

**THE HIGH COURT**

[2022] IEHC 518

**High Court Ref. WOC11127**

**WARDS OF COURT**

**IN THE MATTER OF JD**

**RESPONDENT**

**JUDGMENT OF Ms. Justice Niamh Hyland delivered on 24 August 2022**

**Summary**

1. This case concerns a 19 year old man, JD, who has bipolar affective disorder and has experienced significant familial disruption. It gives rise to the difficult question as to how to evaluate and assess capacity where there is medical evidence – in this case from eminent psychiatrists – expressing divergent views. No explicit test for evaluating capacity exists under the Lunacy Regulation (Ireland) Act 1871 (the “1871 Act”). Rather, the High Court is charged with deciding whether a person is of unsound mind and incapable of managing their person or property. Under the Assisted Decision Making (Capacity) Act 2015 (the “2015 Act”), the position will be quite different. Section 3(2) of that Act identifies a specific four-part test for assessing capacity. Although that Act has not yet been commenced, medical practitioners have been availing of s.3(2) as a tool for assessing capacity under the 1871 Act. In this case, at least three of the principal psychiatric witnesses employed it.
2. A person may have capacity in some areas but not others. The 2015 Act requires an identification of the specific areas where a person’s capacity requires to be assessed. It specifically provides that a lack of capacity in one area does not prevent that person having capacity in other areas. The existing regime, on the other hand, tends towards a

more global assessment of capacity but even that is likely to necessitate an identification of the relevant areas where capacity is at issue.

3. In this case, those areas are the following: how JD approaches his enduring mental illness i.e. bipolar affective disorder, and in particular his approach to taking medication for same, how JD conducts himself in his current environment i.e. a residential placement where he lives pursuant to Orders made by this Court under its wardship jurisdiction, and how JD approaches the question of his future, including where he would like to live.
4. Unwise decisions do not connote a lack of capacity. So, for example a decision not to take medication, made with an understanding of the consequences of same, and a decision to live with those consequences, does not indicate a person lacking capacity, even if it is likely that the decision to avoid medication will have negative consequences for that person. In this case however, for the reasons set out below, I have concluded that JD's patchy compliance with his medication even with significant support by the staff, is indicative of a lack of a capacity rather than a conscious decision to avoid taking medication.
5. Where possible, a court should look not just at the person's identified wishes but also at their conduct in relation to those spheres of decision making. Often, in cases necessitating a capacity assessment, a court will have available to it evidence in relation to a person's behaviour in respect of those spheres. Past behaviour may be highly relevant to a capacity analysis.
6. Here, JD's words and actions are distinctly at odds. In interviews with the psychiatrist giving evidence on his behalf, Dr. Hillery, JD has identified that he understands the need to be compliant with his medication. Yet the extensive evidence available of his actions over the last 20 months indicates the opposite. Despite (a) having information

indicating that medication works very effectively for him in controlling his bipolar illness and that without medication he is likely to relapse into a psychotic and at times violent state, and (b) having information that such a relapse will militate against his strongly expressed wish for independent living in [X], JD has very frequently been non-compliant with his medication regime in various ways.

7. Similarly, in relation to his extensive assaultive and sexually inappropriate behaviour towards staff in the residential setting where he lives, information is available to him that such behaviour will make his goal of living in [X] unachievable and may precipitate his entry into the criminal justice system. Yet he has continued to persistently engage in that behaviour, even during periods when his bipolar illness was firmly under control.
8. That disconnect between his words and actions is relevant to an assessment of capacity. In this case, I have concluded that JD's behaviour over a 20 month period (despite extensive support from his treating team) has been so consistently at odds with his fervently expressed goal of returning to [X] that it is indicative of a lack of capacity, either because he cannot understand the information in relation to the consequences of his actions, or because, if he can understand it, he cannot use or weigh appropriately.
9. The lack of appropriate use or weighing of information may be discernible either through a person's words or their conduct. In this case, JD can appropriately reflect the information in discussion at times, but cannot reflect that belief in his actions, i.e. he expresses an understanding of the importance of taking his medication but nonetheless has resisted taking it over a prolonged time.
10. A proportionate approach is necessary when analysing capacity; if the behaviour and refusal to take medication consisted of isolated incidents, then, particularly given JD's youth, it would be disproportionate to conclude it was significant evidence of lack of

capacity. Unfortunately, that is not the case here as JD's pattern of behaviour has been consistent over time.

11. When assessing capacity, the person must be placed in an appropriate context. JD is a young man having just turned 19 and his actions and approaches to decisions must be evaluated from that point of view.
12. Finally, the Court must be satisfied that it can assess capacity having regard to the living situation of the person in question. It was argued here that JD had failed to demonstrate capacity because he has not yet been in an independent living environment. Based on the evidence, I conclude JD has had an opportunity to take actions and express his thoughts and desires in relation to the relevant spheres of decision making while in his residential setting. This means I can evaluate his capacity. The fact that the placement is resisted strenuously by him and he is not in an optimum setting does not undermine my ability in this respect.

### **Factual and procedural background**

13. JD is a young man aged 19 from [X]. He is the son of MD and has three siblings. His father is not in his life. He has suffered from mental illness since 2011 and has now been diagnosed as having bipolar affective disorder. He has spent a considerable amount of time in foster care and is now in residential care in Co. Westmeath. He has also spent some time in psychiatric units.
14. The evidence establishes the following chronology of events in relation to JD's placements:
  - (i) 1 December 2020 to 16 April 2021 - involuntary detention in the Department of Psychiatry, CAMHS, in Merlin Park Hospital, Galway as an inpatient pursuant to the Mental Health Act 2001.

- (ii) 17 April 2021 to 17 June 2021 - residential placement with Nua Healthcare.
- (iii) 18 June 2021 to 30 July 2021 - involuntary detention in the Department of Psychiatry CAMHS in Merlin Park Hospital, Galway, as an inpatient pursuant to the Mental Health Act 2001.
- (iv) 20 August 2021 to 19 January 2022 – residential care in Westmeath.
- (v) 20 January 2022 to 10 February 2022 - Department of Psychiatry, in Donegal.
- (vi) 11 February 2022 to date – residential care in Westmeath.

15. The Westmeath facility is run by Nua Healthcare, a private residential care provider.

JD has an apartment within the house. Nua served a discharge notice on the HSE on 9 May 2022 requiring that JD’s placement within Nua be terminated. However, Nua have agreed to keep JD until an alternative placement can be found for him.

