Neutral Citation Number: [2020] EWCOP 75

Case No: 13258625

IN THE COURT OF PROTECTION
SITTING AT NORTH SHIELDS COUNTY COURT

Kings Court, Earl Grey Way, Royal Quays,
North Shields, NE 29 6AR

Date: 21/10/2020

Before:

HER HONOUR JUDGE MOIR

B E T W E E N:

SUNDERLAND CITY COUNCIL
and
FP, RT & ST

Mr S Garlick appeared on behalf of the Applicant
Mr J O'Brien (instructed by **Switalskis**) appeared on behalf of the First Respondent
Mr A Fullwood (instructed by **Richmond Anderson**) appeared on behalf of the Second Respondent
The Third Respondent appeared In Person

Approved Judgment

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Mr Justice Poole, with the agreement of 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 other than the Second Respondent, RT, must be strictly preserved. A transparency order is in place preventing the publication of communication of any information that identifies or is likely to identify FP. All persons, including representatives of the media, must ensure that this condition and the transparency order are strictly complied with. Failure to do so will be a contempt of court.

HHJ MOIR:

1. This application is made by Sunderland City Council in respect of FP, who was born on [date of birth] and so is now 34 years of age. She is the daughter of RT, and ST is her stepfather. Throughout the course of this judgment, I will refer to FP, RT and ST, as those names obviously must be kept confidential for the transcript.

2. The Council seeks declarations under Section 15 of the Mental Capacity Act 2005 that FP lacks capacity to conduct these proceedings and to make decisions as to her residence, care and support and contact with others including RT. The Council seeks detailed findings on the issues raised in the Schedule of Allegations which is before the Court. The Council also seeks revocation of FP's health and welfare lasting power of attorney which appointed RT as her attorney on the grounds that RT has acted and is likely in the future to act in a way which is not in FP's best interests.

3. The Council, in light of FP's present circumstances whereby FP is presently detained in hospital under Section 3 of the Mental Health Act, seeks an interim declaration that it is not in FP's best interests to reside with or receive care from RT and/or ST. The Council also seeks injunctions restraining RT from publicising the proceedings and restraining RT from certain conduct towards FP and those supporting her.

4. The final hearing commenced in front of me on 25 November 2019 and was heard over seven days until 4 December 2019. The matter then went part-heard until 16 March 2020. It had been anticipated that a planned leave of absence would have been completed by that date. Unfortunately, it was not until 24 April 2020 that I was able to return to full judicial duties. The parties were notified, it has to be said, in error, that the matter would be listed for final hearing and heard before Her Honour Judge Smith instead on 16 and 17 March. The case was of course part-heard, and the Court had heard from all the witnesses in the case apart from RT and the new social worker, NH. The relisting of the hearing was bedecked with difficulties and that was before the pandemic caused a lockdown of all the courts. As the case was part-heard, it was necessary to determine a date upon which all the advocates, the Court, and ST and RT were available. Thus, it was not until 20 August 2020 that the hearing concluded.

5. Thereafter, counsel and ST filed written final submissions which were completed by 17 September 2020. Unfortunately, the date identified last week of 13 October for judgment could not be met, for which I apologise. I am very grateful to the advocates, including ST of course, and to the Russian interpreter for their careful approach to this hearing, the entire hearing. ST has tried to get RT to focus upon the details of the evidence which was required to determine the issues in the case, not always, it has to be said, successfully but usually with more success than the Court or the other advocates achieved in this regard.

6. Since the commencement of the proceedings, the Court has made a number of interim orders under Section 48 of the Mental Capacity Act 2005, including:

> (a) that FP lacks capacity to make decisions on conducting the proceedings, her residence, care and contact with others,

(b) that FP should reside at [address] and receive care there in accordance with her assessed needs,

(c) that contact between FP and RT should take place three times each week for four hours and should be supervised.

7. Supervision has been undertaken by external supervisors, namely supervisors other than those within FP's placement, and FP's deprivation of liberty has been authorised by the Court at the placement at [the placement].

8. By order dated 25 July 2018, the Court gave the parties permission to instruct Dr Christopher Ince, Consultant Psychiatrist, to report to the Court on FP's capacity to make decisions on conducting the proceedings, residence, care and contact with others. Dr Ince was duly instructed, and he provided his first report to the Court on 7 January 2019.

