

**TRANSCRIPT OF PROCEEDINGS**

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Ref. COP/1317321/FD18P90019

**IN THE FAMILY COURT AT CAMBRIDGE**

East Road  
Cambridge

**Neutral Citation: [2019] EWCOP 32**

**Before THE HONOURABLE MR JUSTICE NEWTON**

**IN THE MATTER OF**

**ROYAL BOROUGH OF GREENWICH**

**-v-**

**CDM (by her litigation friend the Official Solicitor)**

**Lee Parkhill (instructed by the London Borough of Greenwich) for the Applicant  
Katharine Scott (instructed by Mackintosh Law) for CDM (by her litigation friend the  
Official Solicitor)**

**JUDGMENT  
20<sup>th</sup> FEBRUARY 2019  
(AS APPROVED)**

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

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MR JUSTICE NEWTON:

1. This is an extempore judgment. Over four days in June 2018, Cohen J heard several applications concerning CDM, a 64-year-old lady, concerning her capacity to make decisions about her residence and care. It is necessary to read that judgment reported at [2018] EWCOP EWHC 1668, before this. At the conclusion of the hearing, Cohen J, having heard evidence from Dr Series, a social worker and CDM herself, concluded inter alia that:
  - a. CDM, had capacity to, in particular: 1. Conduct proceedings. 2. Make decisions about her residence. 3. Decide on surrendering her tenancy. 4. Decide on being accommodated in relation to the care home for the purposes of receiving care and treatment.
  - b. CDM had fluctuating capacity to decide as to the management of control of her diabetes particularly, as a result of her personality disorder, and that that aggravated her diabetes because it led to poor diabetic control and her making unwise decisions, and therefore her treatment and inability to cooperate with professionals. And,
  - c. That CDM had capacity to make decisions about her property and financial affairs.
2. As part of Cohen J's order and continuing case management, he gave permission to the parties to instruct a jointly-instructed second expert to report on the triggers which could cause CDM to lack capacity to make decisions about her diabetes management, i.e. as to when and why her capacity would fluctuate. As a result, Dr Alison Beck, consultant clinical forensic psychologist, was instructed.
3. The Official Solicitor sought to have the decision made by Cohen J reviewed by the Court of Appeal on a number of grounds. Essentially, however, permission was only given on one, concerning the finding of fluctuating capacity. That is to say, about the interpretation and management of her fluctuating capacity, because there might be an argument that the evidence possibly was deficient in those circumstances.
4. That matter came before the full court on the 6<sup>th</sup> of November 2018, but the Court, declined to hear argument on the specific issue. It being remitted back for primary determination, since the Court considered that the very issue of CDM's capacity to make decisions about the management of her diabetic care was not before them on an evidential basis judicially considered.
5. The Court of Appeal, of course, by that stage had Dr Beck's initial report, which had not been before Cohen J. Thus, it came before me.

It has been suggested during the course of this hearing that, effectively, this is a novel point (which requires extensive consideration by the senior courts). One which has not previously been before or decided by the court. I do not think, with all respect, that is the case at all.

Having regard at least to the 2012 decision of Jackson J, as he then was, in *Re E* [2012] EWCOP 1639. Essentially, the questions for me have been:

1. Whether the assessment of capacity to make decisions about diabetic management or “the matter” in relation to which CDM is being assessed is one macro-decision which encompasses all of the many micro-decisions that CDM is required to make when managing her diabetes, or, whether CDM’s capacity should be assessed in respect of each micro-decision or group of micro-decisions.
  2. In the light of that determination, whether the presumption that CDM has capacity to make decisions about her diabetes has been rebutted, and if so on what basis.
  3. If I conclude that as a matter of fact CDM’s capacity to make decisions about any aspect of her diabetes management fluctuates, what preparations the court can and should make to reflect that finding (section 15 of the MCA). Having regard, to the factual and legal background and I have reached very clear conclusions.
6. Firstly, it is necessary to put “the issue,” in the context of the factual background which I summarise: this case comes before the Court of Protection pursuant of to section 21(a) of the MCA. As a result of CDM being deprived of her liberty in a care home under a standard authorisation by the Borough of Greenwich, pursuant to its power under the MCA. CDM objected to the deprivation of her liberty and wished to be able to return to her home.
7. CDM is a 64-year-old woman with a personality disorder with components of different types. Dr Beck, to whom I have already referred, concludes that CDM has an emotionally unstable paranoid histrionic and dependant personality disorder. CDM also suffers from a number of physical health conditions, including hypertension, chronic obstructive pulmonary disease and unstable diabetes, which has led for instance to her having a below-the-knee amputation.
8. Historically, she has had recurrent episodes of diabetic ketoacidosis, requires insulin, and a controlled diet. Insulin is administered, I think, twice a day by the district nurse team, but CDM has a history of declining insulin, or claiming she had already had it; generally, she is compliant in the administration of the insulin, but not compliant in relation to other forms of medication. The management of her healthcare has, certainly more recently, been increasingly very difficult.
9. CDM has not had an easy life. Since 1986 she has lived in a bungalow on a secure tenancy, she lived there with her husband who also was severely disabled before his death in 2014. It is obvious that CDM was devoted to her husband. The fact that she has spent upwards of 30 years in a home with her husband is one of the reasons why it has such importance to her, reasons which are easy to understand, and why she wishes to return to live there now.

10. The couple had no children but did have a number of animals including three small dogs and a cat, who remain of central importance to CDM. Those issues, about the animals, have been crucial to CDM's well-being, indeed her very existence, and that has finally been reflected in the care provided, whilst one of the dogs cannot live with her (because its given to ante social behaviour), two do. The cat, I think, is at the moment in a cattery, because it cannot live with the other dogs in the home.
11. It appears that following the death of CDM's husband in 2014, a package of care was provided to CDM in her own home. Including the twice daily administration of insulin to which I have referred. However, the home conditions have deteriorated markedly, CDM is now described as living in squalid conditions, as well as failing to comply with the management of her diabetes.
12. Between June of 2015 and September 2017, when CDM was found collapsed on the floor by carers and taken to hospital, over that two-year period she was admitted from her home to hospital 11 times. Most of those admissions appear to be related to her diabetes, although one is in relation to a fall. CDM is obviously an individual with strong views. She may have different ideas about her hygiene to many, but not such as to previously cause a major issue in this case, or in her care.
13. CDM has been described as not just difficult but, on occasions, oppositional and downright awkward. She does not readily take to professional advice, preferring to manage her disabilities and her diabetes in the way that she had done over the years. That is to say, her own way. That has put her in conflict with professionals, but results in her also making, what others may consider to be, unwise decisions. That has been the picture now for many years. Such a pattern will be familiar to many healthcare professionals doing their very best on a daily basis for people who need attention and care. The professionals involved in CDM's care know her, know her well, and they have each done their very best to provide optimal care for her.
14. Until September 2017, CDM had been consistently assessed by a number of agencies, (including the applicant in these proceedings, her GP, the Anglican service and the District Nursing Service) as having mental capacity to make decisions in respect of her residence, personal care and management of her diabetes. That all changed on admission to hospital in September 2017, and since that time she has been assessed as having fluctuating capacity and or lacking the capacity to make decisions about her residence, personal care and the management of her diabetes.
15. It appears that the applicant's view (about CDM's capacity) had changed at that point because of the unsafe decisions that she was making which went far beyond unwise. At the best interests meeting held on the 12<sup>th</sup> of September 2017, it was determined that it was in CDM's best interests to be discharged from hospital into residential care and not to return to her own home, despite her strongly expressed wish to do so. She was therefore discharged to a dementia nursing home. CDM objected in the strongest possible terms. And so the Court of Protection proceedings were instigated.
16. CDM, a matter which has caused her particular distress, and a matter to which I am especially sympathetic, was exceedingly distressed about being separated from her animals. Her solicitors urged that they be reunified, and eventually a care home was identified which would accept both CDM and the dogs. She reluctantly agreed to

move to the new care home, there being really, now, no options, and as I have indicated, was reunited with two of the three dogs. The third I think is being very kindly looked after by the home manager, as a result of a serious fight between that dog and another dog on its arrival. The cat, as I say, remains in a cattery. A source of considerable unhappiness to CDM.

