Neutral Citation Number: [2020] EWCOP 34

Case No: 13444937

IN THE COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 03/07/2020

Before :

THE HONOURABLE MR JUSTICE HAYDEN
VICE PRESIDENT OF THE COURT OF PROTECTION

- -

Between :

London Borough of Tower Hamlets **Applicant**

- and –
PB
(By his litigation friend, the Official Solicitor) **Respondent**

- -
- -

Ms Catherine Rowlands (instructed by the **London Borough of Tower Hamlets**) for the **Applicant**
Ms Fenella Morris QC & Mr Peter Mant (instructed by **Bindmans LLP**) for **PB**

Hearing dates: 12th March 2020

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Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

.....

THE HONOURABLE MR JUSTICE HAYDEN

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judgment) in any published version of the judgment the names and addresses of the parties and the protected person must not be published. 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.

Covid-19 Protocol: This judgment was handed down remotely by circulation to the parties' representatives by email and release to BAILII. The date and time for hand-down is deemed to be at 2pm on Friday 3rd July 2020.

Mr Justice Hayden :

1. This application concerns PB who is a 52-year-old man with a lengthy history of serious alcohol misuse. He has developed alcohol related brain damage and is assessed as meeting the criteria for a 'dissocial personality disorder'. Unfortunately, PB has a range of physical comorbidities, including Chronic Obstructive Pulmonary Disease (COPD), Hepatitis C and HIV.

2. On 17th January 2020 this application was listed before DJ Eldergill. At that hearing it was considered that the case presented a number of complex issues which might have wider resonance. Most immediately, there are two central issues for the Court to determine, namely:

    i. Whether PB has capacity to conduct this litigation and/or make decisions relating to where he lives and the care he receives;

    ii. If PB lacks capacity whether his current care and accommodation provision are in his best interests (in this context it is important to highlight that the restrictions with these arrangements are aimed at preventing PB from gaining access to alcohol, which he strenuously resents).

3. Manifestly, the resolution of these issues turns on their particular facts. District Judge Eldergill and the advocates before him considered that the issues presented by this case provided an opportunity for the Court to look more widely at the scope and ambit of the restrictions placed on those who are dependent on alcohol and have lost capacity in key areas of decision making. The order identifies the following:

    i. How the Court should approach the assessment of capacity of individuals who are alcohol dependent;

    ii. Whether or in what circumstances the Mental Capacity Act 2005 (MCA) should be used coercively to prevent people who are alcohol dependent from gaining access to alcohol.

4. The circumstances presented by this case are not uncommon and engage, paradigmatically, some of the fundamental principles which underpin the twin pillars of the MCA i.e. mental capacity and best interests.

5. The MCA provides a specific statutory definition of mental capacity which is termed to be "decision specific", predicated on a "functional approach", evaluated in the framework of a "diagnostic threshold". Thus, at the core of the Act is a central distinction between the inability to make a decision and the making of a decision which, objectively, would be regarded by others as unwise. Fundamentally, the Act emphasises the right of the individual, in exercising his or her personal autonomy, to make bad decisions even extending to those with potentially catastrophic consequences (see: **Barnsley Hospital NHS Foundation Trust v MSP [2020] EWCOP 26**).

6. It is necessary here to emphasise the cardinal principles of the Act. The presumption of capacity, Section 1(2), is the bench mark for decision makers in this sphere. To my mind it is every bit as important as the presumption of innocence in a criminal trial.

The Act reinforces this by requiring that a person is not to be treated as unable to make a decision unless *"all practicable steps to help him to do so have been taken without success"*. The scope of these unambiguous provisions requires fully to be recognised and vigilantly guarded. The philosophy informing the legal framework illuminates the point that this case highlights, namely *'a person is not to be treated as unable to make a decision merely because he makes an unwise decision'*. This statutory imperative reflected extensive common law jurisprudence, prior to the Mental Capacity Act, recognising that the law does not insist that a person behaves *"in such a manner as to deserve approbation from the prudent, the wise or the good"*: **Bird v Luckie (1850) 8 Hare 301.** It is the ability to take the decision, not the outcome of it which is in focus: **CC v KK and STCC [2012] EWHC 2136 (COP); Kings College Hospital NHS Trust v C & V [2015] EWCOP 80.**

7. McFarlane LJ made the following observation in **PC v City of York [2013] EWCA Civ 478** at [54], which strikes me as capturing and distilling the true essence of this principle:

> *"there is a space between an unwise decision and one which an individual does not have the mental capacity to take and … it is important to respect that space, and to ensure that it is preserved, for it is within that space that an individual's autonomy operates".*

8. It is important to identify and define the issue in question, see: **PC v NC and City of York Council [2013] EWCA Civ 478 at [35],** there the Court of Appeal stated that:

> *"The determination of capacity under MCA 2005, Part 1 is decision specific…. all decisions, whatever their nature, fall to be evaluated within the straightforward and clear structure of MCA 2005, ss 1 to 3 which requires the court to have regard to 'a matter' requiring 'a decision'. There is neither need nor justification for the plain words of the statute to be embellished."*

9. Equally as important is the responsibility, properly to evaluate the relevant information most likely to inform the decision in focus. In **LBX v K, L and M [2013] EWHC 3230** (**Fam)** at [48], Theis J identified the following information as relevant to a person's decision about their care: *"what areas he needs support with; what sort of support he needs; who will be providing him with support; what would happen if he did not have any support or he refused it; that carers might not always treat him properly and that he can complain if he is not happy about his care."*

10. It is important to set out Section 3 MCA, which provides:

> "3. Inability to make decisions
>
> (1) 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).
>
> (2) A person is not to be regarded as unable to understand the information relevant to a decision if he is able to understand an explanation of it given to him in a way that is appropriate to his circumstances (using simple language, visual aids or any other means).
>
> (3) The fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him from being regarded as able to make the decision.
>
> (4) The information relevant to a decision includes information about the reasonably foreseeable consequences of—
>
> (a)deciding one way or another, or
>
> (b)failing to make the decision."

11. Paragraph 4.30 of the Code of Practice also requires to be considered:

> *"Information about decisions the person has made based on a lack of understanding of risks or inability to weigh up the information can form part of a capacity assessment – particularly if someone repeatedly makes decisions that put them at risk or result in harm to them or someone else."*

12. Intrinsic to assessing capacitous decision taking is the ability to weigh and sift the relevant information. In **PCT v P [2011] 1 F.L.R. 287, AH and The Local Authority [2009] COPLR Con Vol 956** at [35] Hedley J, with characteristic conciseness, analysed the capacity to use or weigh information thus:

> *"the capacity actually to engage in the decision-making process itself and to be able to see the various parts of the argument and to relate one to another".*

13. It is not necessary for a person to use or weigh every detail of the respective options available to them to demonstrate capacity, the salient factors are key: see **CC v KK and STCC [2012] EWHC 2136 (COP)** at [69]. Importantly, it must always be recognised that though a person may be unable to use or weigh some of the information objectively relevant to the decision in question, they may nonetheless be able to use or weigh other elements sufficiently well so as, ultimately, to be able to make a capacitous decision, see: **Re SB [2013] EWHC 1417 (COP)**. It is not necessary to have every piece of the jigsaw to see the overall picture.

14. Even where an individual fails to give appropriate weight to features of a decision that professionals might consider to be determinative, this will not in itself justify a conclusion that P lacks capacity. Smoking, for example, is demonstrably injurious to health and potentially a risk to life. Objectively, these facts would logically indicate that nobody should smoke. Nonetheless, many still do. In **Kings College NHS Foundation Trust v C and V [2015] EWCOP 80** at [38] MacDonald J stated:

> *"It is important to note that s 3(1)(c) is engaged where a person is unable to use and weigh the relevant information as part of the process of making the decision. What is required is that the person is able to employ the relevant information in the decision-making process and determine what weight to give it relative to other information required to make the decision. Where a court is satisfied that a person is able to use and weigh the relevant information, the weight to be attached to that information in the decision-making process is a matter for the decision maker. Thus, where a person is able to use and weigh the relevant information but chooses to give that information no weight when reaching the decision in question, the element of the functional test comprised by s 3(1)(c) will not be satisfied. Within this context, a person cannot be considered to be unable to use and weigh information simply on the basis that he or she has applied his or her own values or outlook to that information in making the decision in question and chosen to attach no weight to that information in the decision making process."*

15. The Courts have, on other occasions, applied these principles in the context of alcohol dependency but before I consider the relevant case law, it is important to contextualise the law in the particular circumstances of this case.

Background

16. PB is a Yorkshire man. He can be stubborn, uncompromising and he is certainly direct, to the point of bluntness, particularly when communicating his feelings. He was unsparing in his criticisms of the privations placed on his liberty by his key social worker, Mr James Thomas, though, I sensed a respect and a trace of affection underlying his expressed complaints.

