



Neutral Citation Number: [2020] EWCOP 13

Case No: 13378066

IN THE COURT OF PROTECTION

Civil & Family Court and Tribunal Centre
Barras Bridge
Newcastle Upon Tyne

Date: 20/03/2020

Before:

THE HONOURABLE MR JUSTICE COBB

Between:

SUNDERLAND CITY COUNCIL

Applicant

- and -

AS

Respondents

(By his litigation friend, the Official Solicitor)

-and-

**CUMBRIA NORTHUMBERLAND TYNE &
WEAR NHS TRUST**

-and-

TWS

Sam Karim QC (instructed by **Law & Governance Services**) for the Applicant and (instructed by **DAC Beachcroft LLP**) for the Second Respondent

Simon Garlick (instructed by **Hadaway & Hadaway**, on behalf of the Official Solicitor) for the First Respondent

The Third Respondent was present but not represented

Hearing dates: 10 March 2020

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.

.....
THE HONOURABLE MR JUSTICE COBB

This judgment was delivered in public. 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 AS 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.

The Honourable Mr Justice Cobb:

1. AS is a 44-year old single man; he has a diagnosis of mild learning disability, and acquired brain injury. He also suffers from a bipolar disorder and personality disorder traits¹. He has lived since 2014, and continues to live, in tenanted supported accommodation in Sunderland.
2. By an application brought under the *Mental Capacity Act 2005* ('MCA 2005') Sunderland City Council seeks *section 15* (ibid.) declarations in relation to AS's capacity to make a range of relevant decisions, and (subject to my determination on capacity) various best interests' determinations; it further seeks authority to deprive AS of his liberty at his accommodation and in the community.
3. AS is the First Respondent to the application, and appears by his litigation friend the Official Solicitor. The Second Respondent is the mental health NHS Trust which is responsible jointly (with the Applicant) for the funding of AS's package of care. The Third Respondent is AS's older brother.
4. AS has been subject to Community Treatment Orders ('CTOs') issued pursuant to *section 17A Mental Health Act 1983*² ('MHA 1983') for many years. His current CTO (which commenced in July 2018) contains the following conditions: (a) a condition of residence, (b) to take his medication, as prescribed, (c) to abstain from alcohol, and (d) to attend all appointments with his care co-ordinator and responsible clinician. From time to time in the past, AS has been recalled to hospital for breach of his CTO conditions.
5. For the purposes of determining questions about capacity, I have received statements from the social worker (Miss H), a report from AS's treating medical practitioners (including his responsible clinician Dr. A, his consultant psychiatrist), a detailed care

¹ See below, Dr. Hill said that the bipolar disorder and personality disorder are not irrelevant to the *section 2* evaluation but not central.

² Note that the relevant criteria for the making of a Community Treatment Order are (per *section 17A(5) MHA 1983*) that (a) the patient is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment; (b) it is necessary for his health or safety or for the protection of other persons that he should receive such treatment; (c) subject to his being liable to be recalled as mentioned in paragraph (d) below, such treatment can be provided without his continuing to be detained in a hospital; (d) it is necessary that the responsible clinician should be able to exercise the power under *section 17E(1)* below to recall the patient to hospital; and (e) appropriate medical treatment is available for him.

plan, an expert report (and answers to supplemental questions) from the jointly instructed consultant forensic and clinical psychologist, Dr. Stephanie Hill.

6. I heard the oral evidence of the social worker and Dr. Hill. AS himself attended court and answered questions (unsworn) from the witness box; it was extremely helpful to hear from AS himself and I was most pleased that he wished to participate in the hearing in this way.