17. An urgent authorisation was granted on the 4<sup>th</sup> of April 2018. That was extended and expired, and a standard authorisation granted on the 11<sup>th</sup> of April 2018. It expired on the 10<sup>th</sup> of October 2018, and a further standard authorisation was granted on the 7<sup>th</sup> of September 2018 is due to expire shortly, on the 6<sup>th</sup> of March 2019.
18. In the new care home, CDM's diabetes remained uncontrolled, she was admitted to hospital on approximately 16 occasions with her agreement. She was, however, strongly advised to attend hospital on many other occasions, but because she was assessed by the London Ambulance Services as having capacity to refuse admission. She did not do so.
19. So, the issue is well-encapsulated in the email of 24<sup>th</sup> of October 2018, describing the circumstances; it was apparent that CDM was very unwell, she had been vomiting green bile for two days, was not able to sit up, was drowsy and barely responsive. Her ketone levels were high; her blood sugar was unrecordably high, and the carers were understandably worried, and stumped with what to do. An ambulance had been called the previous day but had not taken her to hospital because of the assessment of her "capacity"; overnight CDM had notably deteriorated and looked extremely unwell.
20. There were inevitably so many mixed messages and confusions. The care staff at the home had been advised that they should not be calling the ambulance service, if she refused to go to hospital, despite the fact that she did seem worried about it. She was then in fact taken to hospital, where she was treated but remained on the ward for some considerable time. It was concluded that she should not return to the care home as it was no longer safe for her to do so. Therefore, she has been medically fit for discharge for some time, but there is no agreement as to the place of her discharge.
21. CDM is completely opposed to being discharged to anywhere other than her own home, and the applicant is of the view that it is in her best interests to move to somewhere which is able to provide continuing care. There are, I hasten to add, a significant number of issues about placement. But those are not for me today and they are not straightforward. Expert advice has been sought and will be available in due course.
22. As I said, when the matter came before the Court of Appeal, the Court declined to hear argument, the basis of which I have already indicated and, as a result, the matter was listed as a matter of urgency and priority before me on the 25<sup>th</sup> of January 2019.
23. The expert evidence I can summarise. Dr Series was the jointly-instructed consultant psychiatrist. He concluded that:

1. CDM suffered from a personality disorder, probably of an emotional unstable type.

2. In addition, she suffered from wide variations in her mental state, arising from the fluctuations in her blood glucose as a result of her poorly controlled diabetes. Those fluctuations in her diabetic control are causing cognitive impairment which range from delirium to mild cognitive disorders, secondly to physical disease.
3. Both of those disorders can cause CDM's to have limited capacity to make decisions about her care and accommodation.
4. When her blood sugars are in the normal range CDM is capable of understanding the relevant information.
5. CDM is capable of retaining information.
6. Significantly though, even if CDM's blood sugar levels are in the normal range, her personality disorder is such that she is not able to weigh up the risks and benefits of accepting and cooperating with care. Decisions to refuse care appear to be driven not by a process of using and weighing information, but by impulse, with a deep-seated wish to take control of her life. Essentially, it is an impulsive and emotionally driven response.
7. Her state of mind and ability to make decisions are also affected by fluctuations in her blood glucose. There are times when she might be able to make a capacitous decision about care and treatment, and but other times when she cannot.
8. CDM lacks capacity to conduct these proceedings.

Further assessment provided more detail:

1. CDM has a personality disorder, but displays the characteristics of several different types.
2. Her personality disorder is present at all times and impacts different upon her at different times depending on the situation, the people, how they interact with her and CDM's emotional state.
3. Her personality disorder can prevent her from using or weighing information. It is not possible to predict the circumstances when this will occur, nor easy to assess at any given time whether CDM is making an "unwise decision" or an incapacitous one.
4. Any of CDM's interactions with others and the decisions that she makes in relation to those interactions are driven by a need to assert control over the situation, and a disregard for the views or opinions of others. That is particularly so in her decision-making in relation to her medical treatment for her

diabetes. That is caused by her personality disorder, albeit high glucose levels arising as a result of her diabetes contribute.

24. In relation to fluctuation, Dr Series opinion is as follows: that on many occasions CDM makes what might appear to be a reasonable decision, despite the fact that she is suffering from a personality disorder and her blood glucose levels are unstable. On the balance of probability, there is insufficient evidence to displace the presumption that she has capacity. However, on occasion that she makes what appears to be an unreasonable or possibly dangerous decision, it appears to me that the effect of her personality disorder on that occasion, possibly a combination of limited blood glucose but not necessarily so as to undermine her ability to use or weigh the relevant information to make a capacitous decision. On those occasions, he concludes that she lacks capacity.

