



**IN THE COURT OF PROTECTION SITTING AT OXFORD**

**BEFORE HER HONOUR JUDGE OWENS**

**Neutral Citation Number: [2021] EWCOP 21**

**CASE NO: 13405103**

**8<sup>TH</sup> AND 9<sup>TH</sup> DECEMBER 2020, HANDED DOWN ON (11<sup>TH</sup> JANUARY 2021)**

**X COUNCIL**

**Applicant, represented by Mr Parkhill, Counsel, instructed by the local  
authority legal department**

**- and -**

**BB and CB**

**First and Second Respondents, represented by Mr Lewis, Counsel, instructed  
by Miles & Partners Solicitors**

**-and-**

**AB**

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

**Third Respondent, represented by Mr Chisholm, Counsel, instructed by Guile  
Nicholas Solicitors**

**-and-**

**The NHS Trust**

**Fourth Respondent (not present for this hearing)**

1. This judgment is being handed down [in private] on 25<sup>th</sup> January 2021. It consists of 24 pages and has been signed and dated by the judge. The Judge has given permission for the judgment (and any of the facts and matters contained in it) to be published on condition that in any report, no person other than the advocates or the solicitors instructing them (and other persons identified by name in the judgment itself) may be identified by name, current address or location [including

school or work place]. In particular the anonymity of the children and the adult members of their family must be strictly preserved. All persons, including representatives of the media, must ensure that these conditions are strictly complied with. Failure to do so will be a contempt of court. For the avoidance of doubt, the strict prohibition on publishing the names and current addresses of the parties and the child will continue to apply where that information has been obtained by using the contents of this judgment to discover information already in the public domain.

2. I am dealing with proceedings concerning AB who is a 24-year-old woman. The First and Second Respondents are her parents. The Applicant and the Fourth Respondent are jointly responsible for her care pursuant to s117 of the Mental Health Act 1983 as a result of AB previously being detained under section 3 of that Act.
3. I have previously determined that AB lacks capacity to conduct these proceedings, make decisions about her residence, care and the contact that she has with others (D102).
4. There is a very long history of professional involvement with AB. AB is diagnosed with a congenital hemiplegia/cerebral palsy following a perinatal hypoxic brain injury. She has a diagnosis of Organic Personality Disorder as well as anxiety and depression and has left-sided weakness and loss of vision in her left eye. She has a full-scale IQ score of 85 on cognitive assessment.
5. AB has a history of multiple psychiatric admissions, imprisonment and breakdown of previous placements. She has violently assaulted people including care workers, committed criminal damage, set fire to her accommodation and has criminal convictions as a result. AB is awaiting sentence in the Crown Court in

respect of further assaults in January 2019, and for assaults upon members of the public, staff and the police in May and September 2019. She was remanded in custody in respect of the criminal proceedings in September 2019 and released on bail on 11<sup>th</sup> March 2020.

6. Proceedings commenced in the Court of Protection in London in March 2019 under the streamlined Re X procedure. Given the issues in the case it was not deemed suitable for determination under that procedure and proceedings were transferred to the SE Region. On receipt they were initially dealt with by HHJ Brown before being transferred to me in December 2019.
7. The issue that I have to decide is what is in AB's best interests regarding the care that she should receive because there is no dispute about where she should live or the contact that she should have with others. At the moment she is living in a care home (F House), having moved there in March 2020 when she was granted bail in the criminal proceedings. The arrangements for her accommodation have previously been found by me to amount to a deprivation of liberty and no party disputes this. At the last hearing I noted that the agreed aim was for AB to return home (9CC) and a recital on the Court order reflects this (D171). The detailed dispute that I need to determine about AB's care is which of two proposals designed to support her returning home should be pursued in her best interests.
8. In line with the majority of Court of Protection Cases since COVID-19, this has proceeded as a remote hearing, and members of the public have observed it in accordance with transparency provisions. I have read the Bundle and heard evidence from the independently instructed consultant clinical neuropsychologist Dr Prangnell, the social work manager, the Trust's consultant psychiatrist and AB's mother BB in the course of this hearing.