16. This matter initially came before the Court on 18 November 2021 by way of an ex parte application from the HSE seeking an inquiry under s.12 of the 1871 Act to take JD into wardship. On that date the Court made several Orders, appointing a Guardian ad Litem (“GAL”), (being Mr. McGrath, solicitor), directing, pursuant to s.11 of the 1871 Act, that a Medical Visitor attend JD on behalf of the Court as well as a detention Order and several other ancillary Orders relating to his detention and treatment. The applicants sought liberty to issue a Notice of Motion, and this was made returnable to 3 December 2021. On the same date the detention and treatment Orders were continued.

17. The Court’s Medical Visitor filed her report on 1 December 2021 and on 8 December 2021 the President of the High Court signed the Notice of Inquiry. JD was personally served with the originating Notice of Order on 7 January 2022. Through his GAL, JD

filed a Notice of Objection on 15 March 2022. The detention Orders in this case have been reviewed on the following occasions:

- (i) 3 December 2021
- (ii) 14 January 2022
- (iii) 24 February 2022
- (iv) 7 April 2022
- (v) 2 June 2022
- (vi) 21 July 2022
- (vii) 29 July 2022

18. The above Orders were made pursuant to the High Court's inherent jurisdiction to make Orders in wardship on an interlocutory basis pending the inquiry hearing determining JD should be taken into wardship. In this case, the inquiry hearing took place on 17 August 2022. The application to take JD into wardship is made by the HSE. The application is strenuously opposed by JD, who has lodged a Notice of Objection through his GAL, Mr. McGrath, solicitor.

19. On behalf of the HSE, I heard evidence from Dr. Sharma, consultant psychiatrist, Clinical Director (Intellectual Disability), Nua Healthcare, who is JD's treating psychiatrist in Nua and from Dr. Haley, Executive Clinical Director and consultant psychiatrist in General Adult Psychiatry with Donegal Mental Health Services, standing in for Dr. O'Donnell, JD's treating consultant in Donegal Mental Health Services. I had the benefit of medical reports from Dr. O'Donnell and Dr. Randall, consultant clinical and forensic psychologist.

20. On behalf of JD, I heard evidence from Dr. Hillery, consultant specialist psychiatrist to the Talbot Group and to the Muiriosa Foundation, and Chairperson of the Mental Health Commission.

21. I received two medical reports from the Court's Medical Visitor (who is of course independent of either party) Dr. Hunt, consultant psychiatrist, Ballinderry Clinic, Mullingar, Co. Westmeath.
22. Finally, I heard from JD himself and from his mother, MD, both of whom made submissions to me.

### **Legal test**

23. In deciding whether to admit JD into wardship I must first consider whether he meets the relevant legal test i.e. whether he has capacity. The 1871 Act identifies that a person lacks capacity when they are of unsound mind and incapable of managing their person or property. I have approached this question on the basis that there is a presumption of capacity and that it is for the HSE to displace that presumption.
24. When considering the question of capacity under the existing legal regime, the Court does not generally isolate a given decision or decisions that a person seeks to make and consider their capacity to make those decisions. Rather, a global assessment of capacity is made addressing the person's ability to manage their affairs across the board. This normally, although not invariably, encompasses both personal and financial decisions.
25. That approach will be altered when the 2015 Act comes into force. This establishes a new approach to determining capacity. First, it does not consider capacity globally, but rather requires an identification of the area in respect of which capacity is to be assessed and an evaluation of a person's ability to make decisions in that area.
26. Section 3(6) makes it clear that capacity is assessed in relation to individual areas of decision making and not globally, providing as follows:

*“(6)The fact that a person lacks capacity in respect of a decision on a particular matter does not prevent him or her from being regarded as having capacity to make decisions on other matters.”*

27. Second, there is a specific statutory test for assessing capacity at s.3(2) as follows:

*“(2) A person lacks the capacity to make a decision if he or she is unable—*

*(a) to understand the information relevant to the decision,*

*(b) to retain that information long enough to make a voluntary choice,*

*(c) to use or weigh that information as part of the process of making the decision, or*

*(d) to communicate his or her decision (whether by talking, writing, using sign language, assistive technology, or any other means) or, if the implementation of the decision requires the act of a third party, to communicate by any means with that third party.”*

28. I refer to the new regime, despite it not yet being in force, because both Dr. Sharma and Dr. Hillery, when considering the question of capacity, employed the four-part test identified by s.3(2). Dr. Sharma assessed JD’s capacity in relation to two distinct areas. The first was decisions in relation to his medical treatment regime and his place of residence. The second was in relation to the negative behaviour JD is displaying in the context of his placement in Westmeath. In relation to the first set of decisions, he concluded that JD did not have capacity. In relation to the second set of decisions, he concluded JD had capacity.

29. On the other hand, Dr. Hillery assessed capacity on a more global basis, while singling out for particular consideration JD’s capacity to make lifestyle decisions, including in respect of medication, treatment, work and place of residence. He concluded that JD had capacity overall.

30. Even though the 2015 Act has not yet been commenced, I consider that the four-part test is a useful tool for assessing capacity, although it is certainly not the only permissible approach.



31. In respect of the areas I must consider, I have looked at the following issues that confront JD at present:

1. Decisions in respect of his enduring mental illness, in particular the taking of medication.
2. Decisions as to how JD will conduct himself in his environment.
3. Decisions in relation to his place of residence.
4. Decisions in relation to his occupation and future activities.

32. In assessing JD's capacity to make these decisions it is appropriate to look not just at the situation at the date of the hearing, but also at the position over the period for which I have evidence i.e. from 1 December 2020 to date. I will therefore evaluate JD's capacity by reference to his stated intentions and conduct over that time.

33. I must also bear in mind that JD is a young man just having turned 19 and therefore his actions and approach to decisions should be evaluated from that point of view. Particularly in relation to his compliance with medication, I am conscious that it is not at all uncommon for patients to be concerned about side effects of medication and be reluctant to take it and that this situation, without more, could not be considered to establish a lack of capacity.

