

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

Sessions House,  
Lancaster Road,  
PRESTON

Date: 12 October 2022

**Before:**

**HIS HONOUR JUDGE BURROWS**

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**Between:**

**LANCASHIRE & SOUTH CUMBRIA NHS  
FOUNDATION TRUST**

**Applicant**

**-and-**

**LANCASHIRE COUNTY COUNCIL**

**- and -**

**AH**

**Respondent**

**(By her ALR, RE)**

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**Adam Fullwood** (instructed by **Hill Dickinson**) for the **Applicants**  
**Ben McCormack** (instructed by **Southerns, Burnley**) for the **Respondent**

Hearing dates: 7 October 2022  
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**JUDGMENT**

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 AH 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.

## **HIS HONOUR JUDGE BURROWS:**

### **INTRODUCTION & OVERVIEW**

1. This case concerns a lady of 46 who I will call Anna (or AH). That is not her real name, but I wish to protect her privacy.
2. Anna lives in a city in the North West of England. She suffers from type 1 diabetes. Provided she is treated properly and consistently with insulin, Anna is able to live happily and healthily. However, if she is not, she is at significant risk of serious harm and even death.
3. Prior to the events I describe below, Anna lived independently in her own flat in the community. Matters came to a head at the very end of last year when she was admitted to a local general hospital suffering from acute confusion and high blood glucose. She was subsequently admitted to critical care with developing cardiorespiratory failure secondary to diabetic ketoacidosis. At that time Anna had been without insulin being prescribed for several months.
4. At the end of her prolonged stay in the general hospital, when she was medically fit for discharge came the issues that gave rise to these proceedings.
5. In very simple terms the issues are these. Anna suffers from mild learning disability. There is a suggestion that she may also have a personality disorder. In the past, she has been very difficult to engage and manage in her diabetes care. Those responsible for that care are clear that her continued health- indeed, her survival- depends on their ability to ensure she receives regular administration of insulin. However, experience has shown that this is near impossible in the community.

6. Therefore, the Applicants initially applied to this Court for an order that Anna be admitted to a care home placement for assessment. I granted that application. It was hoped she would only need to be in the care home for a few weeks, following which a care plan in her own home could be formulated following the assessment process. That has not happened and, at the moment the Applicant considers it necessary for AH to continue in a care setting possibly in the long term.
7. That was earlier this year. There have been considerable difficulties with capacity evidence in this case- the details of which I will address later on. However, in order to obtain a definitive capacity assessment the Court directed a single expert report from Dr Camden-Smith. There was some delay in this, for reasons I will not explain here. The matter was listed for a one day hearing today to deal with the issue of capacity alone.
8. In the event, the parties agreed that there was no need to challenge the expert evidence, and neither was it necessary to hear from any other witnesses. The one exception to that was that Anna herself did want to speak to me- as she had done in April.
9. This judgment is concerned only with the issue of capacity.
10. Following brief submissions, I gave a very brief oral decision. That was that I was satisfied that Anna lacks the capacity to make the decisions with which the Court is concerned. I promised to give fuller reasons in writing. This is my judgment.

## **A BRIEF HISTORY**

11. Anna's history was contained in the records and in a Chronology taken from her GP and community records.

12. It seems that she was subject of care proceedings as a child which focused on her relationship with her father and the fact that she appeared to have been neglected, with no attention being given to personal care needs. She attended a special school at that time. There seem to have been concerns that Anna's father's behaviour was "strange", insisting that she should not be examined in his absence. At the same time, there was concern that he was unable to care for her or meet her needs.
13. There was involvement of a diabetes nurse and the diabetic clinic. She appears to have been the patient of both diabetes clinics and the community mental health team in Blackpool in the early 2000s. As early as 2005 there is an entry: "Refused insulin as 2 nurses present". This hints at the issues that were to come with her diabetes care. She was also recorded as "not taking insulin and eating chocolate deliberately".
14. Anna has had involvement with and input from the community mental health team (CMHT) where she lives since 2018. There have been ongoing concerns over her physical health from diabetes nurses. She has shown a reluctance to register with GPs despite being offered assistance in doing so by the CMHT.
15. In December 2021, matters reached a crisis point when Anna was admitted to hospital suffering from the serious and life-threatening consequences of her failure to take adequate insulin. The problems facing those responsible for Anna's care are most clearly highlighted in the Discharge Planning Meeting of 26 January 2022:

"[Diabetes Nurse] had a case discussion with Dr A, Diabetes Consultant. Dr A. confirmed capacity assessment had been completed yesterday (25.01.2022) by a junior doctor on the ward. Doctors focused on Anna's understanding of outcome of not accepting insulin and effects of this. Anna is knowledgeable about Ketoacidosis. [Nurse] informed Dr A that the issues are around the barriers Anna is highly likely to put in place when discharged. Historically Anna has refused insulin from District Nurses and would not accept required amendments to the diabetic care plan despite risks to her safety. This needs to be discussed with Anna, to determine whether she will accept any changes to her insulin

medication, and if she will accept involvement from the Diabetic Nurses, who she has previously refused to work with causing her to move her seek input from the Diabetic Consultant in Blackpool..... Whilst the outcome of the Capacity Assessment was that Anna has capacity in this area, members of the MDT expressed concerns about this and that the hospital had not created the detailed, easy read version of a care plan for Anna's insulin upon discharge and had potentially failed to ask detailed questions covering the proposed clinical intervention required / diabetic care plan.”

16. Then came a contribution from the Community Learning Disability Nurse which in my view identifies a major issue in this case:

“[Nurse] requested a clear capacity assessment focusing on a definitive answer if Anna will accept the care plan implemented going forward, highlighting concerns around Anna's fixation on a sliding scale of insulin.”

17. In answer to that question, the following is recorded:

“Anna remains medically fit for discharge, with ongoing Diabetes Specialist Nurse review for blood sugar levels. Yesterday Anna demonstrated she needed insulin therapy and District Nurse input for insulin therapy, in agreement with this. Capacity assessment documented on Anna's inpatient notes on 25th Jan at 16:07, looked at understanding the diabetes and need for treatment, completed by Dr A. Dr confirmed Anna was able to demonstrate understanding of her diabetes, she is aware of T2 following testing and understands the risk of not taking her insulin. Anna demonstrated ability to retain information, was able to make informed decisions based on the information and can provide reasoning for refusing, Anna refused to give her own insulin, due to needle phobia, which Dr A stated contributed to her weighing information. Anna is able to communicate her needs in full. Anna stated she wishes to allow the District Nurses to administer her insulin to help manage her diabetes.”

18. However, there was obvious concern that Anna was dictating to the treating team certain requirements that may, in fact, be a way of frustrating the treatment entirely.

The Locality Lead for Learning Disabilities:

“.....expressed concerns around Anna's requirements of the District Nurses providing her insulin. Anna has previously stipulated where the District Nurses can park, have to provide name of person administering insulin and telephone 30

minutes before arriving. District Nurses previously stated they did not have capacity to meet these requirements. Anna continues to blame the District Nurses for not meeting her requirements and provided this as a reason for her declining health, [the locality lead] expressed her view that this highlights lack of capacity. Anna has repeatedly stated that her recent hospital admission is the District Nurses fault, which is why the care agency was presented as an option for administering Anna's insulin, because Anna was declining District Nurse involvement. However, Anna has now expressed she wants them involved in her care again. It was highlighted within the MDT that this is a fundamental part of discharge planning around who will provide this care in the community, and assessing her capacity against this.

19. Later, the service manager of the agency providing care:

“.....provided historical context and informed the MDT that Anna historically neglected herself in regards to her diet. [Agency] staff have attempted to support Anna with cooking and bathing. Anna began moving appliances out of her kitchen - cooker, microwave and fridge freezer were potentially removed by Anna, as [Agency] staff were unaware of any plans. Anna has historically had issues with rigid thinking, and this has been exacerbated since injuring her shoulder and furthermore since additional care agencies become involved. Concerns were raised that the more people become involved, the more paranoid Anna can become, and will decline multiagency information sharing. Anna previously would allow information sharing between District Nurses but not care providers. [service manager] felt the LD nurse involvement around health has been a positive step for Anna. The importance of sharing information was highlighted, and has been reiterated to Anna, to keep her safe and have a robust MDT approach to her care

20. It has to be said, that at that meeting it was abundantly clear that the issue of capacity in this case was complex. This was particularly so because a proper assessment of Anna's needs and how they could be met in the community was required and that may involve a further stay in some form of facility or residential placement- raising issues not only of care but also residence and because of Anna's clear reluctance to engage, her deprivation of liberty.

