



Neutral Citation Number: [2024] EWCOP 24

Case No: 14002430

**IN THE COURT OF PROTECTION**

Royal Courts of Justice  
Strand, London, WC2A 2LL

Date: 22/04/2024

**Before :**

**MS VICTORIA BUTLER-COLE KC**

**(SITTING AS A DEPUTY HIGH COURT JUDGE)**

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**Between :**

<b>Leicester City Council</b>	<b><u>Applicant</u></b>
<b>- and -</b>	
<b>HC</b>	<b><u>1<sup>st</sup> Respondent</u></b>
<b>(By her Litigation Friend, the Official Solicitor)</b>	
<b>-and-</b>	
<b>RC</b>	<b><u>2<sup>nd</sup> Respondent</u></b>
<b>-and-</b>	
<b>Leicester, Leicester and Rutland Integrated Care Board</b>	<b><u>3<sup>rd</sup> Respondent</u></b>
<b>-and-</b>	
<b>NHS Leicestershire Partnership Trust</b>	<b><u>4<sup>th</sup> Respondent</u></b>

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**Mr Parishil Patel KC** (instructed by **LCC and Mills and Reeve LLP**)  
for the **Applicant and 3<sup>rd</sup> Respondent**

**Mr Nicholas O'Brien** (instructed by **Star Legal Limited**) for the **1<sup>st</sup> Respondent**

**Ms Katherine Hampshire** (instructed by **Thaliwal and Veja Solicitors**)  
for the **2<sup>nd</sup> Respondent**

(4<sup>th</sup> Respondent attendance excused)

Hearing date: 18<sup>th</sup> April 2024  
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**JUDGMENT**

**Ms Victoria Butler Cole KC:**

1. These proceedings concern a 27-year-old woman called HC. HC has a degree in photography and videography, and enjoys arts and crafts, yoga, and rock climbing. Sadly, while at secondary school, she started to suffer with mental health difficulties, and shortly before she went to university, she was diagnosed with anorexia. Since then, she has had a number of admissions to hospital for treatment for her mental health, and in particular for anorexia, both as an informal patient and under s.3 MHA 1983.
2. The local authority and ICB responsible for meeting her care needs under s117 MHA 1983 (the applicant and 3<sup>rd</sup> respondent), jointly seek declarations that HC lacks capacity to decide where she should live and receive care, and that it is in her best interests to move to a new placement – D House – immediately, using physical restraint if necessary. On 31 January 2024, HC's current placement, K House, gave four weeks' notice to the applicant and 3<sup>rd</sup> respondent to terminate HC's placement there. Following the identification of D House as a suitable placement for HC, K House said that it would not keep HC beyond 15 April 2024. This application was issued on an urgent basis on 10 April 2024, leaving only two working days in which a decision could be made.
3. HC's father, RC, is the 2<sup>nd</sup> respondent. The 4<sup>th</sup> respondent was excused attendance at this hearing as it does not presently have any role in HC's care.
4. Proceedings in the Court of Protection concerning HC started in October 2022 by the NHS Trust with responsibility for HC's mental health needs in the community. At that time, HC was severely underweight, with a BMI of only 12, and there was no agreement as between the statutory bodies and RC about her care. RC was of the view that HC had suffered trauma as a child as a result of the care provided to her by mother, and that HC required specialist trauma intervention as well as treatment for anorexia. The Trust said that he had not engaged with professionals and had been obstructive. There was, very evidently, a breakdown of trust, with RC critical of earlier decisions about care provision for HC. That lack of trust persists on both the part of RC and the statutory bodies. For example, RC and HC continue to hold the view that they would not accept any treatment from the eating disorder service in Leicestershire.
5. The orders initially sought in 2022 were aimed at enabling professionals to obtain access to RC to assess her care needs and her capacity. The evidence of the Trust as to HC's capacity was that anorexia prevented her from using and weighing information about the serious risks to her health of refusing a care package, and that HC was unable to exercise any capacity she might have due to coercion and control by her father. The question of capacity was obviously a complex one, with different professionals holding different opinions. HC held the same view as her father, that therapy addressing past trauma was an essential element of any care package.
6. During the course of the proceedings in 2022-2023, various issues were raised as regards the relationship between HC and RC which were never tested or determined, but which remain pertinent to the situation HC now faces. Professionals reported that HC repeated her father's views, would not express an opinion without checking with him first, and was subject to his influence. It was reported that RC had written letters to professionals which purported to be from HC without telling her. The independent expert instructed to assess HC's capacity, Dr Tyrone Glover, said that RC had not acted

in RC's best interests, by failing to seek appropriate medical treatment for HC even when she was very unwell, and that "*although his intentions are not malign, his intransigence is potentially putting his daughter's health at serious risk*". While Dr Glover had not observed direct evidence of coercion, he said that "*RC exerts a powerful influence over H's thinking which appears to be urging her towards unsafe preferences in domains in which she lacks capacity*". A treating psychiatrist, Dr B, expressed the view that "*There is an enmeshed and rather circular relationship between RC and HC*", explaining that HC fears loss of attachment, and so any attempts by RC to extract himself from the position of primary carer results in distress to HC – he therefore continues in that role. This has the effect of reinforcing HC's belief that she cannot function without RC.

