IMPORTANT NOTICE

This judgment was delivered in private. The judge has given leave for this version of the judgment to be published on condition that (irrespective of what is contained in the judgment) in any published version of the judgment the anonymity of the incapacitated person and members of their family must be strictly preserved. All persons, including representatives of the media must ensure that this condition is strictly complied with. Failure to do so will be a contempt of court.

Case No: 12177934

COURT OF PROTECTION

MENTAL CAPACITY ACT 2005

IN THE MATTER OF QR

First Avenue House
42-49 High Holborn,
London, WC1V 6NP

Date: 5th August 2014

Before :

District Judge Batten

Between :

London Borough of Islington	**Applicant**
- and –	
-	
QR	**Respondent**

- -

- -

Ms Anuara Ali solicitor for the London Borough of Islington
Ms Bethan Harris instructed by Messrs Needham Poulier for QR
Hearing date: 3rd June 2014
- -

APPROVED JUDGMENT

Application

1. This is an application originally made by Camden & Islington NHS Foundation Trust for an order that QR's current tenancy of a property owned by the London Borough of Islington ("LBI") be terminated due to QR's lack of capacity to make such decision for herself.

Persons involved in the case

2. QR is the subject of these proceedings. She is 62 years old. She currently resides and receives care at ABC a treatment centre run by Camden & Islington NHS Foundation Trust. The community mental health team responsible for QR is the Islington Assertive Outreach Team ("IAOT").

3. Dr Killaspy is the consultant psychiatrist who has been QR's responsible clinician since October 2009.

4. Dr Kingett is a consultant psychiatrist to the IAOT and has known QR since April 2008.

5. Sue Dinham is a community mental health nurse who has worked with the IAOT since July 2012. She has been QR's care coordinator since September 2012.

6. LBI is QR's landlord and the local authority responsible for commissioning care and health services for QR. It is the Applicant in these proceedings.

Progress of the application

7. The application was issued on 12th July 2012. On 4th February 2013 the court made an order authorising the authorised officer for property and affairs deputyships of IAOT to terminate QR's tenancy. QR instructed solicitors who made an application for reconsideration pursuant to Rule 89 of the Court of Protection Rules 2007 for the order of 4th February 2013 to be set aside. They filed medical evidence as to capacity in support. By order dated 3rd April 2013 Senior Judge Lush set aside the order of 4th February 2013.

8. Camden & Islington NHS Foundation Trust applied to the court by COP9 filed on 16th October 2013 for an order joining LBI as a party and for declarations that QR lacked the capacity to make a decision about where she is to live for the purposes of relinquishing/agreeing to a tenancy agreement and that it is lawful and in QR's best interests that QR's current tenancy is terminated and a new tenancy agreed on her behalf.

9. The court gave directions by order dated 20th November 2013 and at an interim and directions hearing on 21st February 2014. At the directions hearing Camden & Islington NHS Foundation Trust were discharged as a party and LBI replaced them as Applicant. A hearing was directed to determine the questions of QR's capacity

(i) to make decisions as to (a) where to reside (b) whether to terminate her tenancy and (c) whether to enter a new tenancy
(ii) to litigate in these proceedings

and directions were given in relation to disclosure of certain documents, filing and giving of oral expert evidence and in relation how QR should be enabled to participate in the hearing. I gave a direction that LBI had permission to file and serve the expert report of Dr Kingett dated 10th February 2014 and include it in the bundle but not to call Dr Kingett to give evidence.

Evidence before me

10. I have been provided with a bundle of documents which contains

(i) applications and orders,
(ii) witness statements of Dr Killaspy dated 15th August 2013 and 14th February 2014 (to which is exhibited a Psychiatric Statement by Dr Kingett dated 10th February 2014 referred to above), witness statements of Sue Dinham dated 6th February, 27th March and 29th April 2014
(iii) QR's care plan
(iv) Expert reports by Dr Anthony Akenzua dated 23rd September 2012, 20th February and 1st May 2014 filed on behalf of QR
(v) Expert report by Dr Killaspy dated 8th May 2014 filed on behalf of the Applicant
(vi) Correspondence from the Official Solicitor

11. I have heard oral evidence from Dr Killaspy, Dr Akenzua and QR. QR spoke to me informally in the presence of her solicitor and counsel and of the solicitor for LBI. Both advocates compiled a list of the questions to be put to QR. Those questions were communicated to her before our conversation to give her the opportunity to consider how she wanted to respond. I was able in the more informal setting to ask one or two follow up questions to clarify my understanding of what she was saying, which were not the subject of any objection by either advocate.

History of the case

12. This history was taken from the witness statements and reports of Dr Killaspy, Sue Dinham and Dr Kingett. QR's counsel challenged some factual points made by Dr Killaspy in evidence. QR does not accept her diagnosis of paranoid schizophrenia or the diagnoses of acute dehydration or renal failure. However the dates and events I have set out were not specifically challenged by her counsel at the hearing.

13. QR was born in Ireland, one of nine siblings. Her mother is alive and living in Ireland, her father has died. She is closest to one of her brothers who currently lives in her flat in London.

14. QR did well at school. She went to a teacher training college in Northumberland where she gained a Certificate of Education. She was a supply teacher in Ireland but found this stressful. She worked in

secretarial and reception posts in England and Ireland until 1995 when she came to England to start a law course.

15. In June 1995, when she was 43, QR had her first breakdown. She was admitted to hospital, diagnosed with schizoaffective disorder and discharged on Clopixol. On discharge she refused medication or any rehabilitation programme. In September 1995 she was reported to have been found brandishing a knife and she accused a male student of attempting to rape her.

16. QR was admitted to hospital under section 2 Mental Health Act 1983 in October 1997, where she remained until March 1998. She is described as having paranoid delusions about her neighbours and stating that her entire family had schizophrenia. She did not comply with community follow up plans.

17. In about 1999 QR entered into a tenancy agreement in respect of the flat which is the subject of these proceedings.

18. QR was admitted to hospital again under section 3 Mental Health Act 1983 from May to September 2001. She had stopped eating properly because of delusions that her food was poisoned. She also entertained delusional ideas about her neighbours and had become preoccupied with "themes of a sexual nature".