9. The Applicant's case is that AB should remain at F House in the short-term (approximately 3 months) with a plan to reduce the level of care provided to her there to no more than 1:1 before she returns to 9CC.
10. The First and Second Respondents want AB to return to 9CC in a timeframe of around 8-12 weeks and propose that AB should be supported by a care agency with a level of care that is initially 2:1.
11. The Official Solicitor on behalf of AB supports the proposal of the First and Second Respondents as being in AB's best interests.
12. Section 1(5) of the Mental Capacity Act 2005 reads:

"An act done or decision made under this Act for or on behalf of a person who lacks capacity must be done or made in his best interests."

13. Section 4 of the Act is headed "Best interests" and section 4(1) details what the court must not rely upon, namely:

"The person's age or appearance and a condition of his or an aspect of behaviour which might lead others to make unjustified assumptions about what might be in his best interests."

14. However, of course, section 4(6) sets out that:

"The court must consider as far as reasonably ascertainable:

- (a) The person's past and present wishes and feelings and in particular any relevant written statement made by him when he had capacity;

- (b) The beliefs and values that would be likely to influence his decision if he had capacity; and
- (c) The other factors that he would be likely to consider if he were able to do so.”

15. Section 4(4) states:

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

16. Before any decision is made on behalf of an incapacitated person, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person’s rights and freedoms of action in accordance with section 1(6). The Act requires the court to look at best interests alongside the least restrictive options. However, it is AB’s best interests which are the imperative and the least restrictive way of achieving those best interests is required.

17. The checklist of consideration for the court is set out at section 4(6) and it is not very extensive. However, it makes clear that the person’s past and present wishes and feelings are as important to someone who lacks capacity as they are to anybody else. I have reminded myself of the decision of Peter Jackson, J, in *Wye Valley NHS Trust v B [2015] EWCOP 60*, where he pointed out that a finding of lack of capacity does not operate as an off switch for her rights and freedoms. AB’s wishes and feelings may not necessarily determine the outcome of the case but

are a factor of significant importance, particularly if clearly and consistently expressed.

18. In *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67 at paragraph 45 Lady Hale opined:

“Finally, insofar as Sir Alan Ward and Arden LJ were suggesting that the test of the patient’s wishes and feelings was an objective one, what the reasonable patient would think, again I respectfully disagree. The purpose of the best interests test is to consider matters from the patient’s point of view. That is not to say that his wishes must prevail, any more than those of a fully capable patient must prevail. We cannot always have what we want. Nor will it always be possible to ascertain what an incapable patient’s wishes are. Even if it is possible to determine what his views were in the past, they might well have changed in the light of the stresses and strains of his current predicament. In this case, the highest it could be put was, as counsel had agreed, that ‘It was likely that Mr James would want treatment up to the point where it became hopeless.’ But insofar as it is possible to ascertain the patient’s wishes and feelings, his beliefs and values or the things which were important to him, it is those which should be taken into account because they are a component in making the choice which is right for him as an individual human being.”

19. I have also considered *N v A CCG* [2017] UKSC 22 which held that:

- The jurisdiction of the Court of Protection is limited to decisions that a person is unable to take for themselves and is not to be equated with that of the Family Court under the Children Act or the wardship jurisdiction of the High Court.
- Unless the desired order clearly falls within the ambit of s.15 (ie a declaration of capacity and/or lawfulness) orders are better framed in terms of relief under s16.
- S.17 did not confer power upon the Court to decide that a named care home must accommodate P or that a person providing healthcare must provide a particular treatment to P and this is consistent with aims of the MCA 2005 as originally intended.
- The court must therefore choose between *available* options.

20. There is, in fact, considerable agreement about the general way forward for AB. All parties agree it is in her best interests to return home and F House was never intended to be where she resides permanently. The issue that I have to determine is now very narrow as I have already noted. But that is not to say that the issue is not of critical importance, especially given the potential risks involved.