1. The only way to test whether CDM is making a capacitous decision is to consider whether the decision is a reasonable one.
2. Her decision-making is driven by emotional impulses. Sometimes when she is calm she is able to use and weigh, but other times when she has opposition, she is not able to use or weigh.
3. CDM's personality disorder exacerbates her diabetes as it leads to poor diabetic control.
4. Her ability to make decisions in respect of residence, care, finances and medical treatment all fluctuate in this way, i.e. she has fluctuating capacity across all decision-making domains in issue in these proceedings.

Yet further questions were put to Dr Series, but his final position, in conclusion, was that:

1. CDM lacked the capacity to make decisions about residence and surrendering her tenancy because a return to her home was an emotionally driven decision which could deprive CDM of the ability to use or weigh anything in relation to those matters.
2. She had capacity to make decisions about her personal care.
3. She had fluctuating capacity to make decisions about the management of her diabetes, financial affairs and the deprivation of liberty question.
4. CDM lacked capacity to conduct litigation.

The social worker's final position in the previous hearing was that she lacked the capacity to make all decisions under consideration, despite having not assessed her for some considerable time.

Dr Beck filed two reports, in August and September. She importantly concluded:

1. CDM suffers from an emotionally unstable personality disorder.
  2. There are times when CDM is able to use or weigh information about her diabetic management but there are other times when she is not able to do so.
  3. As a result of her personality disorder, CDM has problems regulating her emotions. She can, at times, experience emotional cascade when she engages in dysregulated behaviour. At such times, her emotions control her. She is unable to use or weigh information. She acts impulsively and without thought of the consequences for her actions.
  4. It is not possible to draw up an exhaustive list of triggers as to when CDM experiences emotional cascade, but she is more likely to become emotionally dysregulated when she feels out of control, humiliated or lonely.
  5. It is doubtful whether CDM has the capacity to manage her diabetes effectively most of the time. Many of the decisions she has to make cause her too much distress in the moment, so she can no longer manage her emotions, she becomes emotionally dysregulated and then loses capacity.
  6. CDM's capacity is not maximised when she is protected from the decisions which cause her distress and with which she cannot cope, such as managing her diabetes.
  7. In order to help CDM regulate her emotions, firm and more consistent boundaries need to be put in place and CDM needs to feel valued and appreciated. She is lonely and needs a great deal of one to one time from someone who can praise strengths and show her warmth and affection.
  8. CDM's dogs help to regulate her emotions and soothe her distress.
25. In due course she provided a further report on the 23<sup>rd</sup> of October, after a number of questions were put to her. She said:
1. It is not possible to describe the behaviours which CDM is likely to exhibit when she is emotionally dysregulated. It follows, it is not possible to rely on when to distinguish whether CDM is emotionally dysregulated.
  2. Only CDM can identify the thoughts, feelings and behaviours which trigger her emotional cascade. CDM lacks insight into the fact that her emotions become dysregulated, so she cannot drive out of her system what is happening to her.



3. CDM's emotions are likely to fluctuate very frequently in response to the many varied stimuli around her and within her. Those fluctuations are not predictable.

4. Emotional cascade is experienced in the non-personality disorder population. Those like CDM with a personality disorder are stuck in this band of behaviour.

5. CDM's capacity to make decisions in relation to her diabetes management cannot be described in categorical terms as either being present or absent. It is likely to fluctuate. A lack of spectrum and different skills are compromised by degrees of emotional dysregulation at different times. For example, CDM might feel extremely agitated and be unable to concentrate at one point in time, which could impact her ability to take in new information, whereas at another time she could feel defiant and unwilling to cooperate with professionals, which could impact on her ability to weigh up information effectively (predisposing those acts against professionals even when she knows that their views are best for her).

6. There is a difference between CDM stating understanding of her diabetes management needs and her ability to put this into practice. She becomes emotionally dysregulated so frequently that her ability to act on her decisions is significantly compromised on a daily basis.