34. I have distinguished in this judgment between JD's words and his actions, a point emphasised by Dr. Haley in particular. At times JD has articulated a point of view that would, if taken at face value, strongly indicate capacity in the relevant area. Indeed, it seems to me that much of Dr. Hillery's conclusions were based upon JD's words and his discussions with JD. JD's articulation of his understanding of issues and intentions in relation to same is of course important. However, JD's behaviour is also critically important in determining his capacity. As Dr. Sharma pointed out, a decision on a particular issue is often made up of multiple small decisions made over time. For

example, when evaluating whether someone has capacity to make decisions in relation to the taking of medication (including of course a decision to refuse to take medication), it may often be very useful to look at the behaviour of that person relating to medication on a daily basis to evaluate their capacity in that area. Because I have had the benefit of detailed evidence in respect of JD's behaviour over the last 20 months, I am able to evaluate both his words and his actions. Dr. Sharma and Dr. Haley have placed considerable emphasis on JD's conduct over the relevant period and it seems to me this is an appropriate approach.

35. Finally, at the hearing, Dr. Hillery contended that JD has failed to demonstrate capacity because he has not yet been in an independent living environment where he would have an opportunity to do so. He argued that JD has not had the chance to have a young adult life or function in a normal setting and that, absent such a setting, his capacity cannot be properly evaluated.
36. If I accepted that point, then it might be impossible to assess JD's capacity at all. In such a situation the presumption of capacity would mean that I would be obliged to refuse the application by the HSE to admit JD into wardship.
37. In a somewhat related point, Mr. McGrath, GAL, says that because there was no opportunity to place JD in [X] after he left the Department of Psychiatry, JD had no chance to demonstrate his ability to engage in community services and he would have been in a better position coming before the Court had he stepped down to [X] in February 2022.
38. I am not persuaded that I cannot assess JD's capacity at this point in time. My analysis of JD's decision-making below demonstrates that JD has had an opportunity to take actions and express his thoughts and desires, albeit while in a residential setting. Indeed, his actions have been carefully recorded precisely because he is in a residential setting

and has been the subject of Orders. This detailed recording has permitted me to analyse his capacity in various areas by reference to very precise evidence over an extended period of time. The fact that the placement is resisted strenuously by him, and he is not in an optimum setting from his point of view, does not undermine my ability to assess his capacity. It is certainly plausible that, had he stepped down to [X] in February 2022 as identified by Mr. McGrath, and his behaviours had settled because of that, it might not have been necessary to bring an application for wardship. But I do not accept that JD is disadvantaged in this capacity assessment because he has not had an opportunity to make decisions that might demonstrate his capacity.

## **Evidence**

39. I summarise below the evidence of Dr. O'Donnell, Dr. Haley, Dr. Randall, Dr. Hillery and Dr. Hunt. However, I have decided not to try to summarise the evidence of Dr. Sharma as it is extensive, and I will identify it in the context of my discussion of the issues. It suffices to say that he considers that JD has a limited understanding of his mental disorder and related treatment, that he lacks the capacity to make treatment related decisions which will lead to poor compliance and place him at high risk of relapse, that he fails to take into account relevant information, that he requires staff to help him on a day to day basis to assist with activities of daily living, that he lacks the capacity to make residence and care/support decisions, that he has shown aggressive and sexually inappropriate behaviour towards staff and on one occasion towards a member of the public, that he resists care and treatment and that he lacks the capacity to make residence related decisions.

### ***Evidence of Dr. O'Donnell***

40. Evidence was given by Dr. O'Donnell, consultant psychiatrist with Donegal Mental Health Service on behalf of the HSE. The first report of Dr. O'Donnell of 11 February 2022 is in fact relied upon by Mr. McGrath in his opposition to wardship for reasons that will become clear. However, Dr. O'Donnell also provided a short addendum to that report on 28 July 2022 and when his evidence is considered in the round, I do not believe it is supportive of JD as having capacity.
41. Dr. O'Donnell was JD's treating psychiatrist while he was in the Department of Psychiatry in Merlin Park and he provided a report the day after JD left. He notes that he interviewed JD on three occasions while JD was an inpatient. Dr. O'Donnell summarised JD's past violent behaviour, referring to damage JD caused to his mother's home and to his foster carer's home and to his apartment in Westmeath. He refers to JD breaking his TV, pulling the doors off kitchen presses, breaking crockery and glasses and attempting to break windows. JD broke a laptop in half following an assessment online by Dr. Sharma. He has punched the perspex off a TV unit. He broke a curtain pole in a shower and attempted to use it as a weapon towards staff. He broke staff's glasses. On 26 November 2021 JD broke a microwave and freezer in the central kitchen and damaged everything in the living area of his apartment including cups, bowls, plates, fridge, shelves, a TV cabinet, kitchen presses etc.
42. He noted that during JD's time on the unit in Donegal, staff found him easy to deal with and that he was at all times pleasant and personable and appropriate. He notes that the possibility of ADHD was ruled out. In respect of capacity, he stated that the staff in Donegal noted a period of improvement in his capacity which helped allay fears that he was a person of unsound mind and permanently lacking capacity. He says that it is his opinion that JD's capacity has been impaired and is likely to improve significantly in the foreseeable future. He concludes that with some consistency in his improvement in

capacity, he could foresee a time when JD can be assessed as having capacity and step away from the wardship process. In those circumstances, Mr. McGrath's reliance upon this report is unsurprising.

43. However, in his updated opinion of 28 July 2022, Dr. O'Donnell identifies that JD had not maintained the improvement in functioning he displayed in Donegal. He identifies that JD was repeatedly informed in Donegal of two facts – that he was not allowed to return home to his mother due to Tusla concerns about JD being in the house with his younger siblings, and that it was necessary for him to maintain his behaviour on return to Westmeath to achieve his primary stated goal of returning to [X]. Dr O'Donnell observes that:

*“The decline in functioning on return to NUA with sexually inappropriate behaviour and assaultive behaviours in NUA has been attributed to a desire to sabotage his placement and return to [X]. If that premise is true, then that would suggest [JD] doesn't understand and retain the information given especially as to likely consequences or he can't use the information to make decisions”.*

44. He goes on to say that JD appears to have a limited understanding of the world around him and there is no thought process evident as to how he might achieve his goals. He notes there is a dissonance between how JD appears to present well in interview at times and how he then lacks capacity in understanding and retaining information, and in his decision making.
45. He concludes that JD's subsequent actions in Nua and the community betray the appearance of capability that he presented in a highly controlled environment in Donegal for 4 weeks.