19. In December 2001 QR relapsed, having been non compliant with her medication and community follow up. She visited her family in Ireland where she expressed fears that her food was being poisoned. After an incident at the airport on her return, she was admitted to hospital under section 3 Mental Health Act 1983. It was recorded that she had stopped eating properly and was noted to have been scrubbing her skin until it bled.

20. Further admissions under section 3 of the Mental Health Act 1983 followed in similar circumstances, between September 2002 and April 2003, and. June 2003 and January 2004 (when she was discharged by her nearest relative). QR stopped taking Clozapine abruptly in July 2004 and was taken to A & E in a mute and catatonic state. She was admitted initially to a medical ward then to a psychiatric ward where ECT was administered. She was discharged in January 2005. She was a voluntary patient from March to May 2005.

21. In June 2005 QR was found by her brother in a mute unresponsive state on the floor of her flat, having stopped taking Clozapine two weeks previously. She was admitted to hospital under section 3 Mental Health Act 1983. She was first taken to a medical ward to treat acute renal failure caused by dehydration. She expressed delusions about her downstairs neighbour. There was an allegation in June 2006 that she had been seen chasing two children holding what appeared to be a knife Her condition fluctuated and she was not discharged from section until October 2006 when she was discharged by her nearest relative.

22. QR was admitted again in February 2008 under section 3 of the Mental Health Act 1983 having been found wandering in a mute state after

stopping her medication for two days. She was again admitted to a medical ward to treat renal failure caused by dehydration.

23. In the autumn of 2008 QR went for a week's holiday to Spain with her brother. She did not take her medication while she was away and deteriorated, being admitted under section 3 of the Mental Health Act 1983 in October 2008. She was discharged in March 2009 under a community treatment order ("CTO") with IAOT providing daily monitoring and administration of medication.

24. Towards the end of April 2009 QR again started to express paranoid thoughts of a sexual nature and said she did not like taking Clozapine. She did not respond to visits by IAOT over three days, so they decided to readmit her. By 2nd May 2009 IAOT workers had still not made contact with QR. While they were trying to gain access to her flat, they heard QR fall. They entered with the help of police to find her collapsed on the floor. There was blood in her vomit. She was again admitted and treated for acute renal failure caused by dehydration. The bloody vomit was thought to be caused by self medicating with non steroidal inflammatory drugs. QR had also broken her arm. She was transferred to a specialist facility as an informal patient, started again on medication and she slowly improved. She remained at the specialist medical facility, being allowed unescorted leave during which she visited her brother who was by now living in her flat and doing some reception work. She started to consider the possibility of supported living and visited some placements.

25. QR was discharged to ABC on 23rd December 2010 where she remains under the terms of a CTO.

The community treatment order

26. QR is currently subject to a CTO which was made on 19th December 2013 and will continue until 19th December 2014. Its terms are as follows:

    (i) to reside at ABC
    (ii) to take her medication (and associated blood tests) as prescribed
    (iii) to meet with her keyworker and IAOT regularly and as often as required

27. QR challenged the CTO and a Mental Health Tribunal was held on 17th March 2014. The outcome was that the CTO remained in place. I have not seen any documentation relating to the Tribunal hearing.

The issues in the case

28. Dr Killaspy and the IAOT consider that QR no longer requires the structure and restrictions of the regime at ABC. In their view she is ready to move into a more independent living arrangement. However they do not agree that she should return to her flat. They argue that, because of the history outlined above, it is too dangerous for QR to live on her own. She must live in accommodation which provides 24 hour support and monitoring, so that QR will continue to be compliant with her medication

and avoid the risk of a possibly fatal relapse. This conclusion by the treatment team determines the terms of the CTO.

29. Sheltered accommodation is available and can be provided by LBI. However because QR will need to sign a tenancy agreement in order to move into a supported living flat, she must first surrender the tenancy of her flat.

30. QR objects to the application on the grounds that she has capacity to decide whether to surrender the tenancy of her current flat and to sign a tenancy agreement for supported living accommodation. She does not wish to surrender the secure tenancy of her council flat which is important to her and she does not wish to move to any of the proposed supported living options which have been proposed by LBI.

31. QR's capacity to decide where she should live, to surrender the tenancy of her flat and to sign a new tenancy agreement are the issues as to capacity in this case.

32. However those issues are to be decided within the context of the terms of the CTO made under the Mental Health Act 1983 which the Court of Protection has no jurisdiction to alter.

33. The choices in front of QR at this point, if she has capacity, are as follows:

    (i) to surrender the tenancy of her flat, sign a tenancy agreement for supported living accommodation and move to it under the terms of a revised CTO
    (ii) to refuse to surrender the tenancy of her flat and remain living at ABC under the terms of the current CTO

34. While the current CTO remains on foot, QR does not have a choice to return to live in her flat.

Dr Killaspy's evidence

35. Dr Killaspy prepared a witness statement and medical report for the purposes of this application. She gave evidence at the hearing.

36. Dr Killaspy said in her witness statement that QR has done well at ABC and has not required re-admission to hospital. She takes her medication regularly. She engages in activities, is free to visit her brother and her flat and is attending a computing course. While she still expresses paranoid delusional thoughts, this happens much less frequently. At her quarterly CPA meetings, she always states that she would like to stop her medication and that she does not need it because she does not suffer from a mental illness. QR recognises that she has to take the medication because it is a condition of the CTO. She has said that the reason she does not want to take Clozapine is because it may make her incontinent as she ages.

37. In Dr Killaspy's opinion QR continues to lack insight into her condition (C7):

"When unwell she becomes deluded about intruders at her home and believes that her water supply has been interfered with. This in turn leads to her becoming severely dehydrated to the point of renal failure. She has required admission to a medical ward, including intensive care units, on a number of occasions due to this sequence of events. The severity of renal failure has been life threatening."

Her history shows that her mental health can deteriorate over only a few days once she stops medication with consequent risks to her physical health.

38. Dr Killaspy considers that QR is able to retain and communicate information but because of her lack of insight she is unable to understand, use or weigh relevant information. QR denies that she suffers from schizophrenia, that she needs to take medication to remain well and avoid consequent relapse of her illness and renal failure. As a result she does not understand the need for supported accommodation.