26. As requested by the Court of Appeal, and the point of issue before this court, Dr Beck provided her own expert assessment of CDM's ability to manage – the capacity to manage her diabetes, rather than working from the findings made by Cohen J about capacity on the 25<sup>th</sup> of November. She reached very clear unequivocal conclusions.

1. CDM has an emotionally unstable personality disorder, as well as a paranoid histrionic and dependant personality disorder. Those conditions are lifelong and unlikely to change.

2. Diabetes management requires a person to maintain consistency in their own care. Single decisions need be coherent with one another. Thus, diabetes management is not a single decision, but a coherent series of decisions over time.

3. These personality disorders may also sit within the context of impairment from untreated diabetes.

4. CDM does not fully understand the foods which increase and decrease her blood glucose levels.

5. CDM does not understand the need to eat the same volume and types of food on a regular or predictable basis. She does

not understand what a consistent or predictable diet would look like.

6. Both of these deficits in CDM's understanding are caused by her personality disorder.

7. CDM understands that she is free to vary her diet and this will impact on her blood sugar level. And she understands that she needs to vary her insulin accordingly, but she does not understand it in the level of detail and accuracy required to make a safe decision herself. She will always require professionals to decide on the amount of insulin she requires.

8. CDM is able to understand that there can be a risk of death associated with her condition, but not the factors that determine the risk being imminent for her.

9. There are times when CDM accepts monitoring of her blood glucose levels and insulin, but this is probably the dependent aspect of her personality pathology rather than based on true understanding of the imminent health risks.

10. CDM is able to understand some of the information relevant to managing her diabetes on some occasions. However, she is not able to understand all of the information relevant to her diabetes management on some occasion. She is unable to understand some of the information all of the time.

11. CDM can retain some of the relevant information in relation to her diabetes management all of the time, but when is CDM is emotionally dysregulated, which is fairly often, she may be less able to retain the information. She is not able to retain all of the information relevant to her diabetic management all of the time.

12. Discussion of diabetes management may in itself caused CDM to become emotionally dysregulated.

13. CDM does not want to die but she does not feel that she was at risk of death. She is not realistically weighing up information about the likelihood of survival with raised ketones or blood glucose levels.

14. There are aspects of her diabetic management that CDM appears to be able to balance, but having made these choices she continues to refuse to act in relation to the results, the compromise of urgent medical care.

15. CDM lacks the ability to weigh up and understand the risks of the immediacy of the threat to her life. If her blood sugar and ketone levels are high, that extends to understanding and

weighing the level of risk if she declines to balance her diet or take part in monitoring her insulin treatment. Her ability to judge when to accept treatment and monitoring and to balance this against the risk of death is not there.

16. CDM's communication can become difficult when she is emotionally dysregulated.

17. CDM does not understand the nature or degree of the risks of death at particular points in time, despite having a real general knowledge of the potential risks and good knowledge of her condition.

18. There may be some times when CDM makes a decision in relation to the management of her diabetes where she understands the elements of the decisions being made, retains the information, weighs it up without the defect of a dysregulated emotional state, and communicates this effectively. However, these times, if they occur, are infrequent and unpredictable. If this is fluctuating capacity, then CDM has fluctuating capacity to manage her diabetes.

19. CDM is able to weigh up some of the information relevant to decisions about her diabetes made on very few occasions, however not coherently or consistently. CDM can fluctuate in her ability to make micro-decisions about her diabetic management. Sometimes she can make such decisions capacitously. This will be infrequent. It is less likely to be a capacitous decision if it is a decision to refuse treatment or advice.

20. CDM does not understand that she can become emotionally dysregulated.

21. CDM's real time decision-making are probably not capacitous ones if they do not accord with her overarching desire to live, but that is not to say that the decisions which cause her overarching desire to live are capacitous.

22. The fact that CDM is accepting treatment is not necessarily a sign that CDM is making capacitous decisions. Those decisions are likely borne out of emotionally dysregulated independence.

27. Dr Series and Dr Beck produced joint reports in December and January. Save for one point of disagreement which is of legal interpretation, they shared the same conclusions.

28. Their second joint report, on the 15<sup>th</sup> of January 2019, concluded as follows:

1. The fact that the staff on the ground, that is the district nurses and the ambulance services (whether they assess CDM

to have or lack capacity to make the decisions), do not have a full understanding of her mental health. For example, when the London Ambulance Service assessment of CDM's capacity to refuse transfer to the hospital was made, in the knowledge that she would in any event have been cared for by staff who could call them back should the need arise.