17. PB moved to live in the London area many years ago. For much of his life he had a heavy dependency on class A drugs, alongside his equally heavy consumption of alcohol. Some years ago, in circumstances that are not wholly clear, PB experienced a moment of epiphany. He realised, he told me, that he would die if he did not stop taking drugs and, in effect, he had chosen to live. I capture, I hope, the essence of what PB told me from his seat in the court room, during the course of the hearing.

18. It is important that I record here that the Official Solicitor informed me, in advance, that PB wished to be heard. The Official Solicitor submitted that even if PB was not deemed to be competent he should nonetheless be allowed to address the Court and the information provided by him taken in to account, as contemplated by Rule 14.2 (e) of the Court of Protection Rules. I entirely agree with this approach.

19. PB continued to consume alcohol excessively, notwithstanding his break with and continued abstinence from class A drugs. He has spent much time living in hostels and in supported placements but each of these, seemingly without exception, has broken down directly in consequence of his continuing alcohol abuse and his behaviour which, with some degree of understatement, is described as *"challenging"*. The most recent eviction occurred on 25th February 2019 when PB was ejected from a specialist residential home. He lived, for the following three months, on the streets of London. This experience took a heavy toll on his physical resilience and he attended hospital on multiple occasions, frequently in very poor condition. This particularly low period in PB's life culminated in a serious hypoxic episode on 16th May 2019. PB remained in hospital for three weeks following this, until an application was lodged, in early June 2019, seeking court authorisation for a planned discharge to a specialist supported living placement with a package of care intending to restrict PB's access to alcohol. The plan amounted, undoubtedly, to a Deprivation of Liberty.

20. Prior to the move to the specialist unit and building upon the inevitable enforced sobriety of his hospital admission, PB spent a period in a Recovery Centre, with the aspiration that he would achieve strategies for abstinence from alcohol. This was not an unqualified success. PB expresses a wish to continue to drink alcohol but asserts an ambition to achieve moderation.

21. The regime in the unit where PB now lives is a rigorous one. PB is not permitted to leave the unit unescorted. The primary purpose, perhaps even the only purpose, of the requirement of an escort is to prevent PB from drinking. These restrictions have been authorised by a variety of orders between September 2019 and the present. It is important to record that to test PB's resolve and respect his assertion of a wish to moderate his drinking, a trial period was negotiated in which it was planned that PB should be permitted to leave the unit unescorted for 2-hour periods. Though PB denies it, I have no difficulty in concluding, on the evidence, that, on a number of occasions in December 2019, he returned far later than arranged, gave the appearance of being drunk and was abusive to members of the staff. On the 16th December 2019 he urinated and vomited in his bed overnight. As I understand it, some empty beer cans were found in his sleeping area. The trial period was terminated.

22. The present arrangement has the effect of granting PB considerably more freedom. This is situational rather than having been achieved by design. PB is left alone in his part of the unit overnight. The unit claims and I accept the evidence that PB gains access to alcohol overnight when he is unsupervised. Happily, there has been no repetition of the behaviour on the 16th December 2019. The Official Solicitor noted that the applicant was unclear as to whether the current arrangements amount to a Deprivation of Liberty, given that PB is content to live where he is, on the proviso that he is permitted to drink. At the moment, he has achieved his wish by default rather than design. I consider that the arrangements amount to deprivation of liberty because they curtail PB's choices and require him to exercise guile and deception to achieve his own wishes. The Official Solicitor agrees.

Capacity

23. Dr Costafreda Gonzalez, who is known as Dr Costafreda, has provided extensive reports, dated 12th November 2019, 6th January 2020 and 3rd March 2020. They are erudite and sensitive documents. Dr Costafreda is a consultant psychiatrist and an

Associate Professor at University College London. His report records that he has extensive experience of assessment of mental health and capacity issues, both as an NHS consultant and in the medico legal context. Ms Fenella Morris QC and Mr Peter Mant, instructed by the Official Solicitor, on PB's behalf, succinctly summarise the conclusions of Dr Costafreda's first report as follows:

i. PB has an impairment of the functioning of the mind or brain, caused by alcohol related brain damage and a dissocial personality disorder;

ii. PB has capacity to make decisions concerning his care and residence;

iii. PB had fluctuating capacity to conduct proceedings.

24. Dr Costafreda stated that which, to me, is self-evident from the history namely, that if PB started drinking again it was *"almost certain that he would lose control and trigger the cycle of homelessness, intoxication and withdrawals, self-neglect and hospitalisations likely, ultimately, to cause his death"*.