***Evidence of Dr. Haley***

46. Dr. Haley has prepared two reports being 2 August 2022 and 8 August 2022 on behalf of the HSE. He also gave oral evidence. Mr. McGrath, GAL, has argued that I should place little or no weight on his evidence given that he did not examine JD and was not his treating psychiatrist. I certainly accept that Dr. Haley's evidence should be given less weight because of the absence of an examination of JD, but I am not persuaded that I should ignore his evidence for the following reasons. Dr. Haley is familiar with JD's case since he first presented to CAMHS in Donegal in 2011. He has knowledge of his admission to Merlin Park and then his transition to Nua Healthcare services. He helped facilitate the admission of JD to the Department of Psychiatry in Donegal. He also notes that he has discussed the matter with Ms. Strain, social worker and attended two multidisciplinary case conferences in July 2022 in which the capacity arguments in these proceedings were reflected upon. That knowledge and experience of JD is sufficient to allow me to rely upon Dr. Haley's evidence.

47. Dr. Haley identifies the constituent elements of a care plan if JD is deemed to have capacity. He concludes in his opinion that:

*“The longitudinal evidence of unbalanced decision making, ill-judged choices and a reckless disregard of consequences alongside a documented history of an Axis I Mental Disorder, namely Bipolar Disorder, form the basis for the current treating psychiatric Consultants, Dr Sharma and Dr Colin O Donnell to favour the view that capacity is sufficiently impaired to meet the criteria for unsound mind”*

48. In his second report of 8 August 2022, he notes that JD appears to lack the capacity to learn from experience and that any periods of improvement such as his time in Donegal are short lived.

49. In his evidence to the Court, Dr. Haley noted that for brief periods JD projects as having full capacity but longitudinally this improvement is not maintained. He notes that JD makes reckless decisions, that there is a lack of balance, and he does not understand the consequences of his actions. He points to the 2:1 nursing ratio that operates in Westmeath meaning that JD has two nurses with him at all times (with both nurses requiring to be male due to the sexually inappropriate behaviour JD displays) and the restriction of JD from the common areas in Nua because of his behaviour. He notes that JD's decisions have set his goals back considerably. In the circumstances he concludes that JD does not have enough capacity to escape a finding of unsound mind.

***Evidence of Dr. Randall***

50. The HSE also relied upon the report of Dr. Randall of March 2022. By way of context, it is important to understand that this report was obtained to assess JD's level of risk for violence and sexual assault and to make recommendations for his future care and does not express any opinion on capacity.

51. Dr. Randall concludes that JD presented a high risk for sexual and violent acting out towards staff and that his use of violence was instrumental in that he had a clear purpose motivating his behaviour. He recommended that JD be discharged from Nua and he stated he did not see evidence of a psychological disorder.

52. In my view this report is of little assistance to me in assessing capacity since it is not directed at the question of capacity and no view is expressed by Dr. Randall in this respect. Nor indeed does Dr. Randall refer at all to JD's bipolar diagnosis. I therefore place little weight on this report as evidence of JD's capacity.

***Evidence of Dr. Hillery***

53. Dr. Hillery is a very eminent psychiatrist with vast experience, including in relation to assessments of capacity, *inter alia*, in his capacity as a medical visitor for the High Court. He provided a detailed report of 18 July 2022 where he addressed the question of JD's capacity and gave an opinion of the analysis of Dr. Sharma. Dr Hillery summarised the previous reports that he had been provided with and he also considered the report from the person in charge of the unit. He interviewed JD on three occasions, twice by video link and once in person. He discussed JD with the person in charge ("PIC"), on two occasions. He also discussed JD on a number of occasions with Dr. Sharma.
54. He noted that JD made some statements suggesting a lack of understanding of the options open to him, but he also described various areas where JD was able to clearly identify his goals and where he could look for support in respect of his physical and mental health.
55. He reports JD describing his behaviour as being attributable to the fact that he does not want to live in Westmeath and wants to return to [X], including his aggression and his non-compliance with medications, assessments, and program planning. He concludes his behavioural issues were explained by his rebellion against his current placement and were understandable in that context although they might damage his chances of achieving his aspirations for independent living. Dr. Hillery concludes that over the course of the three interviews he presented with no signs of mental ill-health. Dr. Hillery said that JD's understanding of the needs of a young man of his age living independently were what Dr. Hillery would expect from someone his age. Dr Hillery identified that he presented as a normal young man of 18 years of age.
56. He concludes that it is not possible to say that JD is incapable of managing his own affairs. He believes JD meets the criteria of the fourfold test. In relation to part (c) he



says it is difficult if not impossible to say that JD cannot weigh up alternative options and consequences where he is in a situation where he sees no option for himself but to cause problems, so he can achieve his ambition which is to return to [X]. In respect of the desire to live at home with his family, he noted that this was congruent with his age and did not indicate a lack of capacity. Dr. Hillery concludes that JD understood the need to continue taking medication and discuss any changes with his doctors and concludes that he has capacity in this regard. He notes that there is no guarantee that he will continue to take his medication as prescribed and this is an issue with many people, especially young people, on long-term medication.

57. In relation to JD's behaviour, he notes that it is instrumental and thus within his control and therefore he concludes that JD retains capacity to make decisions related to his sexually and physically aggressive behaviour towards staff. I explain below why I do not agree that the voluntarism that appears to exist in relation to JD's behaviour equates to capacity.

58. As I discuss above, in his oral evidence he identified a concern that JD's capacity could not be assessed in his current placement. I have explained above why I do not agree with that assessment.

### ***Evidence of Dr. Hunt***

59. Dr. Hunt is a consultant psychiatrist employed in private practice She provided a report of 30 November 2021 after having carried out an in-person examination on JD in Westmeath on 29 November 2021. JD remained in bed throughout the meeting and chose not to leave the bed or speak to her at all despite invitations to do so.

60. In relation to the capacity analysis, Dr. Hunt observed that in her assessment JD showed no ability to make any decision to weigh information in the round, to appreciate the importance of information or of a decision, to give reasons for a decision, to listen to

an explanation, recall what he was told or to communicate a decision. She observed that despite his adequate verbal intelligence he was quite disabled by his ambivalence, his lack of insight and his lack of judgment.