21. AB's wishes and feelings have not been entirely consistent as her recent views differ from ones previously expressed. That is not at all surprising given the progress that she has clearly made since she has been in F House. The social work manager's evidence confirmed the amount of progress that AB has made, and the Official Solicitor through Mr Chisholm's submissions has also highlighted how far AB has come. The earlier evidence about her wishes and feelings in the Bundle is that she found 2:1 supervision intolerably restrictive and that it led to her violent outbursts (for example, see F4, G1228, G1230, G1231). Mr Parkhill on

behalf of the Applicant emphasised how negative AB was about the possibility of returning home with support when discussing her experience of returning to 9CC after her first period of incarceration in 2018 (G1260 statement of the social work manager dated 17<sup>th</sup> February 2020). The views relayed by AB in that statement are undoubtedly striking since AB also told the social work manager that she had more freedom where she was in February 2020 than she had had at home. At the time the social work manager spoke to her, AB was in prison. The earlier wishes and feelings expressed by AB do seem largely consistent about how difficult she finds supervision, that she is not a 'people person' and that she views restrictive supervision by care workers as a trigger for her violent outbursts.

22. However, the most recent evidence about her wishes and feelings about supervision comes from the attendance note of her solicitor's meeting with her on 18<sup>th</sup> November 2020 (G2066-2069). At G2067 and G2068 it is common ground that for the first time AB demonstrated some acceptance of the possible need for 2:1 support in order to allow her home sooner. It is clear from AB's earlier comments in that meeting (G2066-G2067 para 4) that overall her preference would be for 1:1 support but, as the discussion developed, her solicitor explored the option of 2:1 support at least at first followed by a possible reduction (G2067 para 6). AB's response to this discussion is very positive, I find, compared to her earlier strong views against higher levels of support. AB commented "so it would be a sideways move. I'd be going where I want to be, but going back in the sense of having less freedom than at F House" and "2:1 at home will only not work if I don't have any freedom. I need a little bit of time to myself. I need to go out a bit to have time to myself" (G2067-G2068 paras 6 and 7). This is quite a mature and reflective view that AB is conveying, I find. Her wishes and feelings are not something that



are clear cut in this case and there is a clear difference between what she has consistently stated in the past and what she has said on 18<sup>th</sup> November 2020. What has remained consistent is her clear wish to return home and in fairness no party disputes that this is the case and that this should be the ultimate aim for AB as I have already noted.

23. Her wishes and feelings are not determinative as I have already noted, although they are clearly important and (as I will cover later in this judgment) link to other aspects of considering what is in AB's best interests.

24. Mr Lewis for AB's parents submitted in closing that there were multiple other factors that are relevant to my decision, citing AB's happiness, her values and goals, her mental health and emotional well-being, her safety, the sustainability of the care package, her right to family life, her engagement with activities and volunteering, and psychotherapy. No party takes issue with that list, though there are differences of emphasis and ultimately a difference of analysis when weighing those factors in the balance.

25. In relation to her happiness, her values and goals, her mental health and emotional well-being there is a clear link on the evidence before me to the issues around her engagement with activities and volunteering. Again, I do not think that is really in dispute, although Mr Chisholm for the Official Solicitor did raise a concern about the absence of any activities or volunteering for AB whilst in FH. All of the professionals involved in AB's care agree that she benefits hugely from engagement in activities and from volunteering. Mr Chisholm summarised those benefits as enhancing AB's self-esteem and enabling her to burn off energy. It is abundantly clear to me that AB derives enormous positive benefit from engaging in activities and from volunteering. In turn it is equally clear to me that these

positive benefits help AB handle other stress factors, based on the evidence of Dr Prangnell, the social work manager and AB's mother, BB.

26. However, it is equally clear (and again not really in dispute) that, as BB told me, AB must not feel that she is being forced to undertake activities or volunteer work. Applying one of the fundamental principles of the MCA, as far as possible AB must be enabled to participate in such things but only in so far as she wishes to and is happy to do so. Otherwise it is coercion of her, more likely to increase her frustration and anxiety and less likely to achieve the positive benefits that I have noted.

27. Enabling AB to have access to activities and volunteer work whilst she has been in F House has not been straight-forward, I note. It is accepted that she is currently residing outside of her local area and is reliant upon public transport. It is also accepted that, as recommended by Dr Prangnell, activities and volunteer work opportunities for AB should ideally be where her home is. He very clearly told me in the course of this hearing that someone with the sort of brain injury that AB has will struggle to generalise what she learns in one context to another and that her learning will be incremental, and that she will struggle with changes in her environment. By extension therefore she would struggle to adapt to carrying out activities in one location only to have to move them to another location with different people involved. Again, no party really takes issue with that.