Factual background

7. It is unnecessary for me to provide a detailed narrative of AS's background history, but it is helpful, to set the context for my review of the capacity evidence, to provide some outline information.
8. AS had a troubled childhood, suffering a range of emotional, physical and sexual abuse, in and out of the care system. When he was 6 years old, he suffered a brain injury as a result of a road traffic accident. His childhood and adult life have been characterised by involvement in risky, impulsive, reckless and dangerous behaviours; in adulthood, this has often been aggravated by alcohol consumption and gambling. The reports and statements carry further, worrying, descriptions of aggression and violence, inappropriate sexualised conduct with others, occasional opportunistic criminal acts, and absconding behaviours. He has received psychiatric services under the *MHA 1983* on and off all his adult life (his first admission to psychiatric inpatient services was when he was aged 17).
9. In 2012, a neuropsychological assessment was completed which showed that AS showed a general impairment of executive functioning, and that some of his impulsive behaviours were/are associated with neuropsychological disinhibition rather than being a functional behavioural problem.
10. In 2018 (as indicated above) he was last discharged from hospital under a CTO. He appealed unsuccessfully against the imposition of this order in January 2019. He now lives in supported living with two (or possibly three) others, all with mental health needs; he has his own bedroom and he shares his communal living area. He regularly fails to adhere to the basic principles of living in a therapeutic community; AS continues to challenge the structure and boundaries in his current placement. Given the vulnerabilities of the other service users, and AS's particular propensities, he is supervised at all times when socialising with them. Without the CTO, he would not be able to live in supported accommodation; the professionals working with him feel that this environment ensures that his behaviour is regulated effectively, and helps to achieve reasonable stability in his mental health.
11. His oppositional personality responds negatively to criticism, and when requests for unsupervised time in the community are not considered to be appropriate by his care team, he often responds aggressively. The evidence reveals that his occasional unsupervised time in the community has been marred by various incidents involving members of the public, and this has led to clashes with staff. He does not appear to have a full understanding of the long-term aim of his CTO; the social worker opines:

“When AS does not comply with his support there was a noticeable negative change to his self-care and becomes high risk of self-neglect. AS does not maintain his hygiene, he urinates himself and walks around with urine-stained trousers, he fails to maintain his home and as he is incontinent overnight his room becomes uninhabitable. ... AS is clinically obese and needs a lot of support around nutrition and making healthy choices...AS has poor mobility and chronic cellulitis which is painful...”

12. I heard evidence of a recent incident (10 February 2020) when he left his supported accommodation without any specific authority or supervision as required. My note of AS’s own account of this incident is as follows:

“A couple of weeks ago, I went out. I went out on my own. I asked for my mobile phone, and the person on shift would not let me have it, so I went out, and the person [member of staff] followed me, and to the bus... to the university in Sunderland, and I went to Newcastle. When I left the house, I did not have my mobile so I could not contact anyone, it was as if they did not care. My mobile is kept in the office. I was in Newcastle all day, walking about, and I did report into the police station in Sunderland, to let the police know that I was out and about on my own. I got back at 6pm in time for my evening medication. I had left at 8.30am that day. The carers were not happy that I had left. I was being followed the police said I was fine.”

13. The social worker gave this account in her oral evidence (again my note):

“AS had acquired £20 from gambling. He was intent on going out into the community and in spite of the efforts of the care team to discourage him, he would not comply; he was pretty much aroused, he asked for his phone, and he shouted some obscenities and he left. He left from [his supported living]. He said that he was going out and into town. A member of staff followed safely behind him. They both got onto the bus. AS got off the bus. The other two members of staff came to look for him. He was missing all day. He returned at 6.40pm. He was fatigued and unkempt and stained with urine.”

The comparison in these accounts is striking. I accept the social worker’s version.

14. His brother (TSW) and mother have written a joint letter to the court in these terms (24 January 2020):

“Since [AS] was a child he has always displayed difficult and challenging behaviours.... We worry about him in the community because he is impulsive and can’t see danger... As a family we strongly feel that [AS] needs 24/7 care...”

[AS] needs a high level of care and support and supervision to meet his social care needs. Without a high level of support, he would not keep clean, he would not wash his clothes, he would not attend medical appointments. If [AS] was left to his own devices he would neglect himself, not engage with any professionals, and would contact family during all hours. [AS] cannot regulate himself ... We therefore feel strongly that [AS]’s liberty needs to be restricted to keep himself and other people safe.”

