified"[36];

v) CMan1: "[BC] was not accepting of anything other than *her* view. She was not accepting of any other plan but her plan."[37]

vi) CP1 told me that she had been in the caring profession for 11 years, and she had "never had an experience of this [she was referring to the level of hostility from BC to the care workers] before"[38]; she added "the arrangements would never work; even if you bring all the nurses, all the doctors, this would never work";

vii) CP6 from the local authority Community Adult Learning Disability Team told me that she did not feel that BC had ever accepted any of the concerns that had

[30] Evidence in chief
[31] Her home: Evidence in chief
[32] Cross examination by BC
[33] Cross examination by Mr. O'Brien
[34] Evidence in chief
[35] Cross examination by Mr. O'Brien
[36] Cross examination by Mr. O'Brien
[37] Evidence in chief
[38] Cross examination by Mr. O'Brien

been raised with her[39]; in her written evidence she alluded to the fact that BC "would not give a straight answer" to the questions; her mannerism "was very confrontational, which was 'passive aggressive' and very condescending… I found that [BC] was one of the most difficult individuals I have had to interview in my career as a social worker";

viii) CMan4, Deputy Director of Adult Physical health for the CCG, told me that the CCG had reached the conclusion that it would not expect its staff to go into BC's home; she said that this decision had not been "taken lightly. We have never done this before…"[40]; "we cannot and will not force our staff to work in an environment where they feel so intimidated by the service user's family due to continued verbal aggression and an incident of physical assault."[41]

139. There is a long list of professional organisations which have now indicated that they will not work with BC:

i) The CCG: the relationship between BC and CMan3 broke down in 2017 when BC allegedly made a "very derogatory comment" in a phone call (see above);

ii) Organisation I: The manager of this organisation complained that BC had been "very hostile and aggressive" towards him. Although I did not hear this evidence directly, I am bound to observe that what is complained of here is all of a piece with the complaints of other behaviours;

iii) Epilepsy Nurse: EN1 has indicated that she is no longer prepared to care for AC in the home and would only do so in a residential setting;

iv) Care agency 2: a number of carers have indicated that they would not work with BC again (CP3, CP9);

v) Care agency 3: Carers from Care agency 3 have indicated that they are not prepared to return to BC's home ("BC made us feel degraded and unwelcomed. I personally felt scared and out of place…");

vi) Placement 1: was constrained to serve notice on AC, as a result of BC's behaviour in the unit;

vii) Placement 2: after three visits, Placement 2 felt that they could not invite BC back into the unit following incidents in which she had upset residents and staff.

140. This allegation is amply made out.

141. **(8) BC has not consistently worked in a constructive way with professionals either whilst AC was in her care, or subsequently whilst AC has been in residential care. At times AC has been present when BC has behaved in a hostile manner. This creates a risk of emotional harm to AC as well as a risk arising from non-engagement with professionals**.

[39] Cross examination by BC
[40] Cross examination by Mr. O'Brien
[41] Statement #7(b)

142. The evidence to support this finding has been rehearsed in relation to (7) above. While I am satisfied that BC has been able to co-operate with doctors (Dr 2, Dr 1 and Dr 4,[42], and Dr 3, for example) she has consistently refused to accept the advice of care, social work and nursing professionals. My assessment is that she regards them as of inferior qualification and skill to herself. Even as recently as 1 September 2018, on the eve of a hearing on the issue of whether AC would be returning home (AC was at that time in hospital), a nursing sister on the ward where AC was an inpatient reported that BC threatened that the "social worker is going down after the court hearing"; this was denied by BC. I accept that it is likely that she said this. It would be entirely consistent with the very low regard which BC had for the social workers, and her threatening conduct to those of the caring professions who have sought to help.

PLACEMENT 2

143. AC remains, currently, at Placement 2.

144. Placement 2 is currently in the throes of converting its registration with the CQC from residential to supported living; this has implications for AC which, in the view of the court (and of the Litigation Friend) have not been sufficiently explored or explained in the documents.