21. Indeed, by the MDT meeting of 2 February 2022 a consultant nurse from the Trust:

“.....expressed concerns that the care plan is currently focusing on what District Nurses are able to deliver and expressed concerns that historical risk indicates lack of engagement on discharge”

22. This was a very pertinent concern. According to the figures given in the MDT that in October 2020 out of 62 planned visits, District Nurses accessed Anna’s property only 8 times. On 13 occasions they were unable to contact her. On 41 occasions she declined access to them. In November 2020, she refused her insulin on 37 occasions.
23. That was, of course, the period leading up to the crisis admission at the end of December and the very real risk to Anna’s life.

**DR CAMDEN-SMITH**

24. Dr Camden-Smith is a consultant Psychiatrist with a specialism in Neurodevelopmental Disability Psychiatry. She was jointly instructed to carry out a capacity report on the following decision-making areas:
  - a) Conducting these proceedings
  - b) Making decisions about residence
  - c) Making decisions about her care
  - d) Making decisions about diabetic care/treatment
  - e) Consent to the arrangements giving rise to a deprivation of liberty.
25. It is interesting that Dr Camden-Smith immediately focused upon the records prepared by Ms Hutchinson, then a community learning disability nurse, later a

consultant LD nurse (and Mental Health Act approved clinician). In July 2007, she quoted a psychiatrist who had commented on Anna:

“She clearly has an extremely paranoid outlook on life, anxious traits and depressive traits and also passive aggressive traits. She doesn’t appear to suffer with a formal mental illness. In my opinion she probably has a mild learning disability (full scale IQ 65). It looks like she has had a lifelong paranoid and suspicious personality associated with anxiety, depression and passive aggressive traits. I think that the most likely diagnosis.”

26. Furthermore, at that time Ms Hutchinson was very concerned about Anna’s behaviour around members of staff. There had been harassment of staff, with Anna developing an obsession with one and following another to their home. Hutchinson said:

“...staff need to be maintain extremely precise and clear boundaries given recent events staff should not give any personal information, telephone numbers or addresses Consistency within the staff team is important as any discrepancies are likely to lead Anna to make paranoid conclusions all explanations and information should be agreed by the staff team in advance and kept to consistently. Staff need to be very open and honest when information has to be shared with other professionals. It is also important for staff not to have conversations amongst themselves when she is present or in her hearing as she is likely to misinterpret the information she overhears. Sometimes people with paranoid personality disorder do need either anti-depressant medication or small doses of anti-psychotic medication during stressful periods although of course this is unlikely to alter the underlying disorder. At this stage I would not recommend any medication.

27. Later, in July 2015, Ms Hutchinson recorded:

“She has many characteristics of a Borderline/Emotionally Unstable Personality Disorder but as I understand, this has never been formally diagnosed. The Learning Disability Psychologist plans to carry out this assessment in the near future. Reason for referral this episode is that Anna is presenting with a consistent obsessive delusion which has become all-consuming for her. Due to her inability to emotionally regulate, both obsession and delusion are not unusual for her, but my current concern is that these “beliefs” are affecting her health and wellbeing, both physically and mentally, to the extent that she claims she has made herself homeless (as she is afraid to return home) and she has also received a verbal caution from the police for harassing/stalking a staff member who has chosen not



to work with her anymore. The staff member had explained to Anna why she could not work with her anymore (witnessed by me and the staff members manager) and Anna was understandably very upset. That same evening, Anna went to the staff member's house, who in turn contacted the police. Anna was quite scared as a result of the police intervention but following this, she has "not gone home" and is consistently saying that she and the staff member will "be together again", "will live together" and will "go and see a solicitor together". These beliefs seem to underpin all her thoughts and actions to the detriment of her health needs and everyday living in general.