39. Dr Killaspy said that IAOT had supported QR to live in her own flat for 8 years between 2001 and 2009. They had done everything they could to try and make that degree of independence work for QR. It had ended in failure and recognition that QR needed more support than could be made available by regular visits from IAOT. On each occasion QR would stop taking her medication and evade calls from IAOT workers. Her mental health would deteriorate leading to a crisis, whether in her mental or physical health, which would necessitate admission to hospital. In 2009 IAOT abandoned that option, recognising that living in her own flat would never give QR sufficient support.

40. In Dr Killaspy's view there is no prospect that QR will regain capacity. She will require supported accommodation for the foreseeable future. She has been ready for discharge into such accommodation for approximately 2 years.

41. In her report Dr Killaspy recounted what QR had told her at an interview on 7th April 2014. In particular QR said that she did not suffer from schizophrenia but that she had experienced mental health problems which were brought on by being placed on a bed as a baby near elderly relative. As a result she does not need to take antipsychotic medication and if she had free choice would prefer not to take any antipsychotic medication. QR also said that the episodes of renal failure were due to the side effects of her medication (Clozapine), because incontinence is a side effect, not because of inadequate fluid intake. QR said that she wanted to retain the tenancy of her flat and did not want to live in supported accommodation because she did not want to live with mentally ill people.

42. Dr Killaspy sets out in her report the information she considers relevant to a decision by QR on the following issues and whether in her opinion QR has capacity to make the following decisions:

(i) to decide where to live
(ii) to terminate the tenancy of her flat
(iii) to enter a new tenancy in supported accommodation

(iv) to litigate in these proceedings

43. In relation to capacity to decide where to live Dr Killaspy identified the following as relevant information
(i) her lack of insight into her mental health condition and the connection between taking medication and remaining well
(ii) her history of stopping medication, leading to relapse of her mental illness, failure to eat or drink adequately resulting in renal failure
(iii)that there is as a result a serious risk to her health if she lives in her own flat because she disengages from mental health services
(iv)that IAOT want her to live in 24 supported accommodation where she would have her own self contained flat with a key but where staff can enter if there is a concern for her safety and she has to engage with staff at least once every 24 hours

Dr Killaspy considers that QR can understand and retain this information but cannot use and weigh the information to make a capacitous decision because she cannot make the connection between taking her medication, relapse of her illness and renal failure. Thus she is unable to accept the need for 24 hour support.

44. In relation to capacity to terminate her tenancy Dr Killaspy identified the following as relevant information:
(i) that she cannot reside in her own flat because of the CTO which requires her to live at ABC
(ii) that she needs 24 hour supported accommodation for the reasons set out at 41 above
(iii) that she is living at ABC because of the life threatening renal failure
(iv) that she cannot be offered the tenancy of a supported living flat without surrendering her current tenancy
(v) that she would be living in self-contained accommodation with living room kitchen bedroom and w.c. not in communal accommodation
(vi) that once she relinquishes her tenancy she no longer has the right to live in her flat

Dr Killaspy states that QR understands and can retain this information, particularly that she will lose the flat and no longer have to pay rent for it. However she cannot use and weigh the information because she does not understand the rationale for terminating the current tenancy set out above at 41.

45. In relation to capacity to enter into a tenancy for supported living accommodation Dr Killaspy identified the following as relevant information:
(i) she will be responsible for internal upkeep of the flat
(ii) she has to pay rent weekly
(iii) she has to live in the new flat as her main home
(iv) failure to keep to the terms of the tenancy agreement will mean she could be evicted
(v) the landlord has the responsibility to maintain the property
(vi) she is required to live in 24 hour supported accommodation because of her mental illness and this is why she has to sign a supported tenancy agreement

(vii) she is currently residing in a community rehabilitation unit and cannot move on to more independent living without terminating her current tenancy and taking on a new one.
(vii) the tenancy agreement she has to sign means she will be subject to the supported accommodation service's policy that allows staff to enter the flat if concerned for her health and safety
(viii) if she does not terminate the current tenancy agreement and sign the new supported living tenancy agreement she will be unable to move from ABC, the regime at which the staff at ABC and IAOT believe she no longer requires

Dr Killaspy considers that QR can understand and retain this information. She understands the terms of the tenancy agreement as they relate to the usual obligations of landlord and tenant. Dr K acknowledges that QR has capacity to manage her property and affairs. She is not able to use the information to weigh up and make a capacitous decision about entering into a tenancy agreement which provides her with the 24 hour support she needs to maintain her mental health. Dr K also said that QR could not understand and weigh up the information relevant to a decision to give up her old tenancy and enter into a new one in order to move on to more independent living than is available to her in ABC.

46. In relation to capacity to litigate Dr Killaspy referred to the judgments in Masterman-Lister v Brutton & Co [2003] 1 WLR 1511 and Sheffield City Council v (1)E(2)S [2004] EWHC 2808 which she summarised as determining that it is unlikely that, where a person lacks capacity about the substantive matter, that person would have capacity to receive, consider, assess and advise in relation to that specific issue in order to give instructions to a lawyer. She agrees with this and concludes that, because in her view QR does not have capacity in relation to the substantive issues as outlined above, she lacks capacity to litigate about those issues.

47. In her oral evidence Dr Killaspy differentiated between QR's understanding that she needs to comply with the terms of the CTO so that she does not have to return to hospital, which she is very anxious to avoid, and her lack of understanding of the connection between her illness, the medication required and the risk of relapse. She still fears contamination of her water supply and gives different accounts of the episodes of dehydration to different people. In Dr Killaspy's view QR's long period of stability on medication since her admission to hospital and then to ABC has not resulted in an improvement in her insight into her condition. Her health and functioning have been maximised but she still does not have capacity to make decisions which require insight into her illness.

48. Dr Killaspy explained that there were three possible supported living options available to LBI. QR had viewed them all. LBI wishes her to live at a supported living option with 24 hour on site at D Road. ("the DR flat"). QR's Counsel asked Dr Killaspy whether QR's reaction of feeling unsafe when she visited the DR flat and found a number of men of an ethnic minority background in the office was delusional. Dr Killaspy responded that QR is sensitive to her vulnerability to sexual violence for good reason and that IAOT take that seriously. She has some good reasons for being reluctant to take up the tenancy of the DR flat which IAOT can address. However she has other

reasons which demonstrate that she lacks insight including the rejection of the need for 24 hour support. The placement is a stepping stone, taking QR towards her goal of living independently and it is not sensible for her to deny it. IAOT have spent some years trying to find a supported living placement to which QR would agree to move. She could have another council tenancy in the future but she cannot move forward without relinquishing her current tenancy.