7. RC's jointly held LPA for health and welfare, registered in 2015, was suspended by order of HHJ Rogers on 10 November 2022. A second LPA for health and welfare was registered after that date, and has not been suspended, but the order of Mrs Justice Lieven of 20 January 2023 recorded in a recital an expectation that no decisions would be made pursuant to the second LPA in respect of matters which were before the court.
8. As HC was seriously unwell, and in light of Dr Glover's opinion, the parties agreed - and HC consented - to admission to hospital as an informal psychiatric patient in January 2023. She was subsequently detained under s.2 and then s.3 MHA 1983. The court did not make any determinations of HC's capacity pursuant to s.15 MCA 2005 in 2022-2023. Recitals were made confirming that the court considered the requirements of s.48 MCA 2005 were met.
9. On 7 June 2023, the parties agreed an order which was approved by the court without a hearing, which recorded the fact of HC's detention under the MHA 1983, that her BMI had increased to a healthy level, and that it was anticipated that she would be discharged imminently. The order provided that the applicant in the proceedings at that time – the NHS Leicestershire Partnership Trust – must apply for further directions by 16 June 2023. No such application was made, and HC was eventually discharged from hospital on 1 November 2023 to K House, following a 6-week transition. The court was not informed of her discharge, and no further communication with the court took place until this application was issued on an urgent basis on 10 April 2024. HC was in agreement with the plan to move to K House, and she was apparently assessed as having capacity to decide on her discharge destination.
10. An urgent hearing of the current application took place before the Vice-President on 15 April 2024. At that hearing, the Official Solicitor and RC complained of the manner in which the application had been made - with little advance notice, inadequate evidence as to the proposed arrangements for HC at D House, and without supplying the court with all relevant documentation. Directions were given for the provision of further evidence. K House agreed that HC could remain there until the conclusion of the full hearing later in the week.
11. At this hearing, which took place on Thursday 18 April 2024, I heard oral evidence from HC's social worker, Ms Earle, and the clinical lead at K House, and one of HC's therapists, Ms T. RC did not wish to give oral evidence. I also met HC by video-link, attended by her solicitor, to introduce myself and to ascertain directly her current wishes. HC did not wish to attend the hearing itself but was in communication with her father during the hearing. I was provided with a bundle of documents which I read in

full. Attendance notes prepared by the ICB's solicitor were provided at intervals, setting out additional information obtained from Ms T and a member of staff from D House, while the hearing was underway.

12. At the start of the hearing, the position of K House was that they would not keep HC there beyond 4pm on Monday 22 April (which they had agreed at the hearing before the Vice-President on 15 April). By the end of Ms T's evidence, there was agreement that this could be extended by a few days, but she was clear that having given notice 11 weeks ago, any longer extension would not be countenanced by K House. This judgment has therefore been prepared very swiftly. The parties and the court have undoubtedly been put in a difficult position by the lateness of the application, an application which could and should have been made in early March 2024 when the local authority social worker assessed HC as lacking capacity to make decisions about where to live and receive care, and RC expressed his belief that HC required a further specialist placement, contrary to the advice of professionals.