9. Prior to the report on 7 January 2019, the Court had given the parties permission to raise questions with Dr Ince. FP, by her litigation friend, and RT raised questions and Dr Ince responded on 6 February 2019.

10. Following the case management of this matter on 23 October 2019, the parties were given permission to instruct Dr Ince to provide a supplemental report. Dr Ince reported on 20 November 2019. Dr Ince's report and his conclusions are before the Court and the Court gave permission for Dr Ince to be called to give oral evidence.

11. By order dated 12 June 2019, the Court directed that:

(a) by order of that date, it was directed that ST, FP's stepfather, should be joined as a party to the proceedings,

(b) Sunderland City Council was to file a schedule of the allegations it sought to prove in relation to RT's interaction with FP, the Council and care providers and the Council was to serve further evidence in support by 3 September 2019.

12. The timetable provided that RT was to respond to those allegations by 4pm on 24 September 2019. A pre-trial review was heard on 23 October 2019 and the final hearing was listed for 25 November 2019.

13. When the matter came before the Court for pre-trial review as planned, the order for that hearing records that on dates in September 2019, and without consultation with any other party, RT arranged for FP to be recorded answering questions about her wishes and feelings. RT confirmed to the Court that she would not, pending further order, cause or arrange for any further recordings to be made of FP for the purpose of adducing evidence in the proceedings.

14. At that pre-trial review, further evidence was required from Dr Ince to address FP's capacity to make decisions on her residence, care and contact with others, the cause of FP's disturbed sleep pattern and what steps, including the removal of her phone, could be taken to address this problem. FP's capacity to execute the powers of attorney dated 8 May 2019 was also to be considered.

15. The Court gave further directions for the filing of witness evidence in relation to the circumstances in which the videos were made and separate orders were made for disclosure

of the solicitors of the papers in relation to the signing of the LPA.

16. Following the part-heard hearing, which concluded on 4 December 2019, the Court has dealt with a number of applications at a number of hearings leading up to the adjourned final hearing commencing on 17 August 2020. Both RT and ST have asserted since December 2019 that FP had regained capacity and that a further capacity assessment was required. By order of 18 May 2020, the Court made an order which gave the parties permission to instruct Dr Ince to report on FP's capacity to make relevant decisions.

17. Dr Ince was, in the first instance, to review the records from [her placement] and to indicate whether there was any realistic possibility that FP had acquired capacity. Dr Ince was then asked to consider whether he thought it was necessary to reassess FP in order to reach conclusions on these issues and, if so, permission was given for him to reassess FP and then report to the Court by 5 July 2020. In fact, Dr Ince reported and provided a third addendum report dated 29 July 2020, in which he re-addressed the issue of FP's capacity and best interests in relation to contact.

18. I have heard oral evidence from both ST and RT. I have also heard oral evidence from Dr Ince, [GR], the social worker allocated in January 2018 and part of the Complex Mental Health Team, IG, the Senior Service Manager for [the community care provider], DS, Healthcare Assistant. I have heard from Mr M, who is described as a Digital Strategist, in respect of the recording which RT commissioned of FP and I have also heard from NH, who is the social worker now with conduct of this matter and who was appointed in June of this year.

19. I have also read extremely detailed documentary evidence from a number of carers and healthcare professionals. I have to confess that I have not read each and every document which has been provided within the five lever-arch files, which Ms Freeman very kindly provided to me when unfortunately, IT problems meant that the bundle, the digital bundle, from which I had worked during the course of the hearing, was no longer available to me.

20. Mr Garlick, on behalf of the Council, recognises that the Council's case has been, to a significant extent, founded upon hearsay evidence, contained principally in the contemporaneous records in respect of the care provided to FP written by a variety of health and social care professionals over a period of, in total, some eight years. These records include daily hospital records, [the placement] records, and records of care providers charged with supervising contact between FP and RT. In addition, I have had access to, and read carefully, the independent investigator's report published on 14 November 2018, which report was commissioned upon complaint by RT and ST in respect of FP's care at [the placement].

21. The Council has relied upon the evidence reported by the investigator from the care team and I am satisfied that the report is a careful and detailed piece of work. ST and RT profoundly disagree with the findings and much of the detail within this report.

22. The Civil Evidence Act requires certain procedures to be followed. Civil Evidence Act notices were served on the parties and no counter-notices were received. I remind myself that hearsay evidence is admissible in these proceedings and it is for the Court to decide how much weight to attach to each piece of such evidence. I take into account that the evidence derives from professionals who, as Mr Garlick, I think, indicated, have no axe to

grind and the fact that the records were made contemporaneously or very shortly thereafter by a number of different professionals of various disciplines, employed by a variety of organisations over a substantial period of time are factors which I consider.