28. The constraints of Covid-19 have added a layer of complexity to the practicalities around organizing activities for AB, something that is sadly inevitable for many people not just AB. This will no doubt include AB learning to adjust to the current necessities of physical social distancing and hygiene measures in public spaces and on public transport. The Trust's consultant psychiatrist also noted that AB is

going to need to adjust to these when he gave me his evidence. Given the geography concerned, using public transport to and from FH to activities or volunteering based closer to AB's home at 9CC was also going to be a limiting factor as well, even before COVID-19. It would be also be unfair to criticise the Applicant for AB not wanting to engage with any offered activities. There is also the complicating factor that the outstanding criminal proceedings will have contributed to a level of uncertainty about what volunteering opportunities may be available for AB to consider, and even a disposal by way of discharge at the forthcoming sentencing hearing in the Crown Court may limit which voluntary opportunities may be open to her. The further period of national lockdown will also have contributed to delays in identifying both activities and volunteering opportunities. BB told me that one of the options in the past which AB has really enjoyed was volunteering at the church foodbank but that is not currently operating due to COVID-19 restrictions. However, I think that it is a fair point to make that the Applicant and any care agency involved in the provision of AB's care do need to plan for activities and volunteering opportunities for her when she goes home and there must be a clear plan in place about that. The current care plan at H279-H280 (which dates from August this year) does record various activities that AB enjoys and also that she likes volunteering. However, it doesn't give any detail about what specific options may be explored for AB and more detail about this in fact appears in the Working with Risk Plan (dated October 2020) which appears at G1983-G2003 and explicitly covers a period of 5 weeks. It is validly raised by Mr Chisholm that, whilst it may be inherent in the plan that it will be reviewed at the end of each week and that the plan for week 6 onwards won't simply be repetition of earlier weeks, this should be made explicit in the plan. Mr Parkhill conceded this

point and I am grateful to the Applicant for accepting that – it can only help in a case of this sort of complexity and when we remember that AB has input to the plan and needs to understand what is proposed, I find.

29. I also have to consider the evidence of the consultant psychiatrist about the plan to enable AB to have community access. It was very clear that his opinion was that a slower and more cautious approach than in the current plan was appropriate. He gave me evidence about this being based on his considerable clinical experience and concerns about moving too fast to enable AB to adapt. However, the consultant psychiatrist accepted that he was not didactic about this view and was prepared to work with the rest of the professionals involved on a multi-disciplinary basis. He also accepted, when questioned by Mr Chisholm, that the plan was robust and had reviews built in at the end of each week which could function as firebreaks if required. It is perhaps pertinent to note at this point that the consultant psychiatrist's ability to work on multi-disciplinary basis has undoubtedly not been helped by his absence or the absence of the Trust's care coordinator from the weekly planning meetings. In saying this, I am not criticising the consultant psychiatrist who told me very clearly that he only works part-time and clearly would struggle to attend the meetings as well as manage his clinical appointments. I am less clear why there has not been more involvement from the Trust and the care coordinator in particular, though the consultant psychiatrist did tell me that there have been issues with one suffering a period of illness and a change in care coordinator too. Regardless of the reasons, it seems that all of the evidence before me makes it very clear that it would be a huge help to AB if the care coordinator were to be more involved in those regular meetings. Presumably that would also help the care coordinator with the co-ordination aspect of their role.