28. Dr Camden-Smith recognised that capacity in this case was difficult and recorded that there had been differing outcomes to capacity assessments within the currency of these proceedings.
29. One aspect of Anna's history the expert focuses on is her social and adaptive functioning. It seems to me this is the central issue in Anna's case. As Dr Camden-Smith puts it:

"[AH] has a long history of seeking care in dysfunctional ways, often by complaining about others or demanding the unattainable from them. She has become obsessively attached to support staff, to the point at which some staff have not been able to work with her anymore and the police have had to be involved".

Also, her:

"care seeking behaviour is predominantly through making complaints and presenting with a variety of physical health concerns. She fosters complexity and confusion, and this is exacerbated by her refusal to allow agencies to speak to each other".

And finally,

"[a] large part of [AH's] behaviours appear to have the function of eliciting care, albeit in a highly dysfunctional and maladaptive way. For instance, she insists

that her insulin be administered by others because of her needle phobia, however failed to take oral medication that would have avoided her having to take insulin. [AH's] care team hypothesise that her increasing demands regarding her care needs have been precipitated by the presence in her building of a woman with substantial physical disabilities who required high levels of care (including 24 hours 1:1 care) and [AH's] desire to have the same level of care as this resident”.

30. In the section of Dr Camden-Smith's report entitled **Mental State Examination** the expert goes into some detail of her interview with AH. I note that the interview was conducted over a video link due to the constraints of time. Although the interaction between the expert and AH were probably not as complete as they would have been had they met face to face, I am satisfied that Dr Camden-Smith has given a great deal of consideration to what AH has said and that is reflected in the comprehensive report. In particular, although AH is noted to be very suspicious, Dr Camden-Smith does not consider her to be paranoid to a clinically significant degree.
31. The expert also considers AH's diet which is said to include foods that the SALT has advised her not to eat due to a choking risk. This is so she can prove she is not at risk of choking.
32. Then there is the 2012 care plan that AH developed for herself. This was an extremely detailed care plan about the care and support she wants and how she wants it delivered. To quote the report:

“...she stated that the district nurses must phone her before they visit, that they must only park in one particular spot, and that she will only accept her insulin from certain members of staff. This is impossible to follow, not least because some of the members of staff no longer work for the district nursing team. This care plan also details the type of insulin device she will accept as well as the dose of insulin. ....this is not possible as the insulin device is no longer manufactured, nor are the insulin cartridges that fit it ”.

33. AH repeatedly refers to the 2012 care plan and to how it is not being followed.
34. Dr Camden-Smith's opinion on diagnosis is extremely important in order to understand the issue of capacity. AH has a confirmed diagnosis of mild learning disability, with which Dr Camden-Smith agrees. However, she is also clearly of the view that there are traits of personality disorder that ought to be explored, with the expert concluding AH almost certainly has a disorder of at least moderate severity:

“her clinical team are exploring the possibility that she may have an additional personality disorder due to her interpersonal difficulties, rigidity, egocentricity and inability to compromise or take the viewpoints of others into account. The most likely personality disorder is one of paranoid personality disorder, which is characterised by pervasive distrust and suspicion of others, the unjustified belief that others are trying to harm you, suspicion about others' motives, holding grudges and a view of the world as hostile. There may also be a degree of attachment difficulties in terms of her intense attachment to some members of staff who then inevitably let her down and she shows some features of emotionally unstable personality disorder”

35. In addition, Dr Camden-Smith concludes there is evidence that AH is autistic. Again, this is an area those treating her shall explore.
36. In conclusion on the question of diagnosis, Dr Camden-Smith says this:

“Although there remains uncertainty about whether or not [AH] would meet the diagnostic criteria for other mental disorders such as a personality disorder and autism, I see little benefit in pursuing additional named diagnoses. [AH's] clinical team know her well and have a clear, considered and effective formulation of her needs which is much more important in providing her with the suitable care, treatment and support than a specific diagnosis would. It would be extremely helpful to [AH's] care if her clinical team were able to speak to her mother to get more information about [AH's] childhood and the origin of her difficulties.”