23. I also take into account the fact that RT disagrees with much of the content of those records. RT has been cross-examined in relation to a significant amount of the content of the records but it has not been practically possible, and I would not have expected, that RT should be cross-examined on each and every account set out within the records. Therefore, again, I remind myself that I must take care in relation to the weight I place upon the written documentation.

24. I have the oral evidence, which I consider in parallel to the written documentation, but for the reasons which I have just set out, I am satisfied that the contemporaneous records, by the variety of individuals, are records which largely provide an accurate picture of events and consideration of FP's daily life and RT's contact and interaction with those individuals who have provided the written reports.

25. Mr Fullwood, on behalf of RT, submits, and I read from his written submissions:

> "The Council accepts that to a significant extent; its case relies on hearsay evidence drawn from records from people who have not been called as witnesses. This has meant that RT and others, including the Court, have been denied the benefit of asking them questions and judging their credibility in person. In contrast to the Council's evidence, RT has made herself available and endured a very distressing and exhausting process whereby she has attended court on numerous occasions and was cross-examined directly for approximately two days."

Mr Fullwood submits that the Council's evidence is therefore fundamentally weakened by its reliance on hearsay evidence and the Court should approach that evidence with caution and, at times, some scepticism. Mr Fullwood reminds me that private care providers may have conflicts of interests and RT is worried that at least to some extent when she has pointed out inadequacies in her daughter's care and support, she has been unfairly criticised.

26. In reaching the conclusions which I have, and in particular detailing my approach to the hearsay evidence, I have taken into account those matters which Mr Fullwood has raised and I have exercised caution in relation to my approach to the evidence which is in written form.

27. In considering the oral evidence, I do not underestimate the stress for RT and ST of being in court in circumstances which are alien to most individuals and particularly in circumstances such as pertain to this hearing and this matter. The issues are of very great importance to RT, who is emotionally very invested in the outcome. It is an emotional and stressful situation and I do take that into account when I come to assess RT's evidence.

28. RT found it very difficult to restrict the oral evidence which she gave, in any way. She gave much of her evidence in English, which was her choice. The Russian interpreter was extremely helpful and professional in the assistance which she gave to RT and the Court. I do take into account that English is not RT's first language, but I am satisfied that no

misunderstandings occurred which were not remedied with the assistance of the interpreter.

29. The Council seeks specific findings, which are set out in the Schedule of Allegations which has been provided within these proceedings, namely:

> (a) finding, one, that RT lacks a basic understanding of how FP's mental disorder affects her,
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> (b) finding two: that over a period of many years, FP and RT have had an enmeshed relationship in which FP is exposed to high expressed emotion,
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> (c) finding three: that RT communicates negative critical thoughts about FP's care to her and to others, sometimes in abusive terms, in FP's presence,
>
> (e) finding four: that RT has often behaved towards carers in an abusive and unpleasant fashion, which may be intended and is likely to demoralise them,
>
> (f) finding five: that RT's contact, both direct and indirect, with FP, whilst of importance and value to FP, is, on many occasions, associated with a decline in her mental health and presentation,
>
> (g) finding six: that RT has sought to control FP's care and treatment and prevented FP from expressing her own views,
>
> (h) finding seven: that RT attempts to challenge FP's medication and has interfered with FP's medication to the detriment to FP.

30. The primary position of RT and ST has been, throughout, that FP has the capacity to make the relevant decisions. RT has maintained that FP has capacity even when acutely unwell and, within her statement dated 31 July 2020, at 283 in the bundle, at paragraph 19, RT sets out:

> "Regarding Dr Ince's report, this man lied in his report again because FP was not in any distress that day. She called me soon after he left and explained that there was no assessment as such. FP never told him that she wants to come home 'because Mum wants it'. She expressed to him her own wishes and feelings, as she expressed to her advocate and to her solicitor. I insist that there is nothing wrong with my daughter's mental capacity, even when she is not well, and she understands and gives her reasoned opinion on everything that is happening, she remembers and can retain the information and she has her own view. This is well-recorded and will be brought up for the attention to the Parliamentary Health and Care Ombudsman and to all to whom it may concern but deteriorations and disturbances in her mental state are due to interference with her treatment that is confirmed and embittered by the social worker and by three hospitals. I believe that this was a deliberate attempt to deteriorate my daughter's condition to suit the Council's needs for the court."