30. Time with her family is also clearly very important to AB and again there is no dispute about this. It also seems clear that AB must as far as possible be given options about this time, however, since the same concerns about forcing her to participate in activities will no doubt also apply to this.
31. The other important aspect of AB being able to access activities, volunteer work and time with her family is that the promotion of independence for her is undoubtedly important when one remembers that she is someone who has a right to respect for private and family life and that concepts of promoting autonomy and self-determination are of great significance in relation to incapacitated adults.
32. I will deal with therapeutic input for AB next as that is also an area that is largely uncontroversial. It is agreed that AB will not only benefit from therapeutic input of various types, but probably requires this if she willing and able to engage with it. It is also agreed, as the social work manager told me when asked by Mr Chisholm about this, that this should start sooner than later and should not wait for AB to return to 9CC. It is agreed that this should include some element of therapeutic input around helping AB to understand the need for support and supervision. Dr Prangnell was also very clear that therapeutic input for AB can be worked alongside standard neuropsychological support and I find that both neuropsychological and the other therapies or support services identified by him (1330 - including community mental health and specialist therapy services such as occupational therapy) should be explored as soon as possible and will give strong approval to the view that neuropsychological input is essential for AB in her best interests, as Mr Chisholm requested.
33. Safety is the next and perhaps most contentious aspect that I have considered. It is common ground that there are risks associated with either option before me. It

is also not in dispute that in the past AB has caused a high level of actual harm to others as well as exposing herself to significant risk of harm during some of her violent outbursts. The issue is around the analysis of likelihood of risk of harm associated with each option.

34. The Applicant's case essentially is that 2:1 staffing represents too great a risk. The evidence from the social work manager was that it will trigger further challenging behaviour from AB because AB has so consistently stated that this is the case and because of the history of her reaction to higher levels of supervision. Her evidence was clear that, in her view, 2:1 staffing is a trigger for AB's challenging behaviour and was more likely to provoke a 'meltdown'. AB is also currently subject to 2:1 staffing in F House but, as the social work manager told me, the size of F House compared to 9CC allows for staff to be less obvious, and the only recent incidents of challenging behaviour from AB were in the last week and were directed towards inanimate objects rather than people. As a result, the Applicant proposes that there should be a plan to gradually reduce support to 1:1 over the next 3 months and that AB should then go home with 1:1 support.

35. AB's parents and the Official Solicitor submit that a return home with 2:1 support would allow AB to return to a less restrictive regime than currently because she would be returning to her own home and this accords with her wishes. It is their case, particularly as put in evidence by BB, that 2:1 staffing is simply one of a number of potential trigger factors for AB. They ask me to consider that, essentially, any potential trigger arising from 2:1 staffing can be mitigated by ensuring that AB is able to spend time out of her home and engaged in activities. They also submit that her appreciation of the need for 2:1 staffing has developed.

36. Dr Prangnell was very clear in his evidence to me that when AB goes home she will need 2:1 staff support. He clarified that this may only be for a relatively short period and suggested that a period of 4 weeks with a review then may be sufficient. His report at I331 para 78 had indicated that he agreed with the independent consultant psychiatrist Dr Lohwala's opinion and rationale about the level of staff support that AB would require on returning to 9CC. Dr Lohwala's opinion about this was in his report dated 18<sup>th</sup> December 2019, I270 para 1.1. Both Dr Prangnell and Dr Lohawala were of the opinion that the 2:1 staffing level would only be required during the day so at night 1:1 would be sufficient. It is also clear that both experts were fully aware that AB may not accept the necessity for 2:1 support and that it may be trigger factor for her.

37. It is equally clear to me that the social work manager has carefully considered the risks associated with 2:1 support for AB, both in her written and oral evidence. The history in relation to AB's violence when frustrated at the level of restriction imposed on her is one that has clearly weighed heavily upon the Applicant's decision making and with good reason, I find. The social work manager also gave very clear evidence about her concerns in terms of the physical limitations created by the size of 9CC and I have seen the property plan (G2048) with dimensions. Despite BB telling me that staff members could simply spend all of their time in the second bedroom (which she deemed a 'staff room'), she did accept when I clarified this with her that they would need to leave that room to use the toilet and to access the kitchen. It is also a very small room in a small property so wholly unreasonable to expect even one staff member to spend the majority of their time in that room. As the social work manager told me, F House is larger and allows staff members to be more unobtrusive. This would clearly be more difficult at 9CC, I find. There

is also the aspect that, as BB told me, clearly AB doesn't regard F House in the same light as her own home at 9CC. It therefore seems quite likely that AB would regard the presence of any staff regardless of number more intrusive in her own property.