2. CDM shows a high degree of emotional dysregulation, marking the severity of her condition. It is extremely debilitating and interferes with her ability to function in most contexts.

3. In the hospital setting, CDM was constantly visited by staff, often at interventions. That created stimuli which seemed to trigger emotionally dysregulated states.

4. CDM frequently emotionally dysregulates and experiences this state most of the time, and in most settings. She would be least emotionally dysregulated if a clear routine could be established. When she was not required to make too many decisions about her life it appears uncertainty and inconsistency can cause her anxiety and leads to emotional dysregulation.

5. CDM was less compliant with the management of her diabetes in hospital than she was when visited by the nurses.

29. With that very much clarified expert opinion and background, I heard the oral evidence. I heard from Miss Smith, who was the Clinical Lead for the paramedics, and Miss Penn who was the Clinical Lead for the district nurses, both equally impressive individuals and witnesses. Both obviously highly qualified and experienced. Though not described as specialist in diabetes. Both gave an overview of the practice applied by the individuals concerned in their daily interactions with CDM.
30. Obviously, they could not report on the specific individual crews or nurses and, in any event, as became crystal clear during the course of the evidence of Dr Beck, the core issue of capacity is in fact a complex one involving so very many aspects. But I noted that Miss Penn advised the court that the diabetic management includes a decision about diet, about glucose testing, eating and administration, decision to go to hospital when results are high, and making decisions and management of conditions which arise, for example in relation to CDM's eyes and her feet.
31. And whilst each district nurse, all of whom I believe or most of them are well known to CDM, is well-trained and aware of CDM's personality disorder, she nonetheless maintained the view that it was still effectively a macro-decision. I especially noted, however, that when she, for example, spoke of CDM's capacity to self-administer insulin, what she in fact really meant was her physical capacity, as opposed to her mental capacity to do that. In relation to her capacity to testing her blood glucose levels, for example, it seemed to me that the evidence, again, was really about establishing CDM's "compliance" as opposed to her consent. Ultimately, impressed

as I was by the quality of the evidence from both Miss Smith and Miss Penn, neither detracts from the conclusions or the depth of the opinions of Dr Beck, in fact the reverse. They supported CDM who has a complex presentation and where there are many complex contributory factors.

32. Dr Beck, spoke to her report. She maintained, despite being repeatedly pressed by counsel, that the decision was a global or macro-decision. That is to say each decision was inescapably related to each other decision. So, in the context of diabetes, for example, if you ate something, it was in the context of what you had eaten before, and what you were likely to eat in the future, and in that exemplified context, CDM simply did not understand, at any level, that some foods might lower her blood glucose levels, and further, she did not understand the information, or weigh it in relation to those foods or factors that might increase it.
33. In fact, Dr Beck is not a diabetic specialist or specialist in diabetic management, but having regard to the care and research which she applied to that aspect, as in all aspects, it did not detract from her opinion. She had informed herself as much as she reasonably could. She reached clear unequivocal conclusions as to whether it should be a macro-decision, a micro-decision or groups of micro-decisions.
34. She concluded, and was forceful about it in a reasoned way, that it was effectively impossible and impractical to decide each decision because, for example, the concept of eating a carrot or not eating a carrot was in the context of what had happened already and what was to happen. So that for the notion of specific decision-making, there were so many elements, all of which fluctuated over time and were or might be related, and where each was a multi-factorial. There were simply too many factors to be brought to bear. In fact, she concluded that CDM is probably not capacious at all.
35. She gave a powerful illustration of somebody managing the micro-decision, but that if she managed it nine tenths of the time, that is to say certainly more than 51 per cent of the time, should they be assessed as having capacity to manage their diabetes? At one level CDM understands what the issues may be, but at every other level did not. The big factor was CDM's emotional dysregulation, which happens so frequently, and has so eroded her understanding of being able to live or make any decision which is not emotionally dysregulated.
36. So, she gave examples of when CDM was likely to be emotionally dysregulated, and what the symptoms might be, how that might show itself. CDM might be angry and shouting. She might be agitated. She might be abusive and rude. She might make statements which were not objectively verifiable. She might acquiesce to something and then change her mind. She might issue paranoid statements or say very unusual things. But equally, a real probability is that even when she does not appear emotionally dysregulated, that does not mean that she is not emotionally dysregulated. Effectively, it is quite impossible to tell at what stage and to what extent she was emotionally dysregulated, and in what way it would be possible to take that into account.