25. Ms Morris has highlighted some features of PB's interview with Dr Costafreda. PB appeared to have forgotten a number of his previous hospital admissions, he acknowledged experiencing symptoms of alcohol dependency and was able to reason why, in future, he would be able to moderate his drinking. His thoughts are coherent on this, he identifies the importance of his present stable home base and the fact that he is no longer "around alcoholics" as factors which can moderate his behaviour. Dr Costafreda considered, in this first report, that PB *"seriously overestimates his ability to keep his alcohol dependence under control"* but, concluded that he had the capacity to make decisions about residence and care on three principle grounds:

i. Minimisations, rationalisations and justifications despite all evidence to the contrary are typical of people with substance dependence who are not generally considered to lack capacity;

ii. [PB] did not exclude the possibility he could die and defended his decision to continue drinking on grounds of autonomy *("it's my life"*) and fatalism *("I've not got long to live"*);

iii. His answers showed *"sufficient understanding and acceptance of the risks to his health and well-being that would result from a decision to go back to drinking".* Although [PB's] aim to keep drinking in moderation was unrealistic, *"he was using the information that returning to more excessive drinking would be dangerous."*

26. In this first report Dr Costafreda also considered that PB had the capacity to conduct proceedings but, as I read the report, suggests that such capacity might fluctuate at times when PB becomes agitated or *"highly aroused"*. This accords exactly with PB's presentation before me.

27. As I have indicated above there are two addenda to the initial report. In the first addendum Dr Costafreda revised his position as to what he considered to be the *"relevant information for [PB] to decide on drinking alcohol*". Ms Morris and Mr

Mant summarise Dr Costafreda's evolved thinking in these terms, in their Position Statement (the emphasis is theirs):

> *"(A)* ***if he is allowed to go out unsupervised he will drink to excess***
>
> *(B) drinking alcohol to excess will result in him* ***developing extreme challenging behaviour with aggression which will likely result in him not being able to access support*** *and becoming homeless*
>
> *(C) drinking alcohol to excess will result in him developing life-threatening physical problems,* ***including aspiration of his own vomit with repeated hospitalisations*** *and a high probability of dying"*

28. Ms Morris emphasises that Dr Costafreda explicitly concluded that PB was able to understand and weigh the information identified as relevant at (B) and (C) above. Further, she highlights that PB accepted that he had drunk to excess when unescorted. In his second addendum, to which I will turn shortly, Dr Costafreda said that PB's blaming staff did not *"necessarily"* mean he could not understand or use the relevant information. This leads Ms Morris and Mr Mant to submit, in their Position Statement, as follows:

> *"23. Despite finding that [PB] could understand and use all of this information, Dr Costafreda nonetheless concluded that he lacked capacity to make decisions about his residence and care on the grounds that [PB] did not accept that recent episodes have demonstrated "beyond doubt" that he is unable to control his drinking, so that it is in fact "certain" that he will continue to drink to excess if he is not supervised."*

29. Ms Morris is correct, in my view, to emphasise the language used in Dr Costafreda's revised criteria. It strikes me as imposing a very challenging test of capacity to expect an alcoholic, who continues to drink, to be required to concede or acknowledge *"beyond doubt"* that he is unable to control his drinking and to such a degree that it has become a *"certain"* fact that he will drink to excess if not supervised. A test which is so absolute and unyielding is difficult to reconcile with the fundamental principles of the MCA, set out above. The effect of such a test strikes me as eroding, very significantly, "the space" to use McFarlane LJ's term (see para 8 above), between a decision which is unwise and one which an individual does not have the capacity to take. The application of Dr Costafreda's test would have the alarming effect of rendering most addicts incapacitous if they are unable to agree with the precepts of the test whilst, to my mind, making a deprivation of liberty almost inevitable to those who are able to agree *"beyond doubt"* that they are *"certain"* to drink to excess. Thus, a paradigm Catch 22 scenario is created.