37. I shall summarise Dr Camden-Smith's conclusions on capacity before considering the legal tests.

38. In relation to AH's capacity to make decisions as to residence, the crux of the issue is her:

“.....inability to understand that the care package she wishes to be supplied to her in her flat is simply not possible. [AH] is further incapable of using and/or weighing the information that she does understand due to her extreme egocentricity and rigidity and refusal to take reality or other views into account. She clings determinedly to her wishes even when these are quite simply impossible. **This is due to a combination of her learning disability and personality traits (potentially autism as well) and has been a consistent factor throughout the years that she has been known to local solicitors and her care team.** Learning disability and autism are lifelong immutable conditions, whilst personality disorder can be amenable to therapy, but this has not been effective in [AH's] case. For these reasons it is my opinion that [AH] will not gain capacity in this area”

(emphasis added)

39. The same is true of her ability to make decisions concerning care and support. Her attitude towards her care and support needs (and how they can be met) follow a similar path of not being able to understand her obsessional attachment to people, as well as the maladaptive way she seeks to obtain certain types of care and support. In particular:

“[AH] does not understand that she has emotional, psychological and mental health needs and that her care needs extend beyond managing her diabetes. She does not identify with other residents at [the care home], stating ‘this is a residential unit for people with mental health, I don't *have mental illness*’. Whilst it is true that [AH] does not have a formally confirmed diagnosis other than learning disability, she has substantial mental health needs relating to her anxiety, emotional dysregulation, disordered attachment and maladaptive coping strategies. She requires a care plan that prevents staff burnout and supports professionals to work with her in a collaborative way that maintains relationships with her in the face of multiple challenges.

40. It is this inability to recognise, let alone to understand that she has mental health needs due to a combination of learning disability and personality disorder (and perhaps autism) that makes it impossible for her to understand that her own chosen care plan

is not feasible. Further, she is unable “to understand the consequences of her behaviour on the care that she receives and continues to behave in maladaptive ways despite repeated evidence of the harm that this causes to her”.

41. For these reasons, Dr Camden-Smith also considers AH to lack the capacity to make decisions about information sharing, restrictions that amount to a deprivation of liberty and to litigate in these proceedings.
42. Dr Camden-Smith does conclude that AH is not deprived of her liberty at the care home because she is not “subject to continuous supervision and control”. None of the legal representatives in this case consider that to be correct, and neither do I.

## **THE LAW**

43. Since those representing AH did not challenge Dr Camden-Smith or her conclusions I need only deal with the law briefly. It is important, however, that I do comment on the legal framework for reasons that will become apparent.
44. The law is contained in the early sections of the Mental Capacity Act 2005 (MCA). There is a presumption of capacity which may only be rebutted by evidence which is accepted by the Court on the balance of probability.
45. Capacity is issue and time specific. One can lack capacity in a particular area at one stage in time but possess it at another. Equally, one may have capacity in one area but lack it in another.
46. Then there is the diagnostic and functional tests of capacity in ss 2 and 3 MCA. There needs to be an inability to make decisions as per s 3(1), and that must be caused by the impairment of or disturbance to the mind of P.

47. In this case, it seems to me that the central issue giving rise to what Dr Camden-Smith identifies as AH's incapacity is complex- with elements of personality disorder and perhaps Autism exacerbating the effects of AH's learning disability on her ability to make decisions about her care and treatment.
48. As a result of the failure of the attempts made to provide care and treatment in the community due to AH's "maladaptive strategies" that she does not (and cannot) understand the need arose for her to be placed in the care home for assessment and care. In assessing AH's capacity, the primary decision is whether AH is able to decide to reside at the care home. However, that decision involves an ability to understand why she is there. For the reasons given by Dr Camden-Smith, AH is unable to understand that, and that is because of her learning disability along with traits of personality disorder and autism.
49. It seems to me this is a clear example of the expert moving away from treating capacity decisions in "silos", but rather considering how making decisions about different subjects interact with each other.
50. It seems to me that Dr Camden-Smith has considered the correct relevant information in her assessment, including crucially the reasonably foreseeable consequences of making the decision one way or another- as has most recently been made clear in A Local Authority v JB [2021] UKSC 52.
51. The decision concerning residence and care involves whether AH would be able to receive her insulin in a consistent way if she were to live at home? There are very compelling reasons to believe that she would not- mainly derived from past experiences, but also from her present approach to her care and treatment, which is based on a wholly unrealistic assessment of her needs and how they can be met, and

on the fact that she has mental health problems. Put another way, she is incapable of understanding the issue because of her learning disability and other features identified by the expert.