This extract from RT's statement, it seems to me, illustrates very well RT's views in relation to the capacity of FP.

31. ST, in his submissions to the Court, sets out that there were not even any concerns about FP's capacity until weeks after the court application, the concern then being raised by GR with no foundation. ST sets out that there have been no records which have shown that FP lacks capacity. I quote directly from ST's final submissions: "Only Dr Ince's evidence and opinion have been used and wrongly interpreted to indicate a lack of capacity despite being totally against the principles of the Mental Capacity Act 2005. Even Dr Ince did not say that she lacks capacity; he merely expressed an opinion".

32. I must consider the ambit of this hearing and the orders which the Court can make. The Council accepts that given that FP is currently detained in hospital under Section 3 of the Mental Health Act, whatever her needs will be at the point of discharge cannot be evaluated presently. Thus, the Council are not seeking any Section 16 or Section 48 orders as to FP's residence, care and contact. Further decisions about contact during FP's detention in hospital are, as a matter of law, for the responsible clinician to make in consultation with the relevant health professionals. However, the Council asked the Court to proceed to make such findings as it can as such findings will form a major part of the information used by the Court to make decisions in respect of FP at the appropriate time.

33. The Court has heard a significant amount of evidence covering an extensive period of time. The Council submits that the patterns of behaviour exhibited over many years by RT towards those supporting FP and indeed towards FP herself, are a reliable indicator of how RT will behave in relation to FP and her carers in the future and, therefore, it is crucial to take advantage of the opportunity which the Court now has and has had in December and August, to hear evidence in this regard.

34. The argument is also advanced that although decisions about contact, as a matter of law, are for the responsible clinician, it is likely that the responsible clinician will wish to take into consideration the conclusions which the Court has reached after a thorough examination of the history of this matter.

35. The litigation friend supports the approach of Sunderland City Council that the Court should consider the findings, if it is able to make such findings, and that the Court, if appropriate, has power at this stage to exclude as an option FP returning to live with RT and, if appropriate, to proceed to make that order.

36. While the Council and litigation friend invite the Court to make a declaration that it is not in FP's best interests for her to live with RT, Mr Fullwood, on behalf of RT, submits that even if the Court has the power to make such a declaration, it would be wholly inappropriate to make such interim declaration.

37. Thus, the Court must consider whether it has the power under the Mental Capacity Act to rule out options at this stage in the proceedings where the final decision on best interests cannot be made because the realistic options are not presently known. The Court must also consider whether, even if it does have the power, whether the Court should exercise such power at this stage of the proceedings or whether it would be inappropriate to so do in all the circumstances.

38. The Council submits that the Court does have the power to make an interim declaration that it is not in FP's best interests to reside with RT. Such declarations, say the Council, would not be in conflict with any course of treatment proposed under the Mental Health Act and

would signal to all those responsible for FP's discharge planning that the Court does not consider that it would be in FP's best interests to reside with RT.

39. Mr O'Brien, on behalf of the litigation friend, submits that the Court does have power to rule out options and he draws my attention to the case of *A North East Local Authority v AC (by her Litigation Friend) and BC* [2018] EWCOP 34 in which Cobb J came to the conclusion that the Court does have power by reference to a number of authorities in the analogous family jurisdiction. I read the relevant paragraphs of that authority. Paragraph 22:

> "As I have indicated above, the Court is presented with quite a range of options as to AC's future placement. The Local Authority and the Litigation Friend speak with one voice in contending that I can and should at this stage rule out the option of AC's return home, even though they both contend that I should adjourn the proceedings for further evidence to be garnered in relation to residential care and supported living. This approach brought to mind the guidance from *In re B-S (Children) (Adoption Order: Leave to Oppose)* [2013] EWCA Civ 1146 in the family jurisdiction. In that case, the Court described the Court being required to conduct: '… a balancing exercise in which each option is evaluated to the degree of detail necessary to analyse and weigh its own internal positives and negatives and each option is then compared, side by side, against the competing option or options.'
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> 23. I raised the question with counsel whether the court could legitimately rule out one possible outcome or option, before reaching a firm conclusion on best interests. In seeking an answer to that question, I referred counsel to the case of *North Yorkshire CC v B* [2008] 1 FLR 1645. In that case, Black J, as she then was, said: 'If the evidence is available, I see nothing wrong in the court determining in advance of the Local Authority presenting its final care plan and the court considering "disposal" that a particular individual is not going to be in a position to care for a child safely in the sort of timescale that the child needs. I do not agree … that that is an unusual course in these courts. It is not at all uncommon for a parent or another individual to be ruled out after a fact-finding hearing' …
>
> 24. Miss Thomas in turn referred me to *Re R* [2014] EWCA Civ 1625. In that case, McFarlane LJ and Sir James Munby P highlighted the "fundamental" importance of the court concerning itself in the final analysis only with "realistic" options. Sir James Munby P explained:
>
> > "*Re B-S* does not require the further forensic pursuit of options which, having been properly evaluated, typically at an early stage in the proceedings, can legitimately be discarded as not being realistic. *Re B-S* does not require that every conceivable option on the spectrum … has to be canvassed and bottomed out with reasons in the evidence and judgment in every single case. Full consideration is required only with respect to

those options which are realistically possible".

And at paragraph 26:

> "And at 67 of *Re R* he made this important point: 'If, in this way, an aunt or grandparent can be ruled out before the final hearing as not providing a realistic option, there can in principle be no reason why, in an appropriate case, one or other or even both parents should not likewise be ruled out before the final hearing as not providing a realistic option. *Re B-S* requires focus on the realistic options and if, on the evidence, the parent(s) are not a realistic option, then the Court can at an early hearing, if appropriate having heard oral evidence, come to that conclusion and rule them out. *North Yorkshire County Council v B* [2008] 1 FLR 1645 is still good law. So, the possibility exists, though Judges should be appropriately cautious, especially if invited to rule out both parents before the final hearing or, what amounts to the same thing, ruling out before the final hearing the only parent who is putting themself forward as a carer.'"

At paragraph 162 [sic], Cobb J states:

> "I have, therefore, reached the conclusion having considered all of the evidence at this hearing that I can and should rule out AC's rehabilitation to the care of her sister, even though the specific placement outcome for her in residential care is not yet clearly identified or identifiable. In eliminating one significant option for AC's future care at this stage, I have followed the essential reasoning of Black J in *North Yorkshire CC v B*, and Sir James Munby P in *Re R*. I have followed the guidance of the Court of Appeal in *Re B-S* in focusing on the realistic options for AC: given that, on the evidence, placement with BC is not a realistic option, then I am entitled to that conclusion and rule her out. In short, I have been driven to the conclusion that rehabilitation would not be a realistic option for AC now or in the relevant future."

40. I am satisfied that I do have the power, having heard all the evidence, if appropriate, to make a declaration that FP should not return to live with her mother and, thus, effectively, rule out that placement. The question remains as to whether it is appropriate so to do. Mr Fullwood sets out very carefully the reasons why it would be inappropriate. At paragraph 7A in his final submissions, Mr Fullwood states:

> "Decisions under the MCA 2005 are time and subject specific. On the evidence before the Court, FP is unlikely to be discharged for many months. It would be contrary to the principles of the MCA to make such interim declarations now. The position in six months or more is likely to be very

different with new factors and evidence that can only be properly and fairly considered then. There is no utility to the proposed interim declarations. The Court should only make orders and declarations that serve a useful purpose, and the proposed interim declarations serve none. This Court can only make declarations in relation to available options *Re N* [2017] UKSC 22. RT has made it clear that she wants FP to return home but her return now is not an option before the Court. FP has, at times, indicated a fervent wish to live with RT. There is no evidence as to what, if any, impact such a declaration may have on FP at this stage. The Council's own submissions accept that the Court cannot and should not make long-term decisions about FP's residence and care. A further but more general point, but no less important, should also be made: it must be common ground that it is in FP's best interest to look forward in a positive and constructive manner. The Court may be concerned that the Council has become somewhat jaundiced in its approach to this family."

41. I am of the view that the appropriateness or otherwise can only be properly determined after consideration of all the evidence and the investigation by the Court of the evidence before it. The burden of proving the accuracy of the findings which it seeks lies with the Council. The standard of proof in these proceedings, and in respect of the facts which the Court is invited to find, is the balance of probability.