Law

15. This hearing has been convened for me to focus on issues of AS’s capacity.
16. In reaching a conclusion on this issue, I have applied the core principles of the *MCA 2005*, starting with the statutory assumption that AS has capacity unless it is established that he does not (*section 1(2) MCA 2005*); that he 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(3) MCA 2005*); that he is not to be treated as unable to make a decision merely because he makes an unwise decision (*section 1(4) MCA 2005*).
17. I must satisfy myself that he satisfies the diagnostic criteria under the *2005 Act* (“a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain” *section 2 MCA 2005*), and the ‘functionality’ test: namely that he is unable to make a decision for himself if he is unable to understand the information relevant to the decision, to retain that information, to 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). Proof of lack of capacity is established on the balance of probabilities (*section 2(4) MCA 2005*).
18. I have followed the guidance offered by the Court of Appeal in *PC v NC and City of York Council* [2013] EWCA Civ 478 at [35], namely that the court should consider the issues specifically:

“The determination of capacity under *MCA 2005, Part 1* is decision specific...all decisions, whatever their nature, fall to be evaluated within the straightforward and clear structure of *MCA 2005, ss 1 to 3* which requires the court to have regard to 'a matter' requiring 'a decision'. There is neither need nor justification for the plain words of the statute to be embellished”.
19. What the ‘relevant information’ is under *section 3(1)(a) MCA 2005* will depend on the particular decision to be made, but includes the reasonably foreseeable consequences of the decision or failure to make a decision (*section 3(4)*). I recognise that it is important not to overload the test with peripheral detail, but to limit it to the “salient” factors (per *LBL v RYJ* [2010] EWHC 2664 (Fam) at [24], and *CC v KK & STCC* [2012] EWCOP 2136 at [69]). On the issue of *residence*, I follow the

guidance offered by Theis J in *LBX v K, L, M* [2013] EWHC 3230 (Fam) (at [43]), and on the issue of *care*, dicta in the same case at [29]. I accept that these formulations are “to be treated and applied as no more than guidance to be adapted to the facts of the particular case” (*B v A Local Authority* [2019] EWCA Civ 913 at [44]³).

20. Two points arose from Dr. Hill’s assessment which potentially gave rise to interesting legal issues:
- i) Whether AS had litigation capacity while not having subject matter capacity;
 - ii) Whether AS’s capacity in certain areas fluctuated/fluctuates dependent upon his mood or state of emotional arousal; whether, in the circumstances, this is a case in which we should be considering ‘anticipatory’ declarations as to capacity.
21. *Litigation Capacity*: At one point in the development of her assessment, it had been Dr. Hill’s view that AS had litigation capacity while not having subject matter capacity; it followed that when she gave evidence she was asked to consider whether the case fell into the “rare” category of case contemplated by Munby J (as he then was) in *Sheffield CC v E and R* [2004] EWHC 2808 (Fam): at [49]:
- “There is no principle, either of law or of medical science, which necessarily makes it impossible for someone who has litigation capacity at the same time to lack subject-matter capacity. That said, however, it is much more difficult to imagine a case where someone has litigation capacity whilst lacking subject-matter capacity than it is to imagine a case where someone has subject-matter capacity whilst lacking litigation capacity. Whilst it is not difficult to think of situations where someone has subject-matter capacity whilst lacking litigation capacity, and such cases may not be that rare, I suspect that cases where someone has litigation capacity whilst lacking subject-matter capacity are likely to be very much more infrequent, indeed pretty rare. Indeed, I would go so far as to say that only in unusual circumstances will it be possible to conclude that someone who lacks subject-matter capacity can nonetheless have litigation capacity.”
22. In fact, on further evaluation, and in her final analysis, she considered that AS did *not* have litigation capacity after all, consistent with her findings about subject matter capacity. Having heard her evidence, I accepted her final position on this.
23. *Fluctuating capacity*: AS’s clinical support worker told Dr. Hill that “when he’s aroused, you’ve lost him completely. You have to let him go through that cycle then he calms down.” This led Dr. Hill to the initial view that “for AS to have capacity, he must be in a calm state of mind as, when he is aroused or agitated, his inability to

³ And also, per [62], “we see no principled problem with the list provided that it is treated and applied as no more than guidance to be expanded or contracted or otherwise adapted to the facts of the particular case”.

think clearly becomes more apparent, although his capacity will return once he has settled back down.” In light of this opinion, Mr Garlick addressed briefly the issue of fluctuating capacity in his written document, citing para.4.26 of the Mental Capacity Act Code of Practice (2007)⁴.