Dr Kingett's evidence

49. Dr Kingett's "psychiatric statement" is exhibited to Dr Killaspy's second witness statement (C24-27). She outlines the history of QR's case and IAOT's conclusion that she could not be safely maintained in her own flat in similar terms to the evidence of Dr Killaspy. She reports on an interview with QR on 7th February 2014. QR told Dr Kingett that she does not believe she has schizophrenia or that she needs medication, which she fears is doing her harm. She blames the Clozapine for the episodes of acute renal failure and denies that she stopped eating and drinking before those episodes. She wants to have her own flat but would prefer to be transferred to a different tenancy from her current flat because of her fears that her downstairs neighbour has assaulted her and can get access to her flat. She does not want supported accommodation because she values her privacy and space.

50. QR mentioned the three supported living flats she has viewed and told Dr Kingett she had a bad feeling about the DR flat because of the men she had noted in the office.

51. Dr Kingett thought QR had a good understanding of the legal process, why it is happening and what might happen and be expected of her at the hearing. She told Dr Kingett she was in regular contact with her solicitor and was able to ask her if there was anything she did not understand.

52. Dr Kingett formed the view that QR did not have capacity to make decisions about where to live because her poor insight into her mental condition affected her ability to understand and weigh up the risks to her in returning to her flat. Her chronic paranoid delusions are affecting her ability to weigh up the pros and cons of moving to a supported living flat because she fears assault wherever she lives.

Sue Dinham's evidence

53. Sue Dinham has provided three witness statements which I have read. Her evidence is consistent with Dr Killaspy's account of QR's history and she agrees with Dr Killaspy's conclusions as to the nature of QR's illness and her capacity to make the relevant decisions. She provided information about the outcome of the Mental Health Tribunal in March 2014. Sue Dinham exhibited to her third statement a copy of the tenancy agreement for the proposed supported living accommodation (C50-67)

The proposed tenancy agreement for supported living accommodation

54. The agreement is for a weekly periodic Assured Shorthold Tenancy. That agreement makes explicit the nature of the arrangement under which QR

would occupy the premises. The Aims of the Project are to provide accommodation and temporary support services for single homeless people who have mental health, drug or alcohol or other similar problems.

55. With regard to support, the tenancy agreement states

"this tenancy is granted to facilitate the provision of support to the Tenant. The nature of that provision and the Tenant's obligations in relation to it, including any obligation to pay for it are set out in a separate agreement with the support provider ("the support contract"). Because the provision of support is fundamental to this Tenancy it shall be regarded as a breach of this Tenancy if the Tenant withdraws from or breaches the support contract and in the event of such a withdrawal or breach the Landlord or Agent may take steps to end the Tenancy."

56. In paragraph 2(3) of the agreement (C54) the landlord agrees "not to interrupt or interfere with the Tenant's right to peacefully occupy the premises except in the circumstances set out in that sub paragraph which include "access is required to carry out support services or to prevent serious physical risk to the Tenant" paragraph (2(3)(ii)).

57. In paragraph 3(15)(b) the Tenant must "allow access by the employees of the Landlord or Agent in order to carry out support services. This will normally be in agreement with the Tenant, however emergency access may be necessary if the Landlord or Agent believes there is a serious physical danger or risk to the Tenant". There is a Schedule which sets out the Landlord's procedure for entering property without consent (C66-67).

Dr Akenzua's evidence

58. Dr Akenzua provided the original report which resulted in reconsideration of the order of February 2013. He provided two further reports, having seen the evidence of Dr Killaspy and Dr Kingett. He acknowledged in his reports and said in evidence that he agreed with Dr Killaspy's diagnosis of QR's condition. He too considers that she has long established and persistent delusions and lacks insight into her condition.

59. In his first report Dr Akenzua gave his opinion that, while QR suffers from delusions, they do not operate in relation to the decision to surrender her tenancy and sign a new tenancy agreement. He considers that QR has capacity to manage her property and affairs, that she understands the concept of choice and is able to set out logical reasons why she does not want to surrender her current tenancy, and understands that that decision might result in legal proceedings to resolve the matter. His second report confirmed his conclusions, having read the views of the treating clinicians.

55. Dr Akenzua carried out a reassessment of QR on 26th April 2014. There was no evidence of any relapse in QR's stable state although her persecutory beliefs remained in evidence. She made it clear to Dr Akenzua that she would do anything to avoid being readmitted to hospital and understood that she had to comply with the terms of the CTO in order to avoid that. Her experience of past sexual assault is a strong motivation for her wish to avoid hospitalisation.

56. Dr Akenzua's account of QR's views on the reason for suffering dehydration and renal failure is consistent with what QR has said to Dr Killaspy. She repeated that she does not accept her diagnosis. She told Dr Akenzua that she had made a trip to Manchester without any community mental health support and had taken her medication for the duration of the trip. She will agree to be observed taking her medication if she is allowed to live in her flat. She said that she will continue to challenge the CTO and the need to take Clozapine.

57. According to Dr Akenzua, QR's reasons for not wanting to live in the proposed supported living are

    a. she does not want to live in a regimented institution having been unhappy at boarding school but wants to live independently
    b. while she might accept a supported living tenancy if it offered sufficient privacy, the flats she has seen are unacceptable. One in particular is unacceptable because of the presence of 3 Afro Caribbean men in the office. Dr Akenzua does not consider QR to be prejudiced against men from an ethnic minority back ground, pointing out that there are people from diverse ethnic backgrounds living at ABC.
    c. QR would prefer to stay indefinitely at ABC rather than move to the DR flat
    d. QR will take her prescribed medication if that is the condition for her to be able to live independently. However she will continue to challenge the CTO because she worries about the long term effects of Clozapine on her physical health.