I turn shortly to the legal framework, which is uncontentious.

37. The test for capacity contained in the Mental Capacity Act is set out in s.2 (1) MCA 2005:

A person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter, because of an impairment of, or disturbance in the functioning of, the mind or brain.

Whether CDM is ‘unable to make a decision for herself in relation to a matter’ is the ‘single test’ and falls to be interpreted by applying the more detailed description given around sections 2 and 3 (York City Council v C [2013] EWCA 478 at paragraphs 56 and 58).

Section 2 provides that a person lacks capacity if ‘at the material time’ they are unable to make the decision for themselves. As to when is the material time:

Paragraph 4.4 of the Code of Practice provides: *An assessment of a person’s capacity must be based on their ability to make decisions at the time it needs to be made, and not on their ability to make decisions in general.* [See also paragraph 4.27 of the Code]

For ongoing decisions that need to be made on a daily basis the Court of Appeal in re M (an Adult) (Capacity: Consent to Sexual Relations) [2014] EWCA Civ 37 [provides](#) at paragraph 84 that:

*‘Where a decision is of a kind which falls to be made on a daily or at any rate repeated basis, it is inevitable that the inquiry required by the Act is as to the capacity to make a decision of that kind, not as to the capacity to make any particular decision of that kind which it may be forecast may confront the protected person.’*

Capacity is issue specific – see:

*PC v York* paragraphs 35 and 37:

*The determination of capacity is decision specific* [paragraph 35]

*The court is charged in section 2(1) in relation to ‘a matter’, with evaluating an individual’s capacity’ to make a decision for himself in relation to the matter’* [paragraph 37].

The Code of Practice at paragraph 4.4 which provides that a person’s capacity must be based on their ability to make a specific decision at the time it needs to be made, and not their ability to make decisions in general.

Section 3 amplifies what it means to be “unable to make a decision,” providing that it means that the person is unable to understand the information relevant to the decision, retain that information, use or weigh that information as part of the process

of making the decision, or to communicate his decision (whether by talking, using sign language or any other means).

38. There are other provisions about capacity in ss 1 and 2 MCA 2005, of which the most relevant are:

s.2(2), which adds that it does not matter whether the impairment or disturbance is permanent or temporary

s.2(4), which provides that in proceedings, the question of whether a person lacks capacity must be decided on the balance of probabilities;

s.1(2), which directs that a person must be assumed to have capacity unless it is established that he does not;

s.1(3), which provides that a person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.

Section 1(4) adds that a person is not to be treated as unable to make a decision merely because he makes an unwise decision.

39. In relation to the arguments that are put before the court on CDM's behalf, it is strongly submitted, (notwithstanding the decision of Jackson J in Re E [2012] EWCOP 1639) that the decision is a novel and previously undecided one, and that I should determine how to define the matter in respect of which CDM is being assessed. Of course, the court is concerned to determine whether she has the capacity to manage her diabetes, but is this to be considered as one macro-decision, a series of micro-decisions which need to be made on a regular ongoing basis, or as a group of decisions?

40. In their joint reports, Dr Series and Dr Beck are clear on the questions posed within the context of this case, the experts were clear that this is a single global macro-decision. Notwithstanding that unanimous expert approach from different perspectives, through the Official Solicitor CDM argues, nonetheless, that in this case that is both wrong and that there are disadvantages to that approach, as clearly there maybe.

1. It may mean that a person has the capacity to make decisions in relation to some or even many aspects of their diabetes management is in fact treated as if they lacked that capacity.

2. It might be inconsistent with the code of practice which suggests that the assessment has and must be based on a person's ability to make the specific decision at the time it needs to be made, not on their ability to make decisions in general.

3. It risks offending against the principle set out as long ago as 2010 in LBL v RYJ [2010] EWCOP 2665. That it is not necessary that P understands every element of what is being

explained to him or her. What is important is that P understands salient factors.