61. After receiving Dr. Hillery's report, it was decided that a further report of Dr. Hunt should be obtained. Dr. Hunt visited JD again in Westmeath on 4 August 2022 and this time he engaged well with her in the company of two staff members. She reported on 15 August 2022.
62. She noted that JD had shown a pattern of inappropriate behaviour including the assaults on his mother and sister and sexually inappropriate behaviour in Nua. She concluded he had poor insight into his mental illness and seemed to believe the Westmeath facility staff members were in part responsible for causing his illness. She noted JD distanced himself from his own agency in his inappropriate behaviour, having a tendency to blame others for episodes of inappropriate behaviour, such as explaining that the two staff members had caused his "*hypers*", that he would be fine if he were just living at home, that he had been on the wrong medication when he hit his family members, the foster carers had not met his needs, the foster care was "*messing with my mind*", that he had made complaints about the Westmeath facility and one foster parent to the relevant authorities, that he would have hobbies if he lived elsewhere, and that it was hard to remember the events of foster care. She concluded that this showed JD's limited insight into his role in the events leading to his being in Westmeath. She concluded that JD was not able to manage his health/medical and residence affairs in that he could not communicate a clear decision, show that he could understand and weigh information in the round, appreciate the consequences of his decisions, and think through the sequelae of any given decision. She noted that as he is a young person with a still changing personality and brain plasticity, his capacity should be reviewed in one to two years.

63. Dr. Hunt has been criticised by Mr. McGrath, GAL, for observing that it is difficult to see how the appropriate supports could be achieved for JD if he were not a ward of court. I do not think this statement correctly reflects the position in this case. Whether or not JD is a ward of court, he will be entitled to support from the HSE. I have seen nothing to suggest that such supports will not be made available to him absent wardship. On the contrary, I have been provided with evidence from Dr. Haley and from Mr. Cartin, social worker, as to what supports will be sought to be provided should JD not be admitted to wardship. In the circumstances, my decision as to whether to admit JD into wardship is solely dictated by questions of capacity and the appropriateness of exercising my discretion in this respect and has not been influenced by the availability or otherwise of supports.

64. Dr. Hunt was also criticised by Mr. McGrath for indicating in her report that JD was already in wardship, with Mr. McGrath arguing that this undermined the totality of her reports. However, as detailed above, JD is the subject of existing Orders detaining him in Nua made following the invocation of the High Court's interim wardship jurisdiction. In those circumstances, Dr. Hunt's description of his situation was understandable. Moreover, I am quite satisfied that Dr. Hunt fully understood that the purpose of her report was to consider whether JD had capacity. Her description of his legal status did not affect her consideration of that question or her conclusions therein.

### **Submissions of JD and MD**

65. MD, JD's mother, related the history of JD's illness and the difficulties she had in obtaining assistance in the early years of his illness. She is obviously devoted to JD and wants the best for him. In particular, she wishes for him to have the chance to return to [X] and be near his family and friends, particularly his siblings who he has not seen for

some considerable time. She feels JD deserves a chance to be out and that he is more than capable of making his own decisions.

66. I had the benefit of hearing from JD directly. He is a personable and compelling young man. He described his years in various schools in [X], and how he left school early. He described his experience in the CAMHS unit in Merlin Park and how he disliked it. He stressed his desire to keep in touch with the friends he made from school in [X] and how he was concerned about losing touch with them. In response to a question as to why he behaved negatively towards the staff in Westmeath, he indicated it was because he wished to distract himself. He confirmed his strong desire to leave Westmeath and return to [X].

#### **Capacity in relation to illness**

67. I start my analysis of JD's capacity with a consideration of capacity in relation to his illness. Unfortunately, JD has a very serious medical condition i.e. bipolar affective disorder. This has had very detrimental effects on his life. In December 2020 he assaulted his grandmother. He had previously assaulted his sisters and his mother. The assault on his grandmother appears to have taken place when he was psychotic because immediately after that he was admitted to Merlin Park. He was detained on an involuntary basis under the Mental Health Act 2001 and therefore by definition he was at that stage suffering from a mental disorder. When he recovered, he went to Westmeath on 20 August 2021.

68. He experienced very significant difficulties in that setting and in late 2021 Dr. Sharma recommended that he attend an inpatient psychiatric unit in Donegal to ensure that his medication was correct and that he was fully compliant with same. He spent 3 weeks in hospital in Donegal in early 2022 and then returned to Westmeath. In other words, JD cannot but be aware that his mental illness has caused significant disruption in his

life, has led to extended time in psychiatric settings and has caused or contributed to violent behaviour towards his family. Indeed, JD indicated to me that he found the experience in Merlin Park to be unpleasant. As per the evidence of Dr. Sharma, it was clear after his stay in hospital in Donegal that the medical team had managed to find the appropriate dose of medication and that he responded very well to that medication.

69. However, despite the negative consequences associated with his mental illness not being controlled by medication and despite the effectiveness of medication in treating his mental illness, JD has unfortunately chosen not to comply with his medication regime. He has done so in two different ways – first, by refusing to take his medication or by taking it inconsistently, and second, by refusing to have his bloods tested to assess his medication levels. This refusal is not an outright one as at times he takes his medication and permits his bloods to be tested.

70. Dr. Sharma's report of 7 January 2022 covers the period 30 November 2021 to 6 January 2021 i.e. prior to his stay in the Department of Psychiatry in a hospital in Donegal. He details 35 instances of JD either refusing his medication altogether, or afternoon or evening medication being withheld due to initial refusals by JD of his morning medication. In this judgment, I intend to focus principally on the period post JD's stay in the Department of Psychiatry as at this stage his bipolar disorder was being better addressed by medication. However, the evidence available to me in respect of JD's behaviour prior to his inpatient treatment demonstrates a pattern of consistent difficulties in taking his medication.

71. In a report of 29 March 2022, Dr. Sharma identifies that on 15 occasions in the report period (16 February to 29 March) JD refused to take his medication and on other days required considerable persuasion to eventually take it, thus delaying his medication time by several hours and causing medication to be withheld.