30. Furthermore, Dr Costafreda's test is not easy to reconcile with the body of case law emphasising that the relevant tests in assessing capacity should not be set at a high level. As Munby J (as he then was) in **Sheffield City Council v E [2004] EWHC 2808 (Fam)** and Baker J (as he then was) in **PH v A Local Authority [2011] EWHC 1704 (Fam)** both emphasise, the Courts must be vigilant to resist the imposition of too high a test of capacity in issues such as residence and care. The consequence of

doing so raises the spectre of discrimination towards people suffering from a mental disorder. It also risks subverting the emphasis on autonomy that is the lode star of the legislative framework. Baker J expressed it in these terms (para 16 (ix)):

> *"In Sheffield City Council v E [2004] EWHC 2808 (Fam) (a case concerning the capacity to marry decided before the implementation of the 2005 Act) Munby J (as he then was) 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".*
>
> *Although that observation concerned the capacity to marry, I agree with the submission made by Miss Morris on behalf of the Official Solicitor in this case that it should be applied to other questions of capacity. In other words, 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 judgement, the carefully-drafted detailed provisions of the 2005 Act and the Code of Practice are consistent with this approach."*

31. Dr Costafreda made the following observations in his second addendum, predicated on the second interview which was arranged, as I see it, primarily to incorporate the fact of the failed trial period (discussed at para 21 above):

> *"[PB] is unable, in his decision-making, to use the **fact** that he does not have control over his drinking. Instead of the true fact of his lack of control over alcohol, his thinking is informed by the belief that he will be able to contain his drinking within relatively safe limits. I think this is due to a combination of his alcohol dependence, with lack of insight in his inability to control his drinking, as well as executive dysfunction caused by alcohol-related brain damage, which causes impairment in the planning and monitoring of his own behaviour, so he is unable to learn from the repeated failures to control his drinking. (counsel's emphasis)"*

32. There is no doubt that PB *"seriously overestimates his ability to keep his alcohol dependence under control"*, to use Dr Costafreda's own phrase but, again as Dr Costfrada said, in his substantive report, *"minimisations, rationalisations and justifications"* in the face of *"all evidence to the contrary"* are "*typical of people with substance dependence who are not deemed to lack capacity"*. Self-evidently, not every addict in some degree of denial can be regarded as incapacitous. Ultimately, for all the above reasons, I do not consider that Dr Costafreda's decision to revisit the criteria, following the failure of the trial period, reflected a proper consideration of the relevant legal framework

33. Ms Morris and Mr Mant make a similar point, expressed in language which is rather stronger than I have used:

> *"61. No person's choices should, as a matter of principle, be regarded as wholly predetermined. Every human being (whether*

> *mentally impaired or not) has potential to develop and change. That a person retains an optimistic view of their own future potential (in the face of past experience) cannot, in itself, be a proper basis for finding a lack of capacity.*
>
> *62. An approach that seeks to ascertain facts about how a person will behave in the future, and assesses their capacity against their acceptance of those facts, is not only unprincipled it is also impractical. The vicissitudes of life are so many and varied that no person can predict with certainty what another person, or he himself, will do in a particular set of circumstances. Professionals could reasonably hold very different views on the topic."*

These rather metaphysical observations may well be correct, but the point is a simpler one, in my judgement. Section 3(4) (set out at paragraph 10 above) makes it plain that the material relevant to a decision includes information about the reasonably foreseeable consequences of deciding one way or another, or failing to make the decision. In his earlier reports Dr Costafreda was quite clear that PB was able to see the reasonably foreseeable consequences of his decision. That is the applicable test, recently endorsed in **B (by her Litigation Friend the Official Solicitor) v A Local Authority [2019] EWCA Civ 913** and set out at paragraph 4.16 of the Code of Practice. 'Reasonably foreseeable consequences' are, self-evidently, quantitively and qualitatively different to the 'certainties' contemplated in Dr Costafreda's elevated criteria.

The approach to capacity.

34. Ms Catherine Rowlands submits that the approach of the Official Solicitor is misconceived. She contends that Ms Morris, by concentrating on PB's understanding of his dependency on alcohol, has conflated the issues and has, accordingly, blurred the questions that require to be considered. I think Ms Rowlands is correct to refocus on the central issue in question i.e. whether PB has the capacity to take decisions concerning his residence and care, recognising that PB's drinking is a relevant factor. In her supplemental submission Ms Rowlands states:

> *"The local authority submits that the Official Solicitor is approaching this question from the wrong slant. The question is not whether PB will drink to excess: the question is whether he lacks capacity to make decisions about his residence and care. The question of whether he will drink to excess is part of that. However, the question should be approached in a structured way.*
>
> *The first question, therefore, is whether PB has an impairment of mind, or disturbance in the functioning of the mind or brain, temporary or permanent, as a result of which he is unable to make decisions. The second is to identify the relevant factors, and the third step is to consider the best interests of PB should the court consider that he does not have capacity."*

35. Ms Rowlands recognises the importance of the presumption of capacity, she submits that this is a *"complex case*" and continues:

> *"Nonetheless [the Local Authority], remains strongly of the view that PB does not have capacity to make decisions as to his residence and care having regard to alcohol consumption and in particular the consequences of alcohol consumption on his behaviour and thence on his care placement.*

36. Ms Rowlands invites the Court to come to the following conclusions:

> *"a. PB has impairments of mind, namely a personality disorder and brain damage;*
> *b. As a result of which he is unable to understand the relevant facts which are:*
> *i. He is likely to drink to excess*
> *ii. If he does he will be abusive and threatening*
> *iii. And will therefore lose his accommodation.*
> *c. It is in his best interests to reside at [F unit] and to receive care there in a way which prevents him from drinking to excess."*

37. In his second addendum Dr Costafreda was asked to consider the significance of PB's diagnosis of Dissocial Personality Disorder. The following passages are pertinent:

> *"I think it is useful to emphasise first that there is significant overlap between the manifestations of dissocial personality disorder and those of alcohol-related brain damage. I had briefly discussed this overlap in the initial report. Two important areas of overlap are executive dysfunction and behavioural abnormalities related to the frontal lobes, which can occur in both conditions.*
>
> *In summary, while it is clear in my view that PB presents with both disorders, it can be difficult to establish whether a specific deficit or behaviour is due to one or the other disorder, or a combination of both, precisely because of this overlap.*
>
> *Deficits in self-monitoring as part of PB's executive dysfunction due to alcohol-related brain damage are therefore likely to compound the difficulty in learning from negative experiences characteristic of dissocial personality disorder, and, in PB, their combined effect is likely to further impair his insight regarding alcohol drinking. PB's personality disorder therefore is likely to contribute to his inability to use the information regarding his lack of control for drinking."*

38. This reasoning, as I see it, suggests that it is difficult to establish whether a specific deficit or behaviour is due to Dissocial Personality Disorder or alcohol related brain damage or a combination of both to varying degrees. Dr Costafreda considered that PB's dissocial personality is likely to contribute to an inability to use information in respect of his lack of control with alcohol.

39. In his oral evidence Dr Costafreda considered that the dominant cause of the defect of PB's decision making was that he *"had a false belief as to the extent that he could moderate his drinking."* Dr Costafreda concluded that defect was due to alcohol dependency and that the alcohol related brain injury and personality were contributory factors. All these, he considered, could not be untangled. Ms Morris submits and I agree, that it is not enough, within the provisions of Section 2 of the MCA for the impairment or disturbance in the functioning of the mind or brain to be one of a number of possibilities or perhaps partly responsible. The test is whether it is *"because of"*:

> *"2. People who lack capacity*
>
> *(1) 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.*
>
> *(2) It does not matter whether the impairment or disturbance is permanent or temporary.*
>
> *(3) A lack of capacity cannot be established merely by reference to—*
>
> *(a)a person's age or appearance, or*
>
> *(b)a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about his capacity.*
>
> *(4) In proceedings under this Act or any other enactment, any question whether a person lacks capacity within the meaning of this Act must be decided on the balance of probabilities…"*

40. PB has made a number of statements which make it clear that he appreciates that "*he will not wake up*" if he drinks to excess. He articulates *"I have got to have the will power not to have excess"*. He suggested that he drinks alcohol which is of lower proof to ameliorate his excessive consumption. It matters not, to my mind, whether the latter is in fact true, what is relevant is that it illuminates PB's understanding of the impact of his drinking on his situation. I have already commented above that the reasoning expressed by PB, namely that his present environment, away from other alcoholics has the potential to support greater sobriety, is also entirely rational. It reveals his understanding of some of the benefits the placement offers.

41. The central question, as Ms Rowlands correctly emphasises, is whether PB has the capacity to decide on where he should live and the care to be provided for him. That assessment requires consideration of many of the factors identified by Theis J in **LBX v K, L and M** (supra), see para 10 above. It also requires an evaluation of whether PB understands the impact on his residence and care arrangements of his continuing to drink, potentially to excess. Ms Rowlands submits that PB does not have the capacity to evaluate the consequences of his alcohol consumption on his behaviour and therefore on his placement.