145. AC's stay at Placement 2 has been and continues to be controversial. There can be no doubt about the seriousness of the incident on 11 August, when AC, with her considerable vulnerabilities, was subjected to inexcusable ill-treatment. It is not only predictable but also wholly understandable that BC has been extremely distressed, indeed incensed, by this event. Her feelings have been aggravated by what has been, in my judgment, a lack of urgency in the investigation of the assault, and a rather casual regard to the additional conditions attached to the standard authorisation. I was, I confess, very surprised to hear the insouciant way in which the social worker reflected the failures to comply with HHJ Lynch's conditions to the standard authorisation; there has been little corresponding or co-ordination with the supervisory body, and minimal supervision over the maintenance of the care records[43]. This needs to be addressed urgently.

146. As I have indicated above, AC's Litigation Friend is far from content with the current arrangements for AC at Placement 2 but, for the time being at least, and on balance submits that she should remain there. I sense that this interim stance is borne more of pragmatism than an expression of satisfaction with the current arrangement; AC is at least familiar with Placement 2, and there is, frankly, no immediate alternative if AC is not to return to the care of BC. I need little encouragement (though I have received it from LF1) to reinforce the sensibly imposed safeguards on the standard authorisation which I propose to maintain and re-state for the interim. The Litigation Friend reasonably points up the benefit of moving AC to a new residential care environment to achieve a "fresh start without the history of concerns and incidents which come with a continued placement at Placement 2"[44].

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[42] BC's and AC's General Practitioner
[43] These deficiencies were identified during the cross examination of the social worker by Mr. O'Brien
[44] Position statement #54

147. It is quite apparent that the Litigation Friend is not currently satisfied that AC should remain at Placement 2, and nor am I.

Capacity to make decisions about contact

148. BC considers that AC has capacity to make decisions about contact, and essentially asks me to find that the presumption of capacity contained in *section 1 MCA 2005* has not been displaced. On the evidence before me, I firmly disagree.

149. There is no doubt that AC has a severe learning disability which amounts to an impairment of or a disturbance in the functioning of the mind or brain (*section 2(1) MCA 2005*). SW3, who I may add I found to be a clear and compelling witness, undertook an assessment of AC's capacity in this regard. She had known AC as the allocated social worker for some time, and had seen AC in that capacity between 10 and 15 times. She undertook the capacity assessment while AC was in the hospital; BC questioned whether the unfamiliar environment in which the assessment was taking place may have had an effect on the result. CD did not accept this, and felt that AC was content and happy in the assessment[45]. CD advised me that AC cannot understand the information relevant to contact, let alone retain it or use and weigh it; she was in no doubt about this[46].

150. This assessment opens the jurisdictional gateway for the court to make orders about AC's contact with others in her best interests.

Conclusions

151. In drawing the threads of this judgment together, I am keen to articulate, indeed emphasise, my recognition and respect for those – like BC – who care for disabled family members; they occupy a special and important place in our society. Their role is undoubtedly a demanding and often an exhausting one. They are mostly very exceptional people, who require (and invariably possess) great depth of personal resources and resilience. Unsurprisingly, family carers cannot fulfil the many tasks involved in caring for their disabled relatives; many require professional support. While caring for a disabled relative brings undoubted pleasures, satisfaction and mutual emotional benefits, it is accompanied by many stresses and upsets. As BC herself has reflected, it "takes its toll". Familial care of this nature cannot be delivered without some sacrifice, and without some impact on the emotional and physical health of the carer.

152. In the context of these comments I pay tribute to the fact that BC cared successfully for AC for a considerable period of time. I do not ignore this important part of the history when I consider the matters specifically under review, and when planning for AC's future.

153. In making this best interests decision I take account of all of the circumstances of the case (*section 4(2) MCA 2005*), including (so far as is reasonably ascertainable) (a) AC's past and present wishes and feelings, (b) the beliefs and values that would be likely to influence her decision if she had capacity, and (c) the other factors that she

[45] Cross examination by BC
[46] Cross examination by Mr. O'Brien

would be likely to consider if she were able to do so (*section 4(6)*). I have assumed, in this regard, that if asked, AC would say that she would want to live in a familiar home, where her physical and emotional needs are met, and her dignity is assured. She would want to be free from exposure to conflict, and free from invasive and unnecessary treatment. She would probably want to live with her sister, and if not living with her, to see her frequently. These conclusions may well point to AC's rehabilitation to her home of old; not to the home as it was described in the evidence of the professionals before me where conflict and tension with professional carers dominated.