38. The Independent Social Worker (ISW) who assessed AB in October 2018 was of the opinion that AB did not require the support which had been in place up to that point (187). This support was 24 hours per day within her home and consisted of a support worker present at all times, increasing to two workers during the night. The ISW was also very clear that AB required input from a neuropsychiatrist and that her complex mental health needs as well as her other needs required a more considered approach combined with the input of wider mental health services. The ISW had noted that the presence of staff within AB's home may be a contributing factor towards her agitation and aggression and her overall conclusion that AB did not require 2:1 support is part of the evidence relied upon by the Applicant in seeking to establish that 1:1 support is in AB's best interests. However, the view of the ISW is more nuanced than this, I find. She noted that AB had complex needs and would require a multi-disciplinary approach as I have mentioned, and also noted that it was not just frustration at the presence of staff in her home that led to escalations in AB's challenging behaviours: "there are similar reports of public order offences with AB displaying violence and aggression whilst in the community" (181).

39. It is very striking that AB is now accepted by everyone to be in a much better place than previously. Mr Parkhill submitted that it was important that all of the good work that has been done is not lost and that AB is not put in a situation that undoes all of that progress. This is a valid concern given the history and not one that



should be dismissed out of hand, but the question is whether it tips the balance in favour of the Applicant's care plan.

40. Dr Prangnell's evidence is very clear that AB would be likely to need 2:1 care on her return home and that he was very cautious about the prospects of success if she were to return with less support. It was submitted by Mr Parkhill that I should prefer the Applicant's analysis of risk to that of Dr Prangnell because, as the social work manager told me, Dr Prangnell has had a far more limited involvement with AB compared to the Applicant. As I have already noted, the concerns expressed by the Applicant about the risks of 2:1 support are valid, especially in the context of the long and troubling history. However, it is not just the impact of that history that I have to consider, and I have looked carefully at that more recent evidence together with the history and all of the professional and expert evidence.

41. Dr Prangnell is a neuropsychologist and therefore has a particular expertise which is not the same as Dr Lohawala, the social work manager or the ISW. All of these, in fact, have areas of expertise and knowledge which need to be weighed and considered in relation to AB's best interests. Both the social work manager and Dr Prangnell told me, in essence, that their concern about the level of support for AB is that it should not set her up to fail. Their concern is the same, therefore, but their conclusions differ. In no small part this seems, in my view, to be due to the extremely finely balanced nature of the decision that has to be made. On the one hand I have a long history of AB reacting badly to 2:1 support and that creating extremely high levels of harm, as well as her previously consistent views opposing 2:1 support. On the other, I have evidence about how much progress AB has made whilst in F House and the change in view expressed by her about 2:1 support on 18<sup>th</sup> November 2020. I also have to weigh in the balance the evidence that AB can

clearly tolerate 2:1 support better in the community or the larger premises at F House than she has historically been able to do at 9CC. Against this background, I can see why the social work manager has reached the conclusion that it is better for AB to return to 9CC. That is not the same as saying that this means 1:1 support is in AB's best interests, though.

42. Both Dr Prangnell and Dr Lohawala were of the opinion that AB requires 2:1 support on her return to 9CC. Dr Prangnell made the very compelling point that returning to 9CC is going to be a change that AB will find stressful and need to adapt to, and this will require a settling in period. He was clear that he advocated a multi-disciplinary approach (much like the Trust's consultant psychiatrist) and also that it was very difficult to predict how AB would cope so he recommended frequent reviews to counter this. He also recommended spending some blocks of time at 9CC before she returned there permanently, as well as time to get to know her care givers. I was very struck by his evidence in answer to questions from Mr Chisholm about weighing the risk of AB refusing to return to F House at the end of the trial periods at 9CC. He pointed out that it was important to involve AB in planning her return to 9CC and for her to be able to see a clear and agreed timeline over which events were taking place. He was of the view that the resulting buy-in from her would be itself a mitigating factor about that risk of refusing to return to F House.

43. Dr Prangnell also gave me very clear evidence about the way in which AB will struggle to generalise skills across different contexts, and this may pose problems for her in transferring what she has learnt at F House to 9CC. He was equally clear that it is very important for AB to get to know her carers before she goes home, and that consistency will be important for the care agency staff in their approach to

providing AB with support once she is home. Partly as a result of her difficulty with generalisation across different contexts, he recommended getting her involved in activities closer to 9CC so that she can continue those once she returns there.