24. Although I was not specifically addressed by counsel about the circumstances in which anticipatory declarations could be made, I for my part brought into my review of the law the decision of Hayden J in *Guys & St Thomas’ NHS Foundation Trust & another v R* [2020] EWCOP 4, in which he made a number of important points at [29], [32] and especially [36]:

“[36] Any declaration relating to an act ‘yet to be done’⁵ must, it seems to me, contemplate a factual scenario occurring at some future point. It does not strain the wording of this provision, in any way, to extrapolate that it is apt to apply to circumstances which are foreseeable as well as to those which are current. There is no need at all to diverge from the plain language of the section. In making a declaration that is contingent upon a person losing capacity in the future, the Court is doing no more than emphasising that the anticipated relief will be lawful when and only when P becomes incapacitous. It is at that stage that the full protective regime of the MCA is activated, not before”.

25. In fact, Dr Hill was of the view, in her final analysis, that in no respect does AS have capacity; his situation is chronic and persistent. Her finding of incapacity was not dependent on any finding of temporary deterioration in his mental functioning caused by emotional arousal.

The First Respondent: AS

26. AS answered questions from counsel, unsworn. He did so with great composure and apparent confidence sitting in the witness box. It was extremely helpful to hear from AS in this way, and I was pleased that he felt able to discuss the issues with me. His counsel had sent him a number of pre-prepared questions in order to help him to anticipate the topics to be covered. I set out in reasonable detail the account he gave me:

“I live with two other residents, one has greater problems than me, but he has unlimited leave. There are staff there 24 hours a day. There are waking night staff.

I do need prompting in relation to my personal hygiene and personal care; but no help with cooking and washing. I don’t get offered any help in the house. The staff spend

⁴ “Some people have fluctuating capacity – they have a problem or condition that gets worse occasionally and affects their ability to make decisions. For example, someone who has manic depression may have a temporary manic phase which causes them to lack capacity to make financial decisions, leading them to get into debt even though at other times they are perfectly able to manage their money”.

⁵ *Section 15 MCA 2005*

time in the office. The other residents spend time in the bedrooms...I can't be on my own with any of the residents.

Q: Do you need the staff to keep you and the other residents safe? A: Yes and no.

I don't think it is necessary to be accompanied out of the house. It is not helpful. I am always polite and courteous. I help old men and women on and off buses. I have had no problems with children. There have only been two issues with children, when I was 17 when I urinated [in public]... and one occasion I took a baby for a walk in the pushchair [without permission of the parent].

I don't stare or touch people inappropriately. The only issues I have had with children when I was 17 years old.

Looking on the internet at children having medical care? No. I was looking pop stars. Justin Bieber having medical treatment. I did not go to the beach during school holidays. Loitering around schools? No that is wrong.

I do voluntary work with Washington Wildfowl Trust, on a Wednesday. And I work in charity shop where I hang clothes. I have support when I am at my work placement. They would not take me without support. They [the work placements] are good for me.

Those conditions [on the CTO]... they do not affect me at all. I can cook. I can do everything that a normal person can do. I cannot iron but I can do everything else. They *never* affect me.

Q: Risks if you were not accompanied? A: There would be no risks. I went out unaccompanied the other week⁶, and asked for access to my mobile phone, and this was refused. I was back in time for my medication. I reported to the local police station that I was out by myself. I would not be at risk in the community.

Q: Gambling? A: I don't think that's against the law. This is freedom of choice. You do get people coming in and out of betting shops. Q: Addicted to gambling? A: no not at all. In the past I did sell things to pay debts, but I bought it all back.

Q: Did you cope well in the community? I think that I coped well in the past. I had my mobile phone. I would tell

⁶ See the account above

people where I was going and where I was and what I was doing.

Q: Feb 17, June 18 and Oct 18... it is said that you stopped going to the activities, and when you came back you were dishevelled? I don't agree that. I was not contacting the family unnecessarily.

You were recalled to hospital [under the CTO]...? Yes, but I was not doing anything wrong. I disagree "big time" that there was a deterioration in my mental health.

...

Accommodation? I would prefer to go back to the accommodation I had at [X Road], my own flat. I would pay the bills. I have had my own property before. Care? that would be something that would be decided by the local authority, as they are in charge of my care. I don't think that I would need a sleeping staff. I would just need someone to take me to the work placement. I would like someone to administer my medication. Every day I would need a visit for someone to administer my medication.

I would follow the care plan. I would still go to work and have some freedom on my own."