154. I must further (*section 4(7)*) consider the views of BC, as she is plainly someone "interested in [AC's] welfare". I have described BC's position on this application at length above (see [84]-[91]).

155. In surveying 'all the circumstances' I have of course borne in mind AC's age, her background circumstances, the extent to which her physical and emotional needs have been (and are being) met, the likelihood of harm, and the effect of moving her either to return to her home or to a new home (a change in her circumstances). I am keen to ensure that her next move is a permanent one, to a home where she can settle and where her various needs (which I discuss below) can be met. I have considered her social and familial relationships, and the promotion of the same; contact between BC and AC is in my assessment an important and currently largely unrequited part of AC's life.

156. Statute enjoins me to satisfy myself (*section 4(4)*) that AC has been encouraged to participate as fully as possible in this process of decision-making: in this regard, I am indeed satisfied that she has been ably and conscientiously represented by LF1 as her Litigation Friend.

157. I bear in mind that while 'the right to private and family life' confirmed by *ECHR Article 8* and *UNCRPD Article 22* will always be a relevant factor in determining a person's best interests, it should not be 'the starting point' or given priority over other relevant factors (*K v LBX & Ors* [2012] EWCA Civ 79, [2012] COPLR 411, at [30]). I was not specifically addressed on the impact of *K v LBX* (Mr O'Brien referred me instead to *Re S (An Adult Patient)(Inherent Jurisdiction: Family Life*) [2003] 1 FLR 2929, and the judgment of Munby J as he then was), but the point about *Article 8* underpinned BC's submission to me, and it is therefore appropriate that I should reproduce two relevant sections of the judgments to which I have had particular regard. At [35] of *K v LBX*, Thorpe LJ said this:

> "… the safe approach of the trial judge in Mental Capacity Act cases is to ascertain the best interests of the incapacitated adult on the application of the section 4 checklist. The judge should then ask whether the resulting conclusion amounts to a violation of Article 8 rights and whether that violation is nonetheless necessary and proportionate".

And Black LJ (as she then was) in the same case at [51]/[52] said this:

> "Judges who try family cases of all types know how infinitely variable are the considerations that may need to be considered in determining what is in someone's best interests. The norms and values of society change over time, as do the ways available to attempt to meet people's needs. There can be no substitute for a careful analysis of the evidence in the particular case. Factual disputes have to be determined and the recommendations and opinions of professionals evaluated in order to arrive at a conclusion. This is the everyday work of those who try cases involving children and, increasingly, it is becoming a routine exercise for those who sit in the Court of Protection. I would not wish to impose upon that exercise a structure which is not contained within the Act which confers the various powers and duties and dictates how they should be exercised.
>
> It is, of course, of great importance that regard should be had to Article 8 when making decisions on behalf of an adult who lacks capacity. Article 8 declares a right to respect for private and family life, home and correspondence. Courts and local authorities are both public authorities and must not interfere with the exercise of that right except as Article 8(2) provides. It does not require a prescribed starting point to achieve compliance with that."

158. These passages underline for me the importance of affording due respect to AC and BC of their right to family life, and their home at her home. However, the passages underline more strongly still that my decision has to be governed by what is in AC's best interests.

159. On the evidence before this court, I am satisfied that BC's ability to care for her sister safely and in AC's interests in their home became seriously compromised by her increasing antipathy towards the majority of the care and health service employees who had been engaged to assist and assess her in 2016-2017, and thereafter. I have discussed this extensively above. While I acknowledge that in some respects the professionalism of the care workers may have occasionally slipped during the period in which they have worked with BC over this protracted period, particularly when under pressure, they have not deserved the anger, aggression, hostility, obstruction, which they have received from BC. I am satisfied that the local authority has, as the safeguarding lead earlier said in 2016, worked conscientiously over the years *not* to separate AC and BC[47]. The authorities, to their credit, have been perseverant and creative in initiating and maintaining services; they have not been easily discouraged. The local authority confirmed that it has much experience of dealing with family carers who are awkward, upset or angry; it is acknowledged that sometimes such

[47] NB "separating [BC and AC] would be a very last resort and after all efforts to work with [BC] in ensuring care and treatment is being delivered in [AC]'s best interests have been exhausted." See [37] above

awkwardness, upset or anger is with just cause. SW2 commented that "I would not make the claim that we always get things right, but we do always endeavour to be fair, objective and respectful". I accept that analysis as generally reflecting the evidence in this case[48].