44. He was equally clear that, in his view, 1:1 care for AB whenever she goes home will not be safe for either her carers or for her, given her difficulty with generalisation and the stress of returning home and even though this is her home and somewhere she has lived before. I do note that when she lived there before and the 2:1 support was last in place this was not long after she had experienced the undoubted trauma of being in prison. It was also without the period of stability that she has had at F House and without input from a neuropsychologist to help identify what her needs may be, and how those may best be met.

45. The social work manager's evidence about the two most recent incidents involving AB at F house was also striking. She was very clear that these showed AB directing her frustration towards inanimate objects rather than people and, whilst they are clearly still of concern, they are not at the same sort of level as has previously been the case. Mr Chisholm noted that their timing so close to this hearing may also not be a coincidence and I agree with that observation. These incidents underline rather than contradict the evidence about AB being in a much better place as a result of her time in F House, I find, and makes it less likely that she would react as strongly to 2:1 support as she has done in the past.

46. I have also been mindful of the likely impact upon AB of failing to acknowledge her clear wish to go home sooner rather than later and find that this is also a factor which will potentially impact upon her ability to cope with any support. Put simply, it seems very clear from the all of the professional evidence before me that the

longer AB has to wait to go home the greater the risk that she will become frustrated by that, and that this will contribute to challenging behaviour.

47. There are also some practical potential benefits to 2:1 support which Dr Prangnell and BB set out in their evidence. Dr Prangnell mentioned that, from a safety perspective, it would provide an additional person to help respond to and manage any outbursts from AB. BB notably described it as having “two sets of wits” to bring to bear. In fairness, I don’t think the Applicant disputes that these are potential benefits to the 2:1 ratio, it is simply that their analysis of the balance between these benefits and the risk of the staffing ratio itself causing outbursts from AB means that they conclude the greater risk lies with outbursts being triggered and that counters the potential benefits.

48. I have given careful consideration to the evidence from the social work manager about the potentially negative impact upon AB of having a period of time when she is going out unescorted in the community and periodically going home only to face more restriction in the 4 week period when she returns to 9CC. She also very properly highlighted that 2:1 support will represent a more restrictive option for AB, therefore. Her evidence about this was careful, considered and I think genuinely from the standpoint of someone who was trying to understand things from AB’s perspective and to try to identify the least restrictive option for AB. As someone who has clearly had considerable involvement in the case it was therefore important evidence. However, the evidence from Dr Prangnell about the risk of AB going home with 1:1 support and a further incident resulting in her being subject to even greater restriction was compelling, I find.

49. The other compelling aspect of Dr Prangnell’s evidence is around AB’s need to have a target date for her move. The Applicant proposes that she should go home

in 3 months' time, a change from their previous position which had been more subject to her being ready to go home only when she was ready for 1:1, I think. The Applicant therefore also accepts that it is necessary to commission a care agency and the social work manager told me that this could be done within two weeks. AB's parents are clearly very dissatisfied with the actions of the Applicant around identifying and commissioning a care agency and had originally sought to ask me to give some indication about which agency may be approached. However, through Mr Lewis, they now accept that this is outside of my jurisdiction given the judgment in *N v A CCG*. Mr Chisholm on behalf of the Official Solicitor also expressed some concern about the stage the Applicant has reached in commissioning a care agency in light of their plan for AB to return to 9CC in 3 months. Again, it is not within my jurisdiction to be able to do much more than note that, whilst this is a clearly a very complex case involving a very finely balanced decision about the care and support that AB will need when she goes home, AB can only be assisted by all of those involved in her care working together (as both Dr Prangnell and the Trust's consultant psychiatrist pointed out) and doing so in good time so that everyone including AB has time to absorb the plan. I include AB's parents in this, since in my view AB's best interests at this stage are better served by a greater focus on helping AB move forward working with the agencies involved rather than what has happened in the past.