58. Dr Akenzua gave oral evidence at the hearing. He considers that QR understands the concept of accommodation and ownership. She understands the difference between independent accommodation such as her flat and supported accommodation. QR has a hierarchy of preferences: she will do everything possible to avoid hospital admission, she would prefer to remain at ABC until she has suitable independent accommodation (she would prefer to get a transfer to a different council tenancy), she would accept supported living tenancy as a last resort as long as the accommodation is not restrictive and invasive of her privacy. Dr Akenzua considers that it is this analysis which has led QR to decide that she prefers to have her own flat and will not willingly relinquish her tenancy, even if it means the matter has had to go to court and the court decides that she has to go into supported living accommodation. He found no evidence that QR's delusional beliefs were affecting her decision making process.

59. For Dr Akenzua, QR has demonstrated that she understands, retains and can use and weigh the necessary information to make a capacitous decision about whether to surrender her tenancy of her flat. She has thought through the options open to her and can make reasoned choices between the alternatives. Even if she had insight into her mental illness and accepted the need for the treatment she takes (which Dr Akenzua acknowledges she does not), Dr Akenzua does not think that QR would make a different decision. She does not want to live in "boarding house" conditions under a regimented pattern of living.

60. Dr Akenzua said that "I accept that QR does not seem to appreciate the severity of the physical condition that emanated from her last exacerbation of

her mental disorder, however it was not her being in independent accommodation that led to this situation but the deterioration of her mental health which occurred because she was not adherent with medication. She agrees to supervision of medication whilst she is under a CTO."

61. Dr Akenzua was questioned as to whether he had discussed the actual choices before QR with her. Counsel for LBI pointed out that returning to her home is not an option; if she does not go into supported living she will remain at ABC. Dr Akenzua said that he had talked through all the options with QR who understands that she cannot return to her flat while the CTO is in force but relies on the court process to assert her preference to live independently which she will take all the way to the European Court of Human Rights if necessary.

62. Dr Akenzua said that QR had not completely ruled out the DR flat. He had put to QR that she was rejecting a less institutionalised option in supported living in favour of a more institutionalised option ABC. QR said she liked the DR flat at first but there were intimidating factors.

63. Dr Akenzua said in evidence that in his view lack of insight into her illness does not prevent QR from weighing up the information to make a decision about her accommodation and treatment. She wants to receive treatment and support in the most independent way possible. There are other options out there. Privacy and dignity are what motivates QR and Dr Akenzua believes she will accept support, despite the problems in the past.

What QR told me

64. QR's counsel clarified QR's position on the DR flat after an opportunity to take instructions over the lunch break. If QR revisited the DR flat and her anxieties were resolved and no new objection arose, so that the flat and surroundings did not carry any objection, QR still did not feel able to say that she would give up her tenancy and move into the DR flat. However she would still consider other supported living options for example where the support workers office was not within the four walls of the accommodation but elsewhere on the site. In those circumstances she could decide to give up the secure tenancy of her flat.

65. I saw QR with her advocate Megan and with her own counsel and solicitor and the solicitor representing LBI.

66. QR told me that she had had a lot of time to think about the issues in this case and had discussed them with Megan.

67. QR told me that her objections to the DR flat were that she did not like aspects of the building, the flat she saw or the garden and that she had a bad feeling about the place. After ignoring her instincts that a flat in Armagh and her current flat were not right for her, she does not want to make the same mistake again because she has not trusted her instincts. In another hostel run by the care provider she felt the staff knew too much about the inmates. She has encountered people who were in hospital at the same time as her at the DR flat and at the other supported living options. She would not be willing to live in the same place as some of them.

68. After living at ABC QR can see the pros and cons of having support. Megan has told her there are supported living arrangements where the support workers do not live on site or act as a concierge. QR wants more independence. She wants to be able to go back to work and to travel so that she can use the languages she has been studying. She has been away successfully three times but cannot be away for more than 2 days at a time because of the requirements for taking her medication.

69. QR told me that she does not have a mental illness but that she does have mental health issues. Medication has helped her to relax and sleep when she has been stressed. She admitted forgetting to take her medication "once or twice". She denied that relapse of her condition had led to dehydration. She said that on one occasion she had been unable to drink water which was too highly chlorinated and that she had been told to drink less water. She said that it would not happen again because she drinks lots of tea coffee and squash.

70. QR said that she wanted to return to her flat then move to other suitable accommodation. She does not want to live in a council flat because of noise and difficulties with neighbours. She would consider other supported living options if they gave her sufficient independence and did not require such intrusive support.

Submissions

71. QR's counsel argued that QR understands and has used and weighed all the information necessary to make a capacitous decision in this case. She understands that she has to comply with the CTO which means that IAOT can determine where she should live and require her to take her medication. She knows that if she does not follow the regime determined by the CTO she will end up back in hospital.

72. The decision left for QR is where she will live. She accepts that she cannot return to her flat while the CTO prevents her from doing so. She does not want to give up her secure council tenancy which is a precious thing and which she has held for 15 years. She wants to sit tight at ABC and wait for an accommodation option to come up which she is willing to accept.

73. QR has good reasons for rejecting the three options put to her so far. Her criteria are no different from those of other people: will I feel all right in the accommodation or is there someone who dislikes me there, is it too small, are the common parts unwelcoming, is it in a bad area, do the male staff have a threatening appearance (as with the DR flat)?

74. QR's Counsel argued that when the court considers the question of residence as it stands it should not embark on a consideration of matters outside the ambit of the decision that QR has to make at the moment. Even if QR exhibits some delusional views, they are not sufficiently in play to prevent her decision on residence being made with capacity. She does not have to have a perfect understanding of the issues; I must not set the test too high. QR may make an unwise decision but that does not make it incapacitous. There is no issue that QR has capacity to understand the terms and obligations of the tenancies or that she lacks understanding sufficient to be unable to instruct solicitors or understand the issues.

75. Counsel for LBI challenged the evidence given by Dr Akenzua. She argued that he had focussed on information irrelevant to the decisions in hand, such capacity to manage finances or daily affairs, and ability to exercise choice while he had not taken into account relevant information, in particular the nature of QR's support needs. It was wrong to view QR's support needs as irrelevant to a decision as to her residence.