160. BC has many qualities, and has been able to demonstrate warm and affectionate care for AC. She has been courteous and pleasant in the court hearings before me. But I am satisfied that she also has a very different side to her character – confrontational, intimidating, angry, and aggressive, and these unpleasant characteristics can be unleashed very quickly. Many witnesses described this. I accept SD's evidence when she described BC as being unpredictable and variable in her moods[49], hard to read, and oscillating suddenly from a good mood one moment to "shouting in the hearing of [AC][50]… shouting that it[51] was taking a toll on [her] life" the next. The evidence is clear that BC reacted very badly to being challenged as a carer; the safeguarding referral in July 2016 was a body-blow to her from which she struggled to recover. I sensed that her upset turned to seething anger with the authorities, which was little disguised.

161. It is this generally hostile attitude to professional support workers which has characterised such interactions for the last two years which, in the end, has become the dominant feature of my review of the background history, and in my assessment of future options. It would be crucial to the future safe management of AC in her home that BC would have a healthy working relationship with professionals supporting them; given the entrenched antipathetic attitudes of BC towards them, and her lack of insight into her behaviours, I have reached the clear conclusion that it is extraordinarily unlikely that professional support would ever be co-operatively, consistently or effectively delivered in BC's home. Without it, as BC herself accepts (she did not argue that she should manage the care of AC herself alone going forward), it would not be reasonable to contemplate rehabilitating AC back to the care of BC. I accept Mr O' Brien's submission (see [97] above) that there is a likelihood that AC would become side-lined, and/or her interests ignored, simply so that BC can prove a point to the professionals. It is fair to say that so clear and overwhelming is this point that the other issues raised in the case (i.e. the failure to produce or adhere to bowel care plans in the past and the incidents of physical harm for instance, in respect of which of course I found BC wanting) assume a much lesser degree of importance.

162. Regrettably I cannot see this situation changing; as I refer in [161] above, BC has little if any insight into her conduct. She sees no need to change, revealed perhaps most starkly through her evidence in cross-examination when she indicated that she

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[48] I am conscious of a recording in the medical notes for 3.9.18 in which it was said that the social worker SW1 was "angry" and "intimidating" to a member of staff at the hospital where AC was an inpatient. I have not heard evidence from the author of the note, and do not feel able to make a finding about this. I am reasonably sure that at that point Ms SW1 was under pressure to obtain information for court; while that would be no excuse for rude behaviour it is possible that this may have affected the way she had presented.

[49] She actually unwisely used the word 'bipolar'; ("she seemed like someone with bipolar"): bipolar is of course a mental disorder characterized by episodes of extreme highs (mania) and lows (depression), but CP1 was not qualified to make such a comment

[50] CP1, in cross-examination by BC

[51] The context of this answer leads me to conclude that that "it" was a reference to the involvement of professionals in BC's and AC's life

does "not believe that my behaviour has at any point been unacceptable. I say that *they* are being unreasonable in their decision to withdraw services from the home" (see [133(iii)] above). And for as long as there is no change, no care agency (and many have been approached locally) is prepared to work with BC and AC. No compromise arrangement would safely allow AC to return.

163. I have therefore reached the conclusion having considered all of the evidence at this hearing that I can and should rule out AC's rehabilitation to the care of her sister, even though the specific placement outcome for her in residential care is not yet clearly identified or identifiable. In eliminating one significant option for AC's future care at this stage, I have followed the essential reasoning of Black J in *North Yorkshire CC v B* (see [23] above), and Sir James Munby P in *Re R*. I have followed the guidance of the Court of Appeal in *Re B-S* in focussing on the *realistic* options for AC: given that, on the evidence, placement with BC is not a realistic option, then I am entitled to that conclusion and rule her out. In short, I have been driven to the conclusion that rehabilitation would not be a *realistic* option for AC now or in the relevant future.