The expert opinion of Dr. Hill

27. Dr. Stephanie Hill was instructed by the parties jointly pursuant to an order of 5 April 2019. She prepared one report, dated 26 July 2019, and two addendum reports (20 September 2019, and 14 October 2019) each answering specific questions.
28. She took the view (a view from which she did not derogate as her opinions developed) that this is a "very complex case" both in relation to AS's "mental health and general functioning":

"[AS] has confirmed diagnoses of mild learning disability, generalised brain damage (specifically frontal lobe), identified personality disorder traits and, more recently, bipolar disorder has also been mooted by his new responsible clinician. These conditions interact and most surface-level symptoms are manifestations of one or more of these conditions... There are also a number of general factors, related to one or more of the above conditions, which influences AS's capacity in numerous areas. These are: AS's concrete thinking which limits his ability to think hypothetically leaving his understanding based on direct experiences only. AS often becomes quickly emotionally aroused and his inability to manage his behaviour at these times also prevents him thinking clearly or weighing

information, the affect needing to burn itself out before he becomes cognitively receptive again.”

29. She assessed his full-scale IQ as 67/68 which put him in the “high mild learning disability range”; the bipolar and personality disorder were more relevant to his emotional state. She added:

“... AS has sufficient intellectual understanding and verbal comprehension skills to manage most daily situations, albeit sometimes requiring assistance from others. However, in terms of his personality, he remains very fixated on his own needs, is impulsive and unable to delay gratification and can quickly become emotionally aroused and physiologically agitated often by minor provocation, across various situations and in relation to multiple individuals. The overall picture therefore is of a highly variable, changeable and difficult-to-manage individual due to a complex mix of problematic personality traits, learning disability ... some frontal lobe damage (impairing planning and emotional self-management) and the recently raised possibility of mental illness (bi-polar disorder).”

30. Dr. Hill’s views on capacity evolved (in some respects quite fundamentally) through her involvement in the case, and in the development of her thinking. She listened to AS’s ‘evidence’ in court; she listened to the brief evidence of the social worker in relation to the unaccompanied visit out of his supported accommodation, and she read counsels’ position statements. While the conclusions which she had reached, and set out in the written reports, have been overtaken by events, there is, in my judgment, still material of value within her evidence-gathering and analysis. She highlighted the relevance of the approach set out at #1.4.19 of the National Institute of Clinical Excellence and Care Guidance on ‘Decision Making ...’ which had :

“Practitioners should be aware that it may be more difficult to assess capacity in people with executive dysfunction⁷ – for example people with traumatic brain injury. Structured assessments of capacity for individuals in this group (for example, by way of interview) may therefore need to be supplemented by real-world observation of the person's functioning and decision-making ability in order to provide the assessor with a complete picture of an individual's decision-making ability”.

31. Her final opinion was summarised at the outset of her oral evidence. I distil her conclusions on the key issues as follows.

⁷ The NICE Guidance defines ‘executive dysfunction’: “The completion of tasks that involve several steps or decisions normally involves the operation of mental processes known as 'executive functions'. If these executive functions do not develop normally, or are damaged by brain injury or illness, this can cause something called 'executive dysfunction'. This involves a range of difficulties in everyday planning and decision-making, which can be sometimes hard to detect using standard clinical tests and assessments”.

32. *Capacity to litigate*: As I have outlined above, having initially opined that AS fell into the rare category of case in which P lacks subject matter capacity but has litigation capacity, she swung round to the view that this was a more conventional case in which AS lacked litigation capacity in line with his lack of subject matter capacity. She had had specific regard to the dicta in *Masterman-Lister v Brutton & Co. (No.1)* [2002] EWCA Civ 1889 at [75] and [79]:

“[75] ... the test to be applied, as it seems to me, is whether the party to legal proceedings is capable of understanding, with the assistance of such proper explanation from legal advisers and experts in other disciplines as the case may require, the issues on which his consent or decision is likely to be necessary in the course of those proceedings. If he has capacity to understand that which he needs to understand in order to pursue or defend a claim, I can see no reason why the law – whether substantive or procedural – should require the interposition of a next friend or guardian ad litem (or, as such a person is now described in the Civil Procedure Rules, a litigation friend)...