72. In a report of 10 May 2022, Dr. Sharma identifies 10 medication refusals and also identifies that JD will often refuse medication up until the last minute to take it and that JD requires a lot of encouragement to take his medication. JD often questions why he is on medication, stating that it causes him to gain weight and that he wishes to reduce his medication.
73. In Dr. Sharma's report of 1 June 2022, it is reported that JD refused to take the medication on 6 occasions between 10 May and 1 June 2022. There were 12 occasions where the afternoon medication was withheld due to JD being asleep in the morning and could not be woken and therefore the morning medication was late and so the afternoon dose had to be withheld.
74. In a report of 8 July 2022 Dr. Sharma identifies that JD can have many refusals and can accept medication in his hand before spoiling it by putting it down his underwear or into the toilet or sink.
75. JD has explained to Dr. Sharma that he is reluctant to take his medication because of the side-effects, particularly weight gain. But JD has not made a decision to refuse medication in the knowledge that this will lead to a relapse in his mental illness. Rather he is patchily compliant. Nor is his explanation as to why he refuses medication always consistent. For example, he explained to me at the hearing that it was because the medication was given too early and that he was often asleep during the medication rounds.
76. In considering JD's capacity in respect of this decision, I must consider his age and maturity. On balance, I have concluded that his actions in failing to take medication consistently over a prolonged period of time despite (a) the very obvious benefits that the medication brings to him, and (b) the very obvious detriments caused by lack of medication, indicate a lack of capacity in this regard. Applying the first limb of the

four-part test from the 2015 Act, it seems to me that JD does not fully understand the information relevant to his decision on taking medication. That information includes the absolute necessity of him taking medication if he is to keep his illness at bay, and the role of medication in assisting his prospects of living a fulfilling life in a place of his choosing. He does not appear to understand the highly detrimental consequences of not taking his medication. He does not appear to understand how to balance the information in relation to side-effects and how to ameliorate them.

77. This is not a question of making an unwise decision. An unwise decision connotes understanding the information but nonetheless choosing to take a course that most people would not agree with. The evidence demonstrates that JD does not understand the importance of taking his medication and permitting testing of his bloods on a consistent basis.

78. If my conclusions are incorrect, and JD understands the information relevant to taking his medication, I am not satisfied in relation to the third limb of the test i.e. whether a person can use or weigh the relevant information. JD does not appear to be able to use or weigh the information when deciding whether to take his medication or allow his bloods to be tested. There is no evidence of any process that JD goes through whereby he identifies on the one hand the negative effects of taking his medication i.e. the side-effects he is concerned about, but on the other hand puts against that the significant benefits that medication affords him and the very real risk that he will relapse if he does not take his medication. In particular, I am struck on the one hand by JD's overwhelming desire to live in [X] and see his friends and family frequently but on the other, his failure to understand that his best chance of doing that is to be compliant with his medication and the testing regime.

79. If JD had capacity, in my view the weighing process would necessarily include as one of the risks of not taking medication the likelihood that his mental state would relapse, thus preventing his relocation to [X] to an apartment or other supported living facility. There was no evidence that JD has factored this into his decision-making process. Nor was there any indication that JD wished to avoid the previous violence visited by him on his family associated with his psychotic state by taking his medication.
80. My conclusions in this regard are supported by the evidence of Dr. Sharma. In his report of 16 February 2022, he stated that JD could not understand that the prescribed medication needed to be taken regularly for it to be effective and to stabilise his mental health.
81. Turning to the evidence of Dr. Hillery, in my view he has not adequately addressed the difference between the statements JD has made to him and JD's behaviour over the course of one year where, as identified above, there have been significant incidents of non-compliance with medication and testing. He relies upon JD's assurances in their discussions that he understands the need to keep taking medication despite the side effects that are upsetting him in order to keep a stable mental state. In oral evidence, he said that JD understands he should stay well and take his medication and keep out of trouble.
82. Where there is an established history of non-compliance it seems to me that this must be taken into account in any analysis of capacity. Dr. Hillery relies very heavily upon JD's words as opposed to his actions. He does address the disconnect to a limited extent, saying that JD's refusal to engage in treatment is understandable where he does not want to be in Nua and feels powerless and considers his only power is to cause problems so he will be ejected. In fact, as I understand it, JD has not voiced his desire to return



to [X] as the reason he is refusing treatment. Rather, he invokes the unpleasant side effects of the medication, specifically weight gain.

83. Moreover, even if he had, that reasoning would be directly contrary to his own interests, as the effect of coming off his medication i.e. the resurgence of his illness, is likely to have the opposite effect to that desired by JD. It would very likely place him back in psychiatric care rather than permit him to achieve his goal of independent living. In my view, Dr. Hillery has not sufficiently addressed this dichotomy between JD's stated reasoning and its impact on his goals. He has attributed this to JD's age. I cannot agree. The disconnect is so great that I consider it relevant to establishing a lack of capacity rather than the contrary. In my view, Dr. Hillery's focus on JD's views and his lack of emphasis on JD's inconsistent behaviour leads me to prefer the evidence of Dr. Sharma in relation to JD's decisions on medication and his general approach to his mental illness.

84. In all the circumstances, I conclude that JD does not have capacity in relation to decisions concerning his mental health.

#### **Capacity in respect of residence/behaviour**

85. I turn now to the question of JD's residence and the interlinked issue of JD's behaviour. Dr. Sharma treated these as separate issues and considers that JD has capacity in respect of his behaviours on the basis that JD identified that the purpose of his behaviour was to ensure that he was not kept in Westmeath and was returned to [X]. Dr. Sharma equated the ability to control the behaviour with capacity on JD's part in relation to same. However, for the reasons I explain below, in fact I think the two issues are interlinked.

86. In relation to JD's ability to make decisions about his place of residence, there was a dispute during the hearing as to whether JD had expressed that he wished to go home

to live with his mother or whether, when he referred to home, he simply meant [X] and not his mother's house. If it was the former, Dr. Sharma noted that JD had been told repeatedly that he was not permitted to go home to live with his mother because of Tusla's concerns about his possible behaviour and he identified JD's failure to absorb this concern as further evidence of lack of capacity on JD's part.

87. First, as a matter of fact, I find that JD's references to going home have been variably references to going to live with his mother and going to live in [X]. In more recent times, he seems to be focusing on home as meaning [X] as opposed to his mother's house and has identified his wish to be near his family and friends in an apartment or in similar supported living. Insofar as he did repeatedly identify a desire to go home to his mother's house despite being informed of the impossibility of doing so because of the attitude of Tusla, I am not necessarily convinced that this displays a lack of capacity and I agree with Dr. Hillery in this regard. JD may not care about the views of Tusla or may not agree with them or may think the question of whether he lives at home or not will be determined by his mother rather than by Tusla. The fact that JD may have wished to return to live at home with his mother is not in my view indicative of a lack of capacity.

88. However, I am very struck by the relationship between JD's behaviours and his strongly expressed desire to live in [X]. It is necessary for me to identify these behaviours in some detail as they are in my view highly relevant to question of JD's capacity. Before I do so I wish to stress that I understand that JD is not defined only by these behaviours and that there has also been a good deal of positive reporting about JD in these proceedings. I do not ignore the many positive aspects of JD's personality and conduct.