42. Whilst I agree entirely with the Local Authority's structured approach to the test to be applied, I do not agree with its conclusion on the evidence. On the contrary, PB's analyses his dependency on alcohol in a way which is both articulate and rational. He is also clear as to the dire consequences of his drinking to excess. He makes the

association between the consequences of drinking to excess and the impact on his care arrangement. He reconciles the two in his own mind by his conclusion that he should stay where he is but moderate his drinking to reasonable limits. There is within his plan an inherent recognition that drinking to excess and the sustainability of the placement are irreconcilable. There is much evidence from PB's history that he is unlikely to be able to achieve this, but the potential gulf between his aspiration to moderation and the likely reality, does not negate the thought processes underpinning his reasoning. In any event I do not consider that there is evidence here which is sufficiently choate to rebut the presumption of capacity. The plan that PB identifies may not be sustainable long term but that does not permit an inference that he is unable to foresee the consequences of drinking to excess on the sustainability of the placement.

43. It is important to consider here what the Court of Appeal emphasised in **PC & Anor v City of York Council [2013] EWCA Civ 478**, per McFarlane LJ

> *51. The difficulty in the case thus arises from the potential for the understandable professional concern about a vulnerable woman going to live with NC to impact upon the mental capacity assessment under MCA 2005 in a case where the degree of mental impairment lies in the borderline area. In such a case Mr Bowen is right to assert that the structure and provisions of the MCA 2005 are to be applied with clarity and care in order to ensure that the autonomy of the individual is not eroded by the court in a case which, in reality, does not come within the statutory provisions.*
>
> *52. Against the background that I have described, the need for the Court of Protection to adhere to the structure established by MCA 2005, Part 1 is all too clear. In particular:*
>
> > *a. a person is not to be treated as unable to make a decision merely because he makes an unwise decision (s 1(4)); and*
> > *b. for the Court to have jurisdiction to make a best interests determination, the statute requires there to be a clear causative nexus between mental impairment and any lack of capacity that may be found to exist (s 2(1))*
>
> *53. Mr Butler's reference to Baroness Hale's description of the approach that underpins the MCA 2005 is timely; the court's jurisdiction is not founded upon professional concern as to the 'outcome' of an individual's decision. There may be many women who are seen to be in relationships with men regarded by professionals as predatory sexual offenders. The Court of Protection does not have jurisdiction to act to 'protect' these women if they do not lack the mental capacity to decide whether or not to be, or continue to be, in such a relationship. The individual's decision may be said to be 'against the better judgment' of the woman concerned, but the point is that, unless they lack mental capacity to make that judgment, it is against <u>their</u> better judgment. It is a judgment that they are entitled to make. The statute respects their autonomy so to decide and the Court of Protection has no jurisdiction to intervene.*

44. It has to be remembered that Dr Costafreda's conclusions in respect of PB's capacity changed during the course of his assessments. There is no doubt, in my mind, that PB's failure to achieve sobriety in the trial period led Dr Costafreda to re-evaluate his approach to the question of capacity. Whilst I accept, in principle, that the relevant issues identified as illuminating capacity may require to be revisited in the context of a particular case, I can see no clear or logical reason for revising them here. The fact that PB consumed excessive alcohol, having expressed his goal as being moderation, does not strike me as requiring the criteria to be recalibrated. It is difficult to resist the conclusion that Dr Costafreda, having plainly identified a regime of abstinence and sobriety as being in PB's best interest, considered that his resistance to it and the stark consequences that might flow from it, must indicate an incapacity in his reasoning. The far more obvious conclusion, on the evidence, is that Dr Costafreda recoiled from PB's bad decision. The decision may hasten PB's death but PB, like any of us and for the reasons foreshadowed above, is entitled to make bad decisions if he chooses to do so. This is the respect for individual autonomy which courses through the MCA.

45. It seems to me that the position here is not dissimilar to that found by the Court in **PC & Anor v City of York Council** (supra), where *"understandable professional concern"* for a vulnerable woman led to the construction of a test for capacity which was too high and motivated by a desire to protect her. Here, an appreciation of and sympathy towards PB's vulnerability and the entirely accurate recognition of his parlous situation, strikes me as having cast a shadow over the forensic rigour required in an assessment. Dr Costafreda's various reports identify this as a difficult and delicate assessment. As I have stated but consider it appropriate to repeat, we are concerned here with that *"space"* identified by MacFarlane LJ between an "*unwise decision*" and one which *"an individual does not have the mental capacity to take."* The imperative, in these circumstances, is not paternalistically to protect PB's health and welfare but to respect his autonomy. PB's desire to live where he is presently based, but on his own terms, strikes me as consistent with his recognition of his limited options.