[79] ...a person should not be held unable to understand the information relevant to a decision if he can understand an explanation of that information in broad terms and simple language; and that he should not be regarded as unable to make a rational decision merely because the decision which he does, in fact, make is a decision which would not be made by a person of ordinary prudence.”

Dr. Hill was of the view that AS would not be able to think through the consequences of issuing instructions and lacked understanding of the information necessary to litigate in the current proceedings.

33. *Residence*: Dr Hill had initially advised that AS did have capacity to make decisions about his residence. At the hearing she told me:

“With extra reflection, I placed too much reliance on the practical matters and insufficient weight on structure and routine. If [structure and routine] is included, then he does not [have capacity], as he clearly does not understand that overarching component. He does not understand the need for boundaries.

Q: does he have the capacity to use/weigh the reasonably foreseeable consequences of deciding one way or another per the *MCA 2005*?

A: He cannot decide between the two choices: structured living and living on his own. His thinking is too simplistic and not nuanced enough to understand the implications of independent living and the effect on his well-being. He said

that he would not reject 1:1 but he was not able to say why. He said that it would be on his terms.”

34. I should make clear that I accept the submission of the Applicant and the Second Respondent (not materially challenged by the First Respondent) that ‘structure and routine’ are an integral (as Dr. Hill put it “overarching”, see above) part of the information relevant to a decision on residence; in many ways these characteristics mark the difference between supported and independent living.
35. *Care*: Dr. Hill concluded that AS does not have capacity to make decisions about his care. Although AS could articulate that he needs support, “he did not do so consistently, and was unclear what support was needed overall”. She added:

“The position is the same [as per residence]. I have always struggled with this. When I looked at my reasoning in relation to care, I realise that I have over-emphasised his ability to look at care plans and the specifics, and they only work because they are held together by staff being there 24/7. AS does not understand that as a concept in relation to his overall well-being. AS is very concrete in his thinking, and very focused on immediacy, and he struggles with the overarching structure and the nebulous; partly his resistance and partly his lack of ability to understand. He cannot consider the consequences of deterioration... he can focus on the practical but not otherwise. One piece of relevant information would be his understanding of *not* having the care. He would not understand the consequences of not having this care package. It is an inability to understand, and accordingly he cannot weigh this up”.

She added

“He is so changeable, with all the factors in play here – the multitude of severe issues, and it is not surprising that he is so changeable. His care package and residence needs to be responsive to that”.

36. *Contact with others*: In this regard, Dr Hill had maintained a consistent view that AS lacks capacity to make decisions about contact with others, including those known to him. This view was based on the “heightened complexity of social relationships and need for hypothetical and abstract reasoning skills, which AS lacks”. She indicated that while there may be a case for distinguishing between his capacity to make decisions around contact with *known* others and *unknown* others, he in fact was not able to understand, use or weigh information relevant to any third person.

Deprivation of liberty

37. I have scrutinised the detailed care plan. The applicant imposes a high level of supervision on AS throughout the day and night, in the supported living accommodation and in the community. He is not ‘free to leave’ his placement; that placement is imputable to the state. The social worker summarised the position thus:

“AS is under constant supervision and control and he lacks capacity to understand his care and support needs. It is agreed by his clinical team that his care plan does amount to a Deprivation of his Liberty ... this care plan and the restrictions proportionate...”.

38. Having regard to all of the matters set out above, I concur that the care plan does indeed deprive AS of his liberty, and am of the view that this can and indeed should be authorised by the Court pursuant to *section 16(2)(a) MCA 2005*.

Conclusion

39. In the final analysis, and at the conclusion of the oral evidence, the parties were of the same view – namely that AS lacks capacity in all of the areas outlined in this judgment. Dr. Hill confirmed that no amount of further information would be likely to make the difference to AS’s ability to exercise capacitous decision-making and that this lack of capacity was permanent. Having heard Dr. Hill’s oral evidence, and her thoughtful revision of her earlier-expressed views, I am satisfied that the evidence displaces the presumption of capacity in relation to AS’s decision-making on residence, contact, care and in respect of this litigation.
40. I am further satisfied that (a) AS is deprived of his liberty in a manner which is imputable to the state, and that (b) the deprivation of liberty is reasonable and proportionate given AS’s needs, and I am therefore prepared to authorise the deprivation of liberty in accordance with the care plan.
41. That is my judgment.