164. I am of the clear view that it would nonetheless be in AC's best interests to continue to have contact with BC, and maintain a relationship with her; this contact should be regular and predictable. This is important to AC. It is equally important, and indeed necessary, for this relationship to managed safely, and in a way which does not place AC in the centre of conflict between BC and professionals. AC needs also to have the chance to see other friends and family (including her brothers), who are concerned for her and love her. I am satisfied that the 2015 Adult Care and Support Assessment is as accurate now as it was when it was written:

> "[BC]… is very important to [AC], as are her two brothers, CC and DC. [AC] enjoys spending time with people she knows and socialising. She will develop relationships with other people and likes people to sit and talk to her."

165. So, where does that leave us? Both BC and LF1 are far from wholly satisfied with the current arrangements of care for AC at Placement 2. I share their current dissatisfaction, on the information available now. I was troubled to read LF1's reports of the visits to Placement 2 over the year (I have quoted from his note of an early visit above); the events of 11 August (and subsequently) have only served to deepen my anxieties. BC now feels disenfranchised from AC's upbringing given her exclusion from the unit, and doubts the accuracy or authenticity of the information provided to her. She asked (not entirely rhetorically) "Are they [the carers at Placement 2] reading AC properly?"

166. It is necessary for the court to consider in more focused way the *realistic* options for AC's future residential care. The local authority needs urgently to identify suitable placements. I consider that a suitable residential placement must be able to stimulate AC; it needs to be a nurturing environment; AC would benefit from a social life at the home (SW2 told me that AC likes to be where there are other things going on[52]). I accept BC's observation that AC has a good awareness of the world around her, and

[52] Cross examination by Mr. O'Brien

has historically enjoyed social interactions at 'The BS' and 'CF' day centres. She needs to have the chance to forge relationships with workers who can be her friends: in this regard, I draw for illustration on the comments of SE visiting AC in August 2018: "she was very responsive, she sprang up in bed, cuddled me, smiled at me and made lots of eye contact. I felt that she recognised me", and LF1's visit in September 2018 "LF1 greeted AC who held out her hand to him. LF1 gave AC his hand and she smiled and pushed his hand away. LF1 and AL interpreted this as being playful, and AC appeared happy". I believe that AC would benefit at least initially from a care environment where her intimate care was predominately achieved by female carers. The recent assessment (5.9.18) confirms that she responds better to females than males.

Directions

167. The parties should therefore return to court for the 3-day scheduled hearing on 23 January 2019 with proposals for AC's future residential care. I will certainly expect there to be more details about BD and the placement which is opening in February 2019 at LM; a balance sheet of the competing benefits and disbenefits of the options should be prepared. I will leave it to Miss Thomas to draw up an order which reflects the essential decision which is reflected by this judgment, and which sets up a case management programme for the final hearing along these lines:

Recitals

i) Recital: The order should reflect as a recital the Local Authority proposal for contact as a minimum, with an encouragement to the parties to mediate;

ii) Recital: The Local Authority should confirm a weekly liaison between the social worker and the supervisory body.

iii) Recital: The social worker must the read records at placement 2, and provide the records to the Litigation friend;

Directions

iv) Local Authority to file evidence of future placement options (setting out all relevant options with a balance sheet) by 21 December 2019;

v) BC to respond to the evidence of the Local Authority by 7 January 2019;

vi) LF1 to respond to the evidence by 16 January 2019;

vii) Position Statements by 21 January 2019;

viii) No further evidence without leave;

ix) A *new* trial bundle containing only those documents which are *strictly relevant* to the issues which will be considered at the hearing (the bundle is not to exceed 350 pages without my express permission) shall be prepared by the local authority and shall be lodged with the court by 21 January 2019;

Order

x) The order shall repeat the conditions which HHJ Lynch attached to the standard authorisation, and tidied up to SJ's satisfaction.

168. That is my judgment.