42. I turn then to the background of this matter. I have utilised the detail set out by Mr O'Brien at paragraph two of his document. FP was born in Russia and moved to the UK in 1997 when she was 12 years of age. Initially, the family moved to Wales where RT married her husband, ST. The family then moved to Kent for seven years and then to the Sunderland area.

43. FP has a history of neurological conditions from birth and has a diagnosis of cerebral palsy. She experiences seizures and has a number of other physical problems such as heart disease, behavioural problems and urinary symptoms. She is able to use a walking frame over short distances but for longer distances uses her wheelchair.

44. In 2011, FP contracted meningitis. This resulted in a deterioration in her mental health. FP had previously had psychiatric in-patient stays in Russia but had more recent psychiatric hospital admissions, including being detained under the Mental Health Act 1983. FP was detained under Section 2 of the Mental Health Act 1983 between 15 March 2017 and then on Section 3 of the Mental Health Act from 11 April 2017. She has a diagnosis of schizophrenia and experienced auditory hallucination including that people are going to kill her and attempt to harvest her internal organs.

45. In October 2017, FP was discharged with the benefit of Section 117 Mental Health Act after-care. It was agreed, following assessments, that FP would require a full and comprehensive care package from 24-hour staff. FP then had been resident at [the placement], the identified and preferred placement, since October 2017 until recently. On 8 May 2018, FP purportedly executed a lasting power of attorney and RT was the donee of that power.

46. For a period of time prior to the application, it is recorded that there have been concerns about RT's conduct and influence upon FP. The care provider expressed concern that RT's conduct had threatened to compromise the safety and person-centred approach that the provider developed for FP. RT was alleged to regularly disregard professional advice and standards. RT constantly challenged health advice and instruction from professionals designed to promote FP's wellbeing. It is right that I underline that RT does not accept the views or recordings of the care provider in relation to her conduct.

47. In 2018, there was an escalation of this behaviour and RT made complaints to Sunderland City Council and also the Ombudsman. RT challenged professional interventions in relation to medication, adaptations and medical advice. It is right that RT has made various complaints in respect of the care that FP has received at the placement and that she has made complaint to the Ombudsman. I should also point out that RT accepts that she has, upon occasion, challenged professional interventions on the basis that the care of FP has been lacking and, at times, very damaging to FP. RT has, throughout the hearing, indicated to the Court that what she has done or said has been with the best interests of FP at the forefront in her mind. RT's behaviour has been categorised as obstructive and the care provider has given notice of the withdrawal of services to FP.

48. RT's engagement with carers and professionals is set out in the evidence which I will consider. The Council invites the Court to make findings in relation to RT's engagement and her failure to further FP's best interests. RT has denied throughout that she has been obstructive and has emphasised that her concern is for her daughter's wellbeing.

49. RT has continued to have contact with FP in accordance with the interim orders outlined. ST has not had contact with FP for some time.

50. The final hearing commenced in November 2019, as I have outlined. During the course of the hearing, the Court was informed that the care provider commissioned to supervise contact between FP and RT in the community on a two-to-one basis, that is Comfort Call, had given notice of withdrawal of its service. In addition, at that hearing, it was known that there was a possibility of FP being given a trial of alternative anti-psychotic medication Clozapine, prescribed for the treatment of treatment-resistant schizophrenia. This trial would involve FP having a period of hospital admission for the purposes of titration and monitoring.

51. I continue the chronology in that FP was admitted to hospital as a voluntary patient on 9 January 2020 for the purpose of titration and monitoring and then she was detained under Section 3 of the Mental Health Act on 6 February following a deterioration in her presentation.

52. Sunderland City Council has informed the Court that there have been significant problems in commissioning a provider to take over the responsibility of supervision of contact. Prior to lockdown, contact continued to be provided twice a week on Monday and Tuesday by CIC at the hospital for four hours on each occasion. It was anticipated that from a date in April 2020, this would change to three times a week on Monday, Wednesday and Friday. In the middle of March 2020, following the Covid-19 national health emergency, visits to FP in the hospital ceased.

53. On 26 May 2020, FP was granted Section 17 Mental Health Act leave and returned to [the

placement]. She was discharged from Section 3 on 2 June 2020. There were daily visits by the Community Treatment Team and, at weekends, the Crisis Team but FP's mental health deteriorated, leading to increased administration of PRN Lorazepam and her eventual readmission to [the] Hospital under Section 3 of the Mental Health Act on 8 July 2020. RT holds [the placement] responsible for the deterioration in FP's condition and the misapplication or misadministration of FP's required medication.