41. The main advantage of that approach, to actually quantify the experts is:
  1. The decisions that relate to each other cannot be so easily and conveniently separated. And,
  2. That it is impractical to expect professionals to assess CDM's capacity in relation to every micro-decision.
42. And so, the strong submission is made to me that that has to be balanced against CDM's right to make her own decisions when she has capacity, and the fact that, irrespective of the orders that the court makes, CDM's care and treatment is going to remain a challenge for the professionals. So, it is submitted, effectively, that the solution is not to treat the management of the diabetes as one macro-decision, but rather is to group the decisions together and, where necessary, include the information about other micro-decisions as part of relevant and informative information.
43. So it is submitted that the appropriate way of "defining the matter", when assessing diabetic management, is not to accept the macro or micro-decision approach, but to group them together and consider whether CDM has the capacity:
  1. To make decisions about controlling her diabetes and diet.
  2. To make decisions about treatment for her diabetes, which is in turn subdivided into three separate decisions:
    - a. The capacity to make decisions about testing and the blood sugar at right glucose levels, which encompasses submissions about weighing and testing blood glucose levels.
    - b. The capacity to make decisions about treatment being offered for her diabetes but falling short of life-saving treatment. Treatment by insulin as required. And,
    - c. The capacity to make decisions about life-saving treatment for diabetes, which will include, in some cases, taking insulin or admitting herself and taking her to hospital.
44. A significant part of the discussion put before the court is that this is a matter of a wider importance and public interest. It is submitted that Diabetes UK estimates that there are 4-and-a-half million people in the United Kingdom with diabetes, and that in the report published by the charity in November 2017 of that group, three in five people experience emotional and mental health problems.
45. And whilst it is acknowledged that defining diabetes management on the macro level has, it is described as, superficial attraction, the Official Solicitor submits that it is contrary to established principles of autonomy, and in fact, it creates more problems than it solves.



46. Notwithstanding the submissions made, I decide this case on the legal principles, which are not controversial, on the evidence as it applied to CDM and which was, to my mind, unshakeably clear. Whereas the submissions made on behalf of the Official Solicitor may have a beguilingly logical attraction, in my view it is simply not open, nor necessary to be drawn into the many wider examples or parallels which were suggested. For example, when somebody is treated for cancer. Each treatment has to be looked at in its own individual context as opposed to a global context. CDM is unique, her position is self-evidently unique, to her.
47. I do not think it is necessary or helpful to draw inferences or parallels on examples of other conditions or other classes of individuals, since the interrelationship between the micro and macro-decisions still needs to be decided, having regard to a particular individual in particular circumstances, and having regard to their particular condition. No two people self-evidently are ever the same, their condition the same condition, or the circumstances the same. The elements in relation to CDM's own particular conditions are unique to her. CDM has diabetes which is not unique to her, being shared with many other millions of people in the United Kingdom, but as an individual the factors are unique.
48. I have reached very clear conclusions, both on the evidence and on the law, on the powerful experts' analysis, which I adopt:
- a) on the assessment of capacity to make decisions about diabetes management, in all its health consequences, the matter is a global decision, arising from the interdependence of diet; testing her blood glucose and ketone levels; administration of insulin; and, admission to hospital when necessary in the light of blood glucose levels. And
  - b) that CDM lacks the capacity to make those decisions, and having regard to the enduring nature of her personality disorder which is lifelong and therefore unlikely to change.
49. I acknowledge, as do the experts, that there may be occasions when CDM has the capacity to make micro-decisions in respect of her diabetes and occasions when she does not, i.e. that her capacity does in fact fluctuate. However, if the court accepts the expert's opinions, as I do, and approaches the matter on the basis of their conclusions, logically, legally and practically, it is a macro-decision, and CDM lacks capacity to take the macro-decision, the issue of fluctuating capacity simply does not arise.
50. During the course of evidence, Dr Beck was asked for more guidance as to the signs when CDM becomes emotionally dysregulated and whether she has lost capacity in respect to either of the micro-decisions but, Dr Beck was simply unable to do so, because it was impossible to do so.
51. I am clear, having regard to my review of the evidence and of the law. That in relation to CDM's diabetes management it is a global decision and one upon which CDM does not have the capacity to decide.
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*We hereby certify that the above is an accurate and complete record of the proceedings or part thereof.*

This transcript has been approved by the Judge