89. On the other hand, JD's negative behaviours are not in the nature of a one off or isolated set of incidents. Unfortunately, they have been persistently present since he has gone to

Westmeath, both before and after his stay in the psychiatric hospital in Donegal. They cannot therefore be attributed solely to his bipolar disorder since the evidence is unambiguous that when he returned in February 2022, his disorder was fully under control. Dr. Sharma identifies in his report of 8 July that JD's mental disorder was at that stage under good control but that it was a challenge to say with certainty which parts of JD's disturbed behaviour are entirely not driven by his mental disorder/relapses as he tends to refuse medication regularly.

90. As with my approach to JD's compliance with his medication regime, I will focus on the period post JD's stay in the Department of Psychiatry in Donegal as at this stage his bipolar disorder was being better addressed by medication. However, I note that the evidence available to me in respect of JD's behaviour prior to his inpatient treatment demonstrates a pattern of consistent assaultive and sexually inappropriate behaviour.

91. In the report of Dr. Sharma of 29 March 2022, covering the time period from 19 February 2022 to 25 March 2022, he reports there were 17 occasions of physical restraints utilised in Westmeath.

92. He also identified that sexually inappropriate behaviours against female staff have resurfaced and there has been verbal and physical aggression towards all staff. It was noted JD had been very inappropriate towards female professionals who attempted to conduct assessments of his communication and daily living skills. Staff had submitted statements against JD for criminal acts he had committed against them. Two were in relation to sexual assaults and three were in respect of physical assaults.

93. Significantly, in Dr. Sharma's previous report of 16 February 2022, he reports that when he assessed JD in the inpatient unit on 8 February 2022 JD stated that he knew that *"he behave well [as it is under his control and not due to a mental illness]'s and become responsible for his decisions/actions as that will potentially help him return to*

[X]". Dr. Sharma discussed with JD his wish to return to [X] and shared with him the need for his behaviour to be appropriate and the need for an appropriate placement to be identified to facilitate his move back.

94. In Dr. Sharma's report of 10 May 2022, he identifies that since his report of March, JD has had 34 aggressive incidents, 26 of which included physical and verbal aggression towards staff. He caused injuries to staff, one of which required hospital treatment and the staff member was absent from work for 3 days due to a small cut to the lip and swelling of lip and cheek following a punch to their face. JD had been physically restrained 6 times since the previous report. He had 34 incidents of sexually inappropriate behaviour, including sexual comments and attempting to grab staff on areas of their body including their groin and buttocks and attempting to hug and kiss staff.

95. In Dr. Sharma's report of 8 July 2022, he identifies 28 incidents of sexually inappropriate behaviour between 1 June and 12 July (the report is dated 8 July, but I am assuming from the reference to 12 July that the report was in fact completed at a later date). These include sexually explicit comments, attempting to touch staff on the groin, attempting to hug and kiss staff, attempting to touch their buttocks and genitals. JD has generally been appropriate in public when he is taken out by the staff. However, on 16 June 2022 he was in an ice cream shop, and he masturbated while watching the shop assistant and did not respond to staff asking him to move his hand from his pants. A report has been made to the Gardaí in relation to this incident.

96. In the same report, Dr. Sharma identifies 19 incidents of physically aggressive behaviour and demeanour including one on 9 July where JD picked up a pencil and attempted to stab a staff member in the eye and was put in a restraint for 25 minutes. The physical assaults included attempting to strike staff towards the head, hitting them

on the head, grabbing them by their wrists, kicking them, punching their arm, pushing them with force, and attempting to knee them in the genitals. Dr. Sharma reports that JD has not engaged in any treatment program i.e. an anger management program to learn skills and techniques to manage his frustration and anger.

97. Dr. Sharma reports that JD has stated to him that he will continue to behave in this way until he is placed back in [X] because he wants to be with his friends and family but he has chosen to disregard the possibility that were he to be charged and convicted in relation to his physically and sexually offensive behaviour his pathway may lead him away from [X] and from his family and friends (see report of 29 March 2022).

98. Dr. Sharma considers that he does have capacity in relation to his behaviour and he identifies this as follows in his report of 16 February 2022:

*“As [JD] was able to control his sexually inappropriate and aggressive behaviour throughout the 4 weeks stay in the mental health unit in [Donegal] and continues to be able to do so when out in the community while a resident in Nua Healthcare facility, he clearly has control over his sexually inappropriate behaviour and aggressive behaviour.”*

99. However, I should add that Dr. Sharma also notes in his last report of 19 July 2022 in response to Dr. Hillery’s report and Mr. McGrath’s affidavit that there is a mismatch between JD’s ability to respond with right answers to questions in the abstract and his decisions when faced with the reality of concrete situations. As one of the examples of this he identifies that JD is aware that efforts are being made to find him suitable accommodation in [X], but he continues to indulge in physically aggressive and sexually inappropriate behaviour to achieve the goal of returning to [X], although aware that with a history of such behaviour, securing an appropriate placement in the

community will be a challenge. In my view this evidence is supportive of a lack of capacity in relation to decisions relating to behaviour.

100. Dr. Hillery notes JD justifies the negative behaviours on the basis that he does not want to live in Westmeath and wants to be back in [X]. He notes he explained to JD that, should he maintain his aggressive behaviour, he could not achieve his career goals, but observes that JD's behavioural issues continued after this. He accepts that JD's behavioural issues may damage his chances of achieving his aspirations but says they are explicable by his rebellion against his placement. Nonetheless, Dr. Hillery does not engage with JD's complete failure to engage with the consequences of his behaviour for his ambitions and the implications of this for a capacity analysis. He does not address whether JD understands the information he is being provided in this respect or whether he is using or weighing that information appropriately. For those reasons, I am unpersuaded by Dr. Hillery's evidence in this respect.

101. Having considered the evidence carefully, it seems to me that JD does not have capacity to make decisions in relation to his desired place of residence or his behaviour because, as with his decisions in relation to his medical condition, he either does not understand the information relevant to the decision or if he does understand it, he cannot use or weigh that information correctly.

102. JD wants to live in [X] in a non-residential setting. Persistently aggressive and/or sexualised behaviour will undermine that goal and may entirely prevent it from being achievable. Yet JD persists in this behaviour and has done so over an extended period of time. That may be explicable by a conclusion that he does not understand that this behaviour will jeopardise his goal. If that is so, then he has demonstrated his lack of capacity on the basis of the first part of the test. Alternatively, if he does understand that information, and has retained it, then he is failing to use or weigh that information

correctly since he continues to engage in behaviours that will torpedo his aim. In other words, he understands that assaulting staff will undermine his aims, but he continues to assault staff.