76. LBI disputes that QR has adequate understanding of her mental state or the options open to her. Neither Dr Akenzua or Megan has put her options correctly to her. IAOT has determined pursuant to the Mental Health Act 1983 that QR needs 24 hour supported accommodation. The Court cannot require LBI to put other options on the table. QR has failed to take this on board. Returning to her flat or moving to accommodation which has off-site support are not available options. Her only decision is whether to surrender her current tenancy and sign an agreement for a supported living tenancy. QR does not demonstrate a logical thought process in objecting to the three supported living options put to her. She is unable to weigh the salient details of her decision. She has given a great many reasons why the DR flat is not suitable but it is clear that fundamentally she does not consider that she needs 24 hour care.

77. LBI urged me to prefer the evidence of Dr Killaspy, who has known QR over 5 years of a close working relationship, over that of Dr Akenzua who has seen her twice. LBI argue that Dr Killaspy's account of the relevant information and her analysis of QR's capacity in relation to each issue are the right ones. Dr Killaspy has not fallen into the trap of making a best interests decision but has carried out a detached and objective assessment of QR's capacity to make the relevant decisions.

Capacity – the law and principles

78. The central principle of the Mental Capacity Act 2005 is the presumption of capacity. Section 1(2) of the Act says

> a person must be presumed to have capacity to make a decision unless it is established that he lacks capacity

79. The question of capacity must be decided on a balance of probabilities (section 2(4)).

80. Section 2(1) of the Mental Capacity Act 2005 sets out the test for capacity.

> For the purposes of this Act a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of the mind or brain.

81. Section 3(1) of the Mental Capacity Act 2005 provides a path to establish whether or not the person has capacity to make the decision in question

> For the purposes of section 2 a person is unable to make a decision for himself if he is unable
>
> (a) to understand the information relevant to the decision
> (b) to retain that information

(c) to use or weigh that information as part of the process of making the decision or
(d) to communicate his decision (whether by talking, using sign language or any other means).

82. The information relevant to a decision includes information about the reasonably foreseeable consequences of deciding one way or another or failing to make the decision (Section 3(4)).

83. Section 15(1) of the Mental Capacity Act 2005 sets out the Court of Protection's powers to make declarations as to capacity.

> The court may make declarations as to:
> (a) whether a person has or lacks capacity to make a decision specified in the declaration
> (b) whether a person has or lacks capacity to make decisions on such matters as are described in the declaration
> (c) ….

84. The decision on capacity is one for the judge to make. See paragraph 16 of MM-L v Jewell & Home Counties Dairies [2002] EWHC 417 (QB) and Charles J's decision in care proceedings A County Council v KD and L [2005] EWHC 144 Fam at paragraphs 39 and 44.

85. I was directed to cases which dealt with the issue of what weight to give to expert opinion about capacity. My attention was drawn to certain passages in the judgment of Baker J in the case of CC v KK COP 12041541

> 64. "I remind myself that the court must be careful when weighing up the evidence of someone in KK's position against expert opinion evidence…. I found her to be broadly realistic as to her physical limitations. My conclusion on this point is that, whilst KK may have underestimated or minimised some of her needs, she did not do so to an extent that suggest that she lacks capacity to weigh up information."
>
> 67. "In this case I perceive a real danger that in assessing KK's capacity professionals and the court may consciously or subconsciously attach excessive weight to their own views of how her physical safety may be best protected and insufficient weight to her own views of how her emotional needs may best be met."
>
> 69. "when considering KK's capacity to weigh up the options for her future residence , I adopt the approach of Macur J in LBJ v RYJ [2010] EWHC 2664 (Fam) namely that it is not necessary for a person to demonstrate a capacity to understand and weigh up every detail of the respective options, but merely the salient factors."

86. In paragraph 16 of the case of PH v A local authority 2011 EWCOP 1704, Baker J alluded to the decision in Sheffield City Council v E [2004] EWHC 2808 (Fam) by Munby J as he then was who said at paragraph 144

> "we must be careful not to set the test of capacity to marry too high lest it operate as an unfair unnecessary and indeed discriminatory bar against the mentally disabled"

Baker J commented

> "Courts must guard against imposing too high a test of capacity to decide issues such as residence because to do so would run the risk of discriminating against persons suffering from a mental disability. In my judgment the carefully-drafted detailed provisions of the 2005 Act and the Code of Practice are consistent with this approach".

87. In the case of Re SB [2013] EWHC 1417 (COP) Holman J dealt with the problem of how to approach an assessment of the capacity of a person who suffers from a delusional disorder. At paragraphs 41 and 44 he said

> 41. "what weighs most significantly with me is that even if the patient has some skewed thoughts and paranoid or delusional views with regard to her husband and his attitude toward her and his behaviour, she gives many other reasons for desiring a termination.
>
> 44. "it seems to me therefore that even if aspects of the decision making are influenced by paranoid thoughts in relation to her husband and her mother, she is nevertheless able to describe, and genuinely holds, a range of rational reasons for her decision. When I say rational, I do not necessarily say they are good reasons nor do I indicate whether I agree with her decision, for section 1(4) of the Act expressly provides that someone is not be treated as unable to make a decision simply because it is an unwise decision".

88. The Court of Appeal in PC & NC v City of York Council [2013] EWHC Civ 478 clarified the nature of the test for capacity: it is decision specific. In paragraph 13 McFarlane LJ quoted and approved Hedley J's judgment at first instance on this issue

> "it seems to me that what the statute requires is the fixing of attention on the actual decision in hand. It is the capacity to take a specific decision, or decision of a specific nature, with which the 2005 Act is concerned….I see no reason why in the construction of the statute in any particular case the question of capacity should not arise in relation to an individual or in relation to specific decision making relating to a specific person. In my judgment, given the presumption of capacity in section 1(2) this may indeed be very necessary to prevent the powers of the Court of Protection which can be both invasive and draconian, being defined or exercised more widely than is strictly necessary in each particular case."