46. In **RB v Brighton & Hove City Council [2014] EWCA Civ 561** Jackson LJ emphasised what he described as the *"wrong way to make use of authorities in this highly fact sensitive jurisdiction"*. Jackson LJ observes that it is "inappropriate" to compare decisions taken by different individuals in different cases, *"that approach sucks the Court into convoluted reasoning. It also drives up costs"*. The entire thrust of the analysis in the Court of Appeal's judgment emphasises the importance of applying the fundamental principles of the MCA within the particular circumstances of the individual case.

Conclusions

47. Having determined that the flaw in PB's decision making was his inability to understand that he would never be able to drink alcohol other than to excess, Dr Costafreda set a test which was too high and did not integrate those facets of PB's reasoning which had caused him, in his earlier assessment, to conclude that PB had the capacity to decide on issues relating to his residence and care. In to this also requires to be factored, as I have stressed, that PB is perfectly happy to remain where he lives but with greater freedom surrounding his use of alcohol. I am not being asked to consider whether PB has the capacity to decide to take alcohol or not but whether

he understands the impact on his present living arrangements should he drink to excess. It is important to restate this point.

48. Ms Rowlands and Ms Morris have expended great energy addressing Dr Costafreda's analysis of what he considers the defect in PB's decision making to be. Having concluded that the test for capacity settled upon by Dr Costafreda was too high, it is not necessary for me to scrutinise his explanation of the likely cause of that deficiency. However, I have noted at paragraph 39 above that I was not persuaded that the evidence established the necessary nexus between the disturbance in the functioning of the mind or brain and inability to make a decision.

49. At court PB was highly agitated but coherent when he spoke. He did not give sworn evidence but he addressed me from the floor of the court where he appeared to feel more comfortable. I have addressed his statements and what he has told me in the course of this judgment. In their closing submissions counsel did not address me on the question of litigation capacity. I agree there was no need to do so. I am satisfied that PB's views were clear, accurately reflected in the submissions of the Official Solicitor and that his voice was heard appropriately.

50. As is plain from my analysis above, I do not consider that it is possible to give guidance in the prescriptive manner which may have been contemplated by DJ Eldergill. I am also conscious that I have not addressed separately and directly the second issue in his order (see paragraph 3 above). I understand the concerns underlying this second issue and I hope I have analysed them in my reasoning above. However, I am uncomfortable with the terminology used in the order. The order enquired *"whether or in what circumstances the Mental Capacity Act 2005 (MCA) should be used coercively to prevent people who are alcohol dependent from gaining access to alcohol."* Coercion has pejorative implications, it implies persuasion by use of force or threats. As such it has no place in the Court of Protection and jars entirely with the applicable principles of the MCA. Moreover, the question only arises when the issue of capacity has been determined. If P has capacity then manifestly the Act does not apply. If P lacks capacity, facilitating compliance with a regime to which he is opposed will always involve the lightest possible touch, the minimal level of restraint or restriction and for the shortest period of time. In other words, the level of intervention must be proportionate. I am entirely confident that this balance is what DJ Eldergill was contemplating.

51. It may be useful to reiterate the following:

    i. The obligation of this Court to protect P is not confined to physical, emotional or medical welfare, it extends in all cases and at all times to the protection of P's autonomy;

    ii. The healthy and moral human instinct to protect vulnerable people from unwise, indeed, potentially catastrophic decisions must never be permitted to eclipse their fundamental right to take their own decisions where they have the capacity to do so. Misguided paternalism has no place in the Court of Protection;

    iii. Whatever factual similarities may arise in the case law, the Court will always be concerned to evaluate the particular decision faced by the

individual (P) in every case. The framework of the Mental Capacity Act 2005 establishes a uniquely fact sensitive jurisdiction;

iv. The presumption of capacity is the paramount principle in the MCA. It can only be displaced by cogent and well-reasoned analysis;

v. The criteria for assessing capacity should be established on a realistic evaluation of what is required to understand the ambit of a particular decision by the individual in focus. The bar should never be set unnecessarily high. The criteria by which capacity is evaluated on any particular issue should not be confined within artificial or conceptual silos but applied in a way which is sensitive to the particular circumstances of the case and the individual involved, see **London Borough of Tower Hamlets v NB (consent to sex) [2019] EWCOP 27**. The professional instinct to achieve that which is objectively in P's best interests should never influence the formulation of the criteria on which capacity is assessed;

vi. It follows from the above that the weight to be given to P's expressed wishes and feelings will inevitably vary from case to case.

52. Beyond the above, which I recognise to be little more than a statement of general principles, it is not possible to offer further guidance.