### Capacity

13. The first and fundamental question for me to decide is whether there is reason to believe HC lacks capacity to decide where to live and receive care. If there is not, the court has no jurisdiction even to make temporary or interim orders. No party sought to persuade me that there was evidence on which a declaration of incapacity could be made pursuant to s.15 MCA 2005. The applicant and 3<sup>rd</sup> respondent and the Official Solicitor submitted that the requirements of s.48 were met; RC contended that they were not.
14. I have considered the judgments of Hayden J and Mostyn J which analyse the purpose and scope of s.48 MCA (**DP (By His Accredited Legal Representative) v London Borough of Hillingdon** [2020] COPLR 769) and **A Local Authority v LD and RD** [2023] EWHC 1258 (Fam). I have applied the guidance in paragraph 62 of **DP v Hillingdon**, save that I have taken subparagraph (vi) to require a focus on whether the evidence establishes reasonable grounds to believe that P lacks capacity, rather than 'may' lack capacity, in accordance with the wording of s.48(a) itself.
15. I have concluded that there is reason to believe that HC lacks capacity to decide where to live and receive care such that s.48(a) MCA 2005 is satisfied. I have reached this conclusion even though I accept Ms Hampshire's submission that there are defects and omissions in the evidence before the court, and even though it is entirely possible that HC will in due course be found to have capacity for the purposes of s.15 MCA 2005. My reasons are as follows:
  - i) HC has diagnosed mental disorders which are capable of satisfying the requirements of s.2 MCA 2005. These include atypical anorexia (although the extent to which this is operative given that HC's BMI is now 27 must be subject to doubt), mixed anxiety and depressive disorder, and dissociative disorder. RC considers that HC also has complex PTSD and it may turn out that this is correct – it was the view of Dr Glover that HC displayed symptoms consistent with PTSD, and K House appear to have been providing treatment to HC on that basis.
  - ii) There is evidence that HC is not able to understand, retain, and use or weigh information. Ms Earle's assessment was that HC could not use or weigh

information as HC was very concrete in her thinking and could not take on board the possibility that D House might be a suitable placement, instead just repeating her view that she needs trauma therapy, eating disorder support and a holistic care package. Ms T said that she did not think HC could “*think things through*”, and that during therapy sessions, it had become evident that HC could not retain information to use it on subsequent occasions. Ms T also said that HC could not understand what her care needs actually are, which ties in with Ms Earle’s assessment.

- iii) The Official Solicitor, who has been involved since 2022, is satisfied that HC does not have capacity to conduct these proceedings, and considers that even though HC may be able at times to say things which suggest she is open to considering options for her future care, she keeps returning to her fixed view that she must have trauma therapy and so on, despite the very clear evidence from K House that trauma therapy has not been successful and that HC is simply not yet in a state of mind to engage in it.
  - iv) There is ample evidence that HC is strongly influenced by RC. That is not to say that RC is deliberately influencing HC or that his behaviour has any malign or inappropriate motivation. K House refer to HC as displaying ‘learned hopelessness’ and as not having any confidence that she can make decisions for herself. That analysis locates the source of HC’s difficulties in decision-making in HC herself. It is consistent with what Dr Glover advised – that RC’s involvement reinforces HC’s difficulties, it is not the cause of them – and that HC’s “*lack of self-worth, ongoing hopelessness and anxiety*” were a further source of impairment of her capacity in addition to her anorexia.
  - v) In the past few months, since K House gave notice and discussions about a move started, HC has become very distressed and now requires 1:1 supervision at all times due to the risk of self-harm. Ms T’s progress report on HC stated that “*My initial impression is that [HC] suffers distress in her current daily life to the point of near constant overwhelm*”. The same impression was given to Ms Earle, whose assessment concluded that HC was unable to weigh up information due to emotional dysregulation.
16. It is correct to note that Ms Earle could not, as a social worker, identify or explain fully the causal relationship between HC’s diagnosed mental disorders and her inability to make a decision. Further, Ms Earle did not inform HC that she was assessing her capacity when she spoke to her about options for moving on from K House. As I understood Ms Earle’s evidence, she started the conversation with HC (at which HC’s father and two therapists at K House were present) without expecting to conduct a capacity assessment, but having heard HC’s responses to questions, she formed the view that HC was unable to use or weigh the information she was being given.
17. It is also correct to record that Ms T’s evidence was at best ambiguous as to HC’s capacity, referring both to HC being able to make her own decisions, but also to HC being unable to retain information, or to understand her care needs. In an email on 31 January 2024, Ms T wrote that HC “*is able to make choices and decisions, but it does feel that they are largely decided or influenced by her father. Our experience of her is that she is able to grasp things, however there does seem to be fluctuations in her logic and ability to compute that learning into action*”. The progress report from Ms T on

10 January 2024 said that HC “*does not have the ability to make any choices or decisions for herself and at times during conversations it felt like there was an expectation that I make them for her or her family make them for her*”. When asked by staff at K House why she did not want to go to D House, HC responded that her family had told her it was not the right place. Ms T told me that she has never assessed capacity, and is not familiar with MCA caselaw. K House’s approach is to treat everyone as having capacity, partly in order to encourage people to assume responsibility for themselves.

18. Although RC’s position is that HC has capacity, he corresponds with professionals signing off as HC’s ‘next of kin’ and ‘LPA holder’. It appears that he does not think that HC can make decisions without significant support, insisting that he or another supporter of HC is present in all meetings and assessments.