89. The Court of Appeal also provided guidance as to how the test of capacity is to be applied in paragraph 58:

> There is however a danger in structuring the decision by looking to s2(1) primarily as requiring a finding of mental impairment and nothing more and in considering s2(1) first before then going on to look at s3(1) as requiring a finding of inability to make a decision. The danger is that the strength of the causative nexus between mental impairment and inability to decide is watered down. That sequence – 'mental impairment' and then 'inability to make a decision' – is the reverse of that in s2(1) – 'unable to make a decision …<u>because of</u> an impairment of, or disturbance in the functioning of, the mind or brain'. The danger in using s2(1) simply to collect the mental health element is that the key words 'because of' in s2(1) may lose their prominence and be replaced by words such as those deployed by Hedley J: 'referable to' or 'significantly relates to'.

My decision

90. In this case there is a considerable measure of agreement between the experts as to the nature of QR's impairment and her capacity to make decisions which are not controversial in this application.

91. Dr Killaspy and Dr Akenzua agree that QR suffers from paranoid schizophrenia as a result of which she has long standing delusional beliefs on sexual themes, persecutory and grandiose delusions, which focus on fears about men entering her home and about the poisoning of her water supply. They agree that such delusions persist despite many years of treatment. They agree that QR lacks insight into her condition and does not accept that she has a mental illness or needs to take medication to stay well.

92. I am satisfied on the basis of evidence from Dr Killaspy and Dr Akenzua that QR has an impairment or disturbance in the functioning of the mind or brain which brings her within the ambit of section 2 of the Mental Capacity Act 2005.

93. Dr Killaspy and Dr Akenzua agree that QR has capacity to manage her property and affairs. They agree that she has capacity to understand the obligations of a tenancy agreement with regard to the payment of rent and other standard obligations of a tenant, and the landlord's responsibilities. They disagree about whether QR has capacity in relation to the matters at issue in this application.

94. What is the decision in hand? It is a decision whether or not QR should change her residence from ABC to a supported living flat, which will involve giving up the secure tenancy of her flat and taking on the tenancy of accommodation on terms that 24 hour support will be provided to her. These are linked decisions rather than decisions which should be viewed independently of each other.

95. I have to determine whether QR is unable to make this series of decisions because of the effects of her mental illness.

96. I have to consider whether QR understands or can use and weigh the information necessary to make the decisions. It is common ground between the experts, and I accept, that QR has no difficulty in retaining information or communicating it.

97. In relation to the move from ABC to supported living, in my judgment the relevant information that QR needs to understand, use and weigh is

(i) She will have to give up the tenancy of her flat.
(ii) The terms of the CTO will determine where she lives
(iii) IAOT will not at this stage allow her to live in her flat or in any other accommodation which does not provide on site 24 hour support
(iv) The move to supported accommodation will offer her greater independence and control over her life than are currently available at ABC
(v) She will have self contained accommodation
(vi) She is at risk of falling ill again, with life threatening consequences, if she does not take her medication
(vii) Her history has demonstrated over a long period of time that without 24 hour support she will not take her medication. While she has had 24 hour support in hospital and at ABC she has taken her medication and has not relapsed.

98. I consider that QR well understands (i) and (ii). Because she does not accept her diagnosis or history she does not understand (vi) or (vii) and so cannot use or weigh the concerns raised by her mental illness and history in making the decision. While she was aware that IAOT were proposing the move because it would provide a less restrictive environment for her, QR did not appear to attach weight to that aspect. She objected to 24 hour support as being regimented, like boarding school and denying her the privacy and independence that she seeks. However if she remains at ABC she will be choosing a living situation which as I understand it is more regimented and offers her less privacy and independence than the proposed supported living

accommodation. I conclude that she cannot use or weigh the information at (iv) or (v). QR did not fully understand (iii) in that she said at the hearing that she would accept moving to supported living accommodation if the support workers were not stationed in the building, which LBI made clear was not an option.

99. In relation to the decision to give up her secure council tenancy, in my judgement the relevant information that QR needs to understand use and weigh is

(i) By surrendering her tenancy she loses the right to live or return there, and thus the opportunity to exchange that tenancy for another secure council tenancy
(ii) She cannot move to a less restrictive environment than ABC unless she gives up her tenancy
(iii) For the foreseeable future the terms of the CTO will not permit her to live in her flat
(iv) She needs 24 hour support in her accommodation in order to remain well
(v) Giving up her tenancy does not preclude the grant of a council tenancy by LBI in the future if she is well enough to live completely independently

100. I consider that QR is able to understand, use and weigh the information at (i) (ii) and (iii). She does not understand and cannot use or weigh (iv). She did not appear to be aware of (v) and indeed it may be too speculative and too far in the future to play any significant role in this decision.

101. In relation to the decision to sign a tenancy agreement for supported living accommodation, in my judgment the relevant information that QR needs to understand use and weigh is

(i) Her obligations as tenant to pay rent, occupy and maintain the flat
(ii) The landlord's obligations to her under the contract
(iii) The risk of eviction if she does not comply with her obligations
(iv) The purpose of and terms of the tenancy which is to provide her with 24 hour support so that she takes her medication and can maintain her mental health
(v) The landlord/support staff's right to enter her flat without her permission in an emergency if there is serious physical danger or risk to her
(vi) If she moves to supported living accommodation the CTO will be changed to require her to live there

102. I consider that QR again is well able to understand use and weigh (i) (ii) (iii) and (vi). She cannot understand or use and weigh the information at (iv) and (v).

103. In formulating the above I have relied on evidence given by both experts although in general I have preferred the approach of Dr Killaspy. Dr Akenzua provided a helpful account of QR's thinking but viewed the decisions to be made on a more discrete basis than I consider appropriate. In my view he did not give sufficient weight to the impact of QR's inability to accept her diagnosis and need for treatment. He rightly identified the rational elements in QR's thinking but did not take adequate account of her failure to

understand and give weight to the role of support in ensuring that she takes her medication so that she can remain well.

104. I need to decide whether the information which QR is unable to understand use or weigh prevents her from being able to make the decision at hand.

105. Does QR understand the relevant information and can she use or weigh the relevant information in order to decide whether or not to sign this contract? She does not accept that she suffers from paranoid schizophrenia. She does not accept that she needs to take medication. She does not accept that, when her delusional state has gone untreated, she has on a number of occasions in the past refused to eat or drink because of paranoid fears of contamination, which has led to acute dehydration and renal failure. She has maintained this position over many years to Dr Killaspy, she expressed the same views to Dr Akenzua (para 10 E12) and to me. She does not accept that there is a reason drawn from her past medical history or her current condition why she needs 24 hour support.