50. On balance, I find that that AB best interests require that she have a care plan for 2:1 support for the initial period of her return home to 9CC. I find that 1:1 support on her initial return home would not be sufficient to deal with the risks associated with the stress of her returning home and would potentially mean that AB would very quickly be subject to even more severe restrictions. 2:1 support for a short

period whilst AB transitions to 9CC is therefore the least restrictive option overall. Whilst 2:1 support at 9CC does have some risks associated with it, I find that these risks are mitigated by ensuring that AB has a clear target date to work towards for going home, that she has a detailed care plan both before and after going home which includes therapeutic support for her and access to activities and available volunteering opportunities, that there is neuropsychological input to her care plan, that regular and frequent reviews take place, and that before she moves preparation is undertaken to introduce her to her carers and to give her trial periods at 9CC. The Official Solicitor also recommends that AB should be given specific psychological support to help her understand why 2:1 support may be necessary, and that this is in addition to more general psychological support. I would endorse that suggestion as in AB's best interests. Combined with the more positive place that AB is clearly in at this point, I find that this will reduce the likelihood of 2:1 support alone acting as a trigger to challenging behaviour. For the avoidance of doubt, during the period that AB remains in F House the plan offering AB options to undertake activities (including any available voluntary work) should cover the whole of the period that she remains there and not just 5 weeks, and will also need to note that this is subject to ongoing review and will be lead by AB so may be subject to change.

51. In light of my findings above, I will therefore make the following declarations and orders:

52. I declare that AB lacks capacity to decide where she should live, the care that she should receive and the contact that she should have with others, pursuant to s. 15 MCA.

53. It is my determination, pursuant to s21A(2), that the mental capacity qualifying requirement is therefore met (para. 15 Sch A1 to the MCA) but that the best interests qualifying requirement is not met for her continuing residence at F House beyond the 12 week date referred to below (para. 16, Sch A1 to the MCA).
54. Accordingly, pursuant to s.21A(3) I direct the Applicant to terminate the standard authorisation no sooner than 8 weeks and no later than 12 weeks from the date of handing down of this judgment in draft form on 10<sup>th</sup> December 2020.
55. It is in AB's best interests for her to move to 9CC with a package of care comprising 2:1 staffing during the day (with a minimum of one female staff member on duty at all times)) and 1:1 at night (which must be a female carer), and that the move shall take place no sooner than 8 weeks (4<sup>th</sup> February 2021) and no later than 12 weeks (4 March 2021) from today.
56. I will direct that by 4pm on 8<sup>th</sup> January 2021 the Applicant shall file and serve a detailed plan from the commissioned care agency setting out how they will manage AB at 9CC.
57. I will direct that the parties shall hold a monthly round table meeting to plan the transfer, to include the care co-ordinator or a designated representative of the care co-ordinator. The agreed minutes of those meetings must be filed no later than 5 working days after each meeting.
58. Once AB has moved back into 9CC, the Applicant shall file and serve a statement exhibiting a 4-week review, having sought the parties' input into that document before filing.
59. I will list a review hearing on [21<sup>st</sup> April 2021] at 10am, time estimate 2 hours, to be conducted remotely via CVP. This hearing may be vacated by consent.

60. I was asked by Mr Chisholm to consider listing what effectively would be an interim review hearing in February 2021, and Mr Lewis asked me include permission to the parties to bring the matter back to court before April if there is a dispute about the planning that cannot be resolved without input from the court. Whilst I can understand the concerns of the Official Solicitor and AB's parents, in my view neither of these directions are necessary. It is open to any party to apply to bring the matter back to court by simply filing a COP9 and, whilst I agree that a long-stop review date is required (which all parties in fact agree) in light of the issues in this case, I am not persuaded that an interim review hearing will do more than reinforce reliance upon the Court when what AB requires is collaborative and constructive working amongst the parties. It is clear to me that the proceedings have themselves placed a toll upon AB and that also has to be taken into account when considering whether anything more than a long-stop review is required.

61. I will conclude by noting that notwithstanding the dispute around the level of support for AB when she returns to 9CC, there is actually a remarkable level of consensus about the way forward for AB. This is to the credit of all concerned, particularly AB herself who, as Mr Chisholm highlighted, also sat patiently through 2 days of this wholly remote hearing.



HHJ Eleanor Owens  
25<sup>th</sup> January 2021