### **Best interests**

19. Having concluded that there is reason to believe that HC lacks capacity to make decisions about where to live and receive care, the next question is whether it is in her best interests to make any orders “*without delay*” (s.48(c) MCA 2005).
20. HC must leave K House within the next week. Decisions have to be made now about where she will go – they cannot be deferred. The local authority and ICB now accept that their proposed care plan for D House requires further work. In particular:
  - i) The assessment of how many hours of 1:1 support HC will need was carried out by D House and has not been independently considered by the statutory bodies to check whether the proposed allocation of 21 hours per week is adequate. It is likely to be increased, in particular to ensure that HC has sufficient 1:1 provision at mealtimes.
  - ii) While D House has access to input from a private psychologist, and even though K House clearly advised that HC will need therapeutic input at her next placement, no steps have been taken to involve the psychologist or confirm funding for the psychologist’s services.
21. From the perspective of the statutory bodies, once K House gave notice, they carried out a wide search for appropriate alternative placements, they were only able to find one that would accept HC and had a suitable room available, and they have made arrangements for HC to move there and for the detail of her care to be fine-tuned once she is there. While that may appear perfectly reasonable to them, it is easy to see why it seems unreasonable from the perspective of RC – who has a longstanding fear that insufficient or inappropriate services will be offered to HC – and from the perspective of HC, who fears abandonment, suffers from anxiety, and feels unable to function without a high level of support. From their point of view, they were losing access to the specialist placement they had been seeking for a long time, they were being told there was only one option and so there was no choice about where HC would go, and the level of support that HC would get was being reduced in quantity and quality.
22. The statutory bodies have agreed to revise their plans urgently, and to arrange for a nurse in the s117 aftercare team who knows HC to explain the arrangements at D House to her and support her to understand how what is on offer fits with what HC herself told

me that she wants – namely some sort of therapy to help her get to a place where she can try again to participate in trauma therapy, support with meal preparation and eating, and access to activities that she finds helpful such as mindfulness. HC can also learn more about the other residents at D House, to be reassured that they are people she would fit in with, which is another of her concerns. By the end of the hearing, Ms Hampshire was able to tell me that RC was now more reassured that D House might be a suitable place for HC, though he still wanted to see the revised plans to consider them.

23. The final position of each party was as follows:

- i) The statutory bodies sought orders requiring them to file updated care planning documents and to support HC to understand more about D House, including potentially visiting it in the next few days. If HC was willing to go to D House having seen this further information, then the court should consent to that move on her behalf. But the court should also order that if HC had not agreed to move by 29 April 2024 (the last day on which she could stay at K House), a conveyance plan should be implemented under which HC would be transported to D House – a journey of over 2 hours – in a secure ambulance with 4 staff who would be authorised to use physical restraint (holding techniques) as a last resort. The plan would not authorise the use of handcuffs, even though this was mentioned in the written plan that had been filed.
- ii) RC agreed that orders should be made for the filing of updated care planning documents, and that if HC was then willing to go to D House, that should take place. But, if by 29 April 2024, HC was not willing, then the court should direct that she return home to live with him as a temporary measure while a new placement was sourced and efforts made to reach agreement as to HC moving to it. As I understand his position, he was willing to accept the care provision being offered by the statutory bodies, namely a 1 hour visit each day at a mealtime, and 2 visits of 2 hours each week for HC to participate in activities outside the home. Unfortunately, there had been no previous discussion with RC and HC about this offer of support at home.
- iii) The Official Solicitor did not support a forced move to D House, and agreed with the approach put forward on behalf of RC.

24. I have given this question the most careful consideration. There are a number of good reasons against HC returning to return to live with her father even temporarily:

- i) Living with RC, and receiving care from him, will reinforce HC's belief that she is dependent on him and will do nothing to enhance her independence. It is unlikely to improve her mental health and could worsen it.
- ii) HC told me that she would only want to be at home with RC for a month while a new placement was found, which she said could be anywhere in the country. (She later told RC and her solicitor by email during the hearing that she thought this would actually take 3 months.) The reality is that there have already been extensive searches and it is very difficult to find placements that are suitable and available. She may well end up at home with RC for a much longer period than she wants.