52. I am persuaded by Dr Camden-Smith's report. I declare that AH lacks the capacity to make decisions about residence, care, sharing information concerning her physical and mental health and care, and to conduct these proceedings.

### **STANDARD AUTHORISATION & THE COURT**

53. During these proceedings an issue arose which troubled me. It concerns the interaction between the assessors for Schedule A1 of the MCA (the so-called DOLS) and expert evidence in this Court.

54. A psychiatrist, Dr Oraegbunam carried out an assessment of AH's capacity in March 2022 for the DOLS process. He concluded that she did not lack the capacity to make the relevant decisions. However, I had before me an assessment from a clinical psychologist, Ms Guzman. She approached the assessment of capacity in what I consider to have been a more appropriate way, and certainly closer to that adopted eventually by Dr Camden-Smith. She focused on AH's long standing and inflexible thinking style and her inability to accept that there is anything about her that needs to change (viz. mental health).

55. I do not think it is necessary to deal with the merits of the assessments at that time. I made orders in relation to AH's capacity and best interests on an interim basis, and I did so on Ms Guzman's compelling evidence and because of the potentially grave consequences for AH if I did not and her insulin regime once again stalled.

56. However, the practical effect of my decision was that AH was a detained resident in a care home, but subject not to the safeguards under the DOLS, but that of the Court. It also meant that I was not able to reconfigure these proceedings under s.21A of the MCA, thereby entitling AH to non-means tested legal aid. Fortunately, due in part to the Trust's willingness to help with funding and AH falling below the threshold whereby she would have to fund her own legal team, this did not have any adverse effects on AH.
57. It seems clear to me that where a court appointed expert reports on a case in which capacity is in dispute, and that expert concludes that capacity to make decisions as to residence and care are absent, that should be sufficient for the mental capacity requirement of Schedule A1 to be met without more.
58. However, after discussing the matter with experienced counsel, instructed by experienced solicitors in this case, there appears to be no way this Court can enforce such a conclusion.
59. Clearly, where any of the assessments are challenged by way of s.21A, the Court has the express power to vary or terminate the standard or urgent authorisation. However, that power is predicated on there being such an authorisation in place. What the Court cannot do is hear a challenge to DOLS capacity assessment which concludes that P has capacity, because then there will be no standard or urgent authorisation to challenge/vary/ terminate.
60. There was a discussion as to what a supervisory body (in this case Lancashire County Council) can do, if anything, where the assessor concludes that P has capacity. The assessors are, of course, independent of the supervisory body. That is necessary in order to make the process compliant with Article 5 of the ECHR. It would be



unfortunate as well as very costly, if the supervisory body had to judicially review one of their assessors because that assessor reached a view that conflicted with a decision of the Court (see analogously, albeit within the context of the Mental Health Act where a Responsible Clinician challenged his own Hospital Managers in respect of the discharge of a patient: South Staffordshire and Shropshire Healthcare NHS Foundation Trust & Whitworth v The Hospital Managers of St Georges Hospital [2016] EWHC 1196 (Admin).)

61. It would be sensible, it seems to me, if the Local Authority as supervisory body agrees that P lacks capacity, that the author of the report ought to carry out the assessment for the purposes of the DOLS, if that is possible. Alternatively, I would expect any mental health or mental capacity assessor to have access to the report and any judgment such as this that has dealt with the issue of capacity.
62. For those reasons, I give permission for Dr Camden-Smith's report and this judgment to be disclosed to any mental health or capacity assessor in respect of AH.

## **CONCLUSION**

63. That is the judgment on capacity. The matter of best interests and, in particular, where AH ought to live in the future will be considered at a hearing just before Christmas.