106. QR has identified a number of reasons why she is not willing to surrender her current secure tenancy. She values the independence and privacy that it gives her. She rightly recognises the value of a secure council tenancy, both for itself and as a means of exchange for another secure tenancy. She wants to keep the option of completely independent living open. She has a number of reservations about the supported living options which have been offered to her which would be shared by any woman: fear of being unsafe in a particular area, fear of being unsafe in relation to other tenants generally and in view of their mental health histories, anxiety when having to face a group of male workers. Dr K acknowledged that QR is sensitive to her vulnerability to sexual violence for good reason and that IAOT take that seriously. She did not like aspects of all 3 options such as room size, back yard. I acknowledge that all of these are good and rational reasons for being reluctant to move somewhere.

107. Nonetheless in my judgment QR is unable to bring to bear on the decision an understanding of the nature of her illness and the risks she faces if she does not take her medication, and thus is unable to use or weigh that information in a decision making process. Without that understanding she cannot give due weight to the risks she faces if she does not take her medication, the implications of her long history of episodes of non compliance with medication and the role of 24 hour support in keeping her well. That is of central importance in a decision about whether to move on to a more independent living situation which requires her to accept 24 hour support to avoid those risks. It also prevents her from understanding the essential nature and purpose of the tenancy agreement for supported living which is based on her need for 24 hour support.

108. I do not accept that it is sufficient for QR, as her counsel proposes, to say that she will take her medication because the CTO requires her to do so. She has failed to take her medication without 24 hour support in the past while under a CTO. Acceptance is not the same as understanding.

109. Returning to the test for capacity in section 2(i) “is the person unable to make the decision for herself in relation to the matter because of an

impairment of, or a disturbance in the functioning of the mind or brain" I am satisfied that QR is unable to make the decisions at stake in this case as a result of the nature of her mental illness.

110. As to the cases I have referred to above, I do not consider that this is a case like that of KK v CC where the person in question may have underestimated or minimised some of her needs but is still able to make a capacitous decision. QR is not able to give weight to the issue of central importance in the arrangements which IAOT propose, the reason why she needs to take her medication. In this case I do not consider that I have set the standard for capacity too high. Unlike the case of Re SB, I consider that the delusions from which QR suffers which lead her to believe that she does not suffer from a mental illness or need to take medication operate to prevent her from making a capacitous decision in relation to the issues in the case.

111. In my judgment QR lacks capacity to make the decisions which are at issue in the case. If I had found that QR had such capacity, then she might well as Dr Akenzua says not choose to go to supported living, but she would be making that decision taking into account the realities of her mental illness and weighing up the risks that having greater responsibility for taking her medication would entail. She might then make what might be regarded as an unwise decision which as a person with capacity she would be free to make.

112. Turning to the issue of capacity to litigate, I am aware of the cases referred to by LBI. The test for litigation capacity in Masterman Lister v Brutton remains relevant to assessment of litigation capacity under the Mental Capacity Act 2005.

> "the test to be applied… is whether the party to legal proceedings is capable of understanding, with the assistance of such proper explanation from legal advisers and experts in other disciplines as the case may require, the issues on which his consent or decision is likely to be necessary in the course of those proceedings. If he has capacity to understand that which he needs to understand in order to pursue or defend a claim, I can see no reason why the law – whether substantive or procedural – should require the interposition of a (litigation friend)".

113. In the case of Sheffield City Council v (1) E(2) S, Munby J (as he then was) addressed the issue of whether a person could have litigation capacity while lacking subject –matter capacity. He said

> "The question, as we have seen, is always issue specific. There may be different answers to the questions, Does this person have litigation capacity? and Does this person have subject-matter capacity? As Bracewell J said, it all depends on the circumstances, There is no principle, either of law or of medical science, which necessarily makes it impossible for someone who has litigation capacity at the same time to lack subject-matter capacity. That said, however, it is much more difficult to imagine a case where someone has litigation capacity whilst lacking subject-matter capacity than it is to imagine a case where someone has subject-matter capacity whilst lacking litigation capacity. Whilst it is not difficult to think of situations where someone has subject-matter capacity whilst lacking litigation capacity, and such cases may not be that rare, I suspect that cases where someone has litigation capacity whilst lacking subject-matter capacity are likely to be very much more infrequent, indeed pretty rare. Indeed, I would go so far as to say that only in unusual circumstances will it be possible to conclude that someone who lacks subject matter capacity can nonetheless have litigation capacity".

114. In the case of Baker Tilly v Makar [2013] EWHC 759 (QB) Sir Raymond Jack said:

> "The court should be most cautious before concluding that the probability is that there is a disturbance of the mind. Such a finding (of lack of litigation capacity) is a serious step for both parties. It takes away the protected party's right to conduct their litigation. It may constitute… a serious disadvantage to the other party."

115. Is this one of those very rare cases where a person may not have subject-matter capacity but has litigation capacity? I have been the judge giving directions and conducting hearings in this case since October 2013. I have been told by QR's solicitor that she has no concerns about QR's capacity to litigate and her ability to get instructions from her. The case has not involved disputes as to the facts. I have noted what Dr Kingett had to say about QR's understanding of the legal process and her relationship with her solicitor (see paragraph 49 above). Dr Akenzua, QR's expert witness, provided evidence which was directed to the issues in the case and was of assistance to me. Her case was most ably presented by counsel at the final hearing. It would fly in the face of my own experience of dealing with the case to find that QR lacks capacity to litigate.

116. I have described above the matters in which QR has understanding and an ability to use and weigh information. She is in a stable state as regards her mental illness and recognises many of the realities of her situation. Her delusional illness affects her core understanding so as to make decisions for herself about the issues in this case, but does not prevent her from being able to manage her life and make most of her decisions for herself. She is able to understand the court process. Removing a person's capacity to litigate is a significant interference. I am not satisfied on a balance of probabilities that QR lacks the capacity to litigate.

117. At the next hearing the court will need to consider what further evidence if any is required in order that a best interests decision on the issues before the court can be made. I propose to publish this judgment in anonymised form on BAILII but will listen to any representations on the anonymisation from either party at the next hearing.

District Judge Batten