54. On 19 July, FP was transferred to [a] ward at [a hospital], which is an acute ward, and then on 4 August, it was confirmed at an MDT Review Meeting, that FP was to be transferred to a Rehabilitation Ward at [that hospital]. The information with which I was provided at the hearing in August was that FP is likely to remain for some time at [that hospital] whilst her medication is optimised, and she undergoes a detailed assessment of her functional abilities and mental health.

55. The care provider at [the placement], served contractual notice on the Council to terminate the care provided at the placement as it considered that it was unable to meet FP's needs due to significant deterioration in her presentation. When [the care provider] gave notice, it also referred to the unsustainable level of complaints made by RT.

56. Thus, up to date, the present position is that the availability of placements or accommodation for FP at a time when, presently unknown, she is discharged from hospital is unclear.

57. I turn then to the issue of capacity and the findings which the Court is asked to make. Mr Garlick, on behalf of the applicant Council, makes submissions on capacity first and then analyses the evidence to support the findings which the Council seeks. Mr Fullwood, in his final submission also considers capacity first. Mr O'Brien considers that the findings should be considered first prior to addressing the issue of capacity. The litigation friend submits that some of the findings sought by the Council will in fact underpin some of the conclusions reached by the Court in relation to FP's capacity to make relevant decisions.

58. While I can see merit in Mr O'Brien's approach, I feel uncomfortable in assessing credibility and making findings and possibly making significant criticism without determining whether or not FP lacks capacity. If the evidence provides that FP has capacity across the board, the role of the Court of the Protection is rendered nugatory. If the Court is satisfied, on the evidence, that FP lacks capacity, in whatever regard, it is then the responsibility of the Court to investigate and reach conclusions about the best interests of FP in respect of matters on which she is found not to have capacity to decide. Therefore, I will consider the issue of capacity before proceeding, if justified, to make findings in this matter.

59. The evidence as to capacity is provided by Dr Ince. Permission was given by the Court on 25 July 2018 to instruct Dr Ince to report to the Court on FP's capacity to make decision on conducting the proceedings, to make decisions as to residence, care and contact. His report is dated 7 January 2019.

60. RT and ST are completely dismissive of Dr Ince's expertise and his approach to the assessment of capacity has been roundly criticised by RT and ST. RT told me in evidence that she did not accept Dr Ince's view because he did not accept any of her concerns and: "Dr Ince's report is based on Council notes", and "All the way from the notes of evidence

which I took, all the way through, she", FP, "has had capacity". When asked by Mr O'Brien if there was any point in the last three to four years when FP's schizophrenia has meant FP lacked capacity, RT responded and, again, I take these responses from the notes which I made in the course of the evidence: "No, she still remembers. Her condition was deliberately when the Court of Protection started". RT, in her evidence, called Dr Ince a 'liar' and doubted his independence. ST, in his final submissions, states that:

> "The only evidence that FP lacks capacity is supposedly from Dr Ince, who, in his reply to my recent questions, states that he did not state FP lacked capacity to sign the LPA or that she will lack capacity in the future. He said it was his opinion that she had possibly lacked capacity to sign the LPA or that she will lack capacity in the future. No medic has ever stated E lacks capacity to make decisions for herself, only Dr Ince and his opinion. Only Dr Ince's evidence and opinion have been used and wrongly interpreted to indicate a lack of capacity despite being totally against the principles of the MCA".

61. I must look at all the relevant evidence in respect of whether FP has capacity to make decisions and, of course, that includes the evidence of RT and ST. The issue of capacity is dealt with in Sections 1-3 of the Mental Capacity Act 2005 and in the numerous authorities to which the Court must have regard. Under the Mental Capacity Act, it is set out that:

> "1 The principles
>
> (1) The following principles apply for the purposes of this Act.
>
> (2) A person must be assumed to have capacity unless it is established that he lacks capacity.
>
> (3) 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.
>
> (4) A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
>
> (5) An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
>
> (6) Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action."

62. Section 1 of the Act sets out the principles which the Court must apply in each and every case when considering the issues required. At Section 2, the Act sets out:

"(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'. Section 3: '(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).

(5) 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...

(6) 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.

(7) 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".

63. As already set out, I have the full report of Dr Ince, namely the report of 7 January 2019 and 6 February 2019, 20 November 2019 and 20 July 2020. At I117 in the bundle, Dr Ince set out his understanding