- iii) If HC requires specialist input for anorexia while she lives with RC, it is unlikely this will be sought, as RC and HC refuse services from the 4<sup>th</sup> respondent.
  - iv) The placement at D House will be lost if an order is not made now which requires HC to move there. Although HC is not yet convinced that D House is the right place, K House are satisfied that it is appropriate, it is fairly near RC's home (but is not in Leicestershire) and it is unlikely that any alternative placement that is found will be markedly different in terms of what services and provision it can offer.
25. Notwithstanding these points, I have concluded that it is not appropriate, and not in HC's best interests, to require her to be moved to D House against her will, for the following reasons:
- i) HC is presently very distressed and is self-harming frequently. Ms T said that forcing her to do something with which her father disagrees is likely to cause HC significant distress. It follows that if HC and RC do not support the move but it is imposed on HC regardless, HC's mental health is likely to worsen, with serious consequences for her, including potentially readmission to hospital under the MHA 1983.
  - ii) The prospect of HC settling in at D House and benefiting from the services it provides is remote, if she has been forced to go there and believes that it is not a suitable placement. It has been difficult enough for HC to benefit from the services at K House, which is a placement that both she and RC supported. Ms Earle was hopeful that staff at D House would be able to bring HC on board, but the weight of the evidence suggests that to be very optimistic.
  - iii) The use of physical restraint to move HC, even on the basis that is a last resort, is not justified. It is neither necessary nor proportionate at this juncture, and I have significant reservations about authorising its use in circumstances where the orders I make are on the basis of s.48 MCA 2005 and there is a dispute about HC's capacity to make her own decisions. HC already suffers from anxiety and it seems extremely likely that the use of physical restraint would be a further source of trauma for her. Her litigation friend, the Official Solicitor, does not support the use of force.
26. In 2022, Dr Glover observed that if the court authorised the unwanted separation of HC and RC for treatment for her life-threatening anorexia, which neither of them supported, this would "*almost certainly be viewed by RC and quite probably HC herself as further evidence of the harmful interference of yet another state agency, potentially cementing the family's negative view of those institutions with an inevitably harmful impact on the effectiveness of any such treatment*". Dr Glover's view was that intervention was nevertheless required at that time because HC was at risk of "*catastrophic and potentially fatal consequences of inaction*". Today, the risks that HC faces are not of the same magnitude. She is not underweight. She does not need urgent medical attention. She does need somewhere to live and receive care and support where she can build trusting relationships with other people, and start to believe in herself. The best way to achieve that, in my view, is not to forcibly move her to a placement to which she objects.



27. Last month, RC was overheard instructing HC what to say to therapists and her social worker – he told her not to tell her therapists how she was feeling, not to sign any documents or trust her social worker, and not to give her email address to anyone. A safeguarding referral was instigated by K House. It is evident that RC is fearful that HC will be moved to somewhere that is not right for her, but HC needs him to support a move to a suitable placement – even if it is not the perfect placement – and to accept that professionals are trying their best to support HC.
28. The orders I will make therefore, will require the provision of additional evidence from the statutory bodies at the start of next week and will consent on HC’s behalf to a move to D House if she is willing to move there. If she is not, then the court consents on her behalf in the interim to her moving home to live with RC, and to receiving the proposed package of domiciliary care. In that event, there will need to be either agreement from RC or orders ensuring that professionals can have access to HC, and can see and speak to her directly and without RC being present.
29. Mr O’Brien submitted that in the event HC moves willingly to D House, an urgent authorisation should be put in place and a standard authorisation implemented to authorise her deprivation of liberty, as D House is a locked facility. I raised a concern as to the appropriateness of this approach given that urgent authorisations are not designed to be used when a move is planned in advance, and that the test for capacity in respect of a standard authorisation is equivalent to that applied in the making of a s.15 declaration, which is not a declaration that I have made, or been asked to consider making. Furthermore, given the complexity of the issue of HC’s capacity to make relevant decisions, there is a risk that an assessment of capacity by a new professional for the purposes of a standard authorisation might result in a conclusion that HC has the necessary capacity, which would then result in an urgent court hearing being required. On further reflection, Mr O’Brien submitted that the court should authorise HC’s deprivation of liberty at D House instead.
30. I consider it inconsistent with my determination that it is in HC’s best interests to move to D House only if she agrees to go there, to order that once at D House, if she changes her mind, she should be prevented from leaving. If the only reason for not imposing a forced move was the use of restraint during the journey, the two propositions would sit together more easily. But that was not the only reason – there are serious concerns about the impact on HC’s mental health and self-harming behaviour of imposing a decision on her to which she objects.
31. However, since HC’s living arrangements at D House would be an objective deprivation of her liberty, and since I have found that there is reason to believe she lacks capacity to make decisions about her care and residence, substitute consent to her objective deprivation of liberty is required while she resides there willingly.
32. I will therefore authorise HC’s deprivation of liberty at D House in the event she has agreed to move there, but that authorisation will end if HC changes her mind about staying there and says that she wishes to return to the family home. The case must be returned to court for further directions immediately if that happens, or if it is intimated. In any event, the case will be listed for review and further directions within a short timescale.