103. If the purpose of him assaulting staff is to ensure his return to [X], then he is either not understanding the information i.e., not understanding that assaulting staff will undermine rather than advance his aim or alternatively he understands this but cannot correctly use that information since he persists in his behaviour.

104. That may be because JD cannot control these behaviours. On balance, I think the evidence suggests that JD can control his behaviour in this regard because he normally (save for the incident of 16 June) does not exhibit such behaviours in public. Equally, he was able to control these behaviours when in the Department of Psychiatry in Donegal. If he can indeed control the behaviours even to a limited extent, that suggests to me that he is certainly lacking capacity in this area since his failure to exercise such control demonstrates a lack of an ability to use or weigh the information as to the consequences of his behaviour correctly.

105. If on the other hand he cannot or can only sporadically control his behaviour, that suggests he is not in position to use or weigh the information correctly, since he cannot control his behaviour to reflect his understanding of the relevant information.

106. In support of the argument that JD has capacity, the GAL relied heavily on Dr. O'Donnell's first report, which noted the stability and consistency of JD's behaviour while an inpatient in hospital in Donegal. However, Dr. O'Donnell's addendum to that report, which considers JD's subsequent behaviour on his return to Nua, supports my conclusions above. In summary, he concludes that it is necessary to look at JD's behaviour over the longer term, that there is often a distinction between JD's words and

his actions and that if JD's behaviour was intended to achieve a return to [X], then that itself is demonstrative of a lack of capacity.

107. In the circumstances I am satisfied that JD does not have capacity in relation to decisions in respect of his place of residence or his behaviour.

### **Capacity in respect of daily living**

108. Finally, I should consider JD's capacity in respect of his future career or direction in life and activities of daily living. The focus of the hearing was on the decisions discussed above and comparatively little evidence was provided on these issues. Nonetheless, it is a relevant part of a global assessment of JD's capacity. JD has two to one support in Nua at present. He requires considerable assistance with activities of daily living, in particular in relation to taking his medication. In relation to activities of daily living, Dr. Hillery noted that JD had not engaged in the type of training that would help someone as regards independent living including managing budgets and planning for household decisions. As noted in the occupational therapy ("OT") report of Dr. Ludden of Nua Healthcare of 26 July 2022, JD refused to complete an independent living skills checklist at either of the two OT sessions or between OT sessions. Given JD's strongly expressed desire to return to [X] to engage in independent living, it is in my view a further sign of his lack of capacity that he has steadfastly refused to engage in any activity that would have assisted him in obtaining this goal during the 12 months that he has been in Westmeath.

### **Cognitive functioning**

109. Finally, I should mention the position in respect of JD's cognitive functioning. As noted in Dr. Hillery's report, psychological assessments showed a wide set of scores with deficits including extremely low scores in working memory and processing speed.



He observes that JD's focus and commitment to completing the tests made an interpretation of his IQ score difficult at an assessment in 2017. Speech and language therapy assessment showed difficulties in the areas of core language, receptive language, expressive language, language content and language memory. Dr. Hillery notes the psychology report of 2021 indicates that those results were indicative of severe difficulty with social communication in everyday life. He further notes that the deficits could have an impact on his decision-making but could be corrected for by giving him sufficient support and time to assess information and make decisions.

110. Dr. Randall observed in his report that an assessment of JD's cognitive function was attempted by a Nua Healthcare psychologist, but JD did not cooperate with the assessment, so it was not possible to assess his cognitive capacity.

111. I cannot reach any conclusion in relation to JD's capacity by reference to his cognitive function given the lack of detailed reporting in this respect, caused at least in part by JD's refusal to participate in same. However, I consider that JD's cognitive function may be impacting on JD's capacity and may merit further attention.

### **Discretion**

112. As correctly identified by counsel for the HSE, I have a discretion as to whether to admit a person into wardship even if they meet the statutory test and are deemed to lack capacity. It was argued by Mr. McGrath that I should not exercise my discretion to admit JD into wardship and that it would be more proportionate to presume capacity. The presumption of capacity is separate from the question of proportionality. As I identify above, I have approached this application on the basis that JD is entitled to the presumption of capacity. The evidence presented to me has displaced that presumption.

113. Counsel for the HSE, Ms. McKenna, has argued that, given JD's behaviours and his lack of awareness of the consequences of same, it is likely he will quickly end up in the

criminal justice system. She submits that JD can make choices but that to support those choices he will need more inpatient care. She argues that it is both necessary and proportionate to admit him into wardship having regard to the alternatives i.e., a likely future in the criminal justice system. That submission is supported by the evidence of Dr. Sharma where he said that unless the approach to managing JD's case is altered, it is unlikely that the outcome will change i.e., there will be deteriorating mental health/behaviour and a rapidly incremental criminal history. He describes that as being a travesty for JD.

114. I have no hesitation in concluding that, having regard to the facts of this case, wardship is in the best interests of JD. Services can of course be provided to JD by the HSE without the protection of wardship. However, wardship will allow JD's placement to be scaffolded with an appropriate legal regime. For example, if JD requires a placement that has elements of detention - as is the position at the present - wardship provides a legal basis for such a placement provided the requisite safeguards are in place. Without that possibility, JD is very likely to end up in the criminal justice system. That system will not be concerned with JD's best interests. I am mindful of the conclusions of Dr. Randall in this respect where he identifies that the risk of JD engaging in sexually inappropriate behaviour is in the high range. Wardship will give the HSE the necessary flexibility to deal with JD's needs. JD will also have the benefit of a committee. Finally, wardship will give JD the benefit of the Court's involvement in significant decisions relating to his care and treatment. In the circumstances, I am persuaded I should exercise my discretion to make JD a ward of court as wardship will advance his interests.

## **Conclusion**

115. As Dr. Hunt observes, JD is still a young man. Given JD's age, background and profile, his present lack of capacity is not a fixed state. It may well change in future. The

question as to JD's capacity should be reviewed within two years of this decision.

However, at present I conclude he lacks capacity.

116. In all the circumstances I am satisfied that it is in JD's best interests that he be made a ward of court and that it is proportionate to admit him into wardship. Accordingly, I will exercise my discretion and admit JD into wardship. I will hear from the parties in respect of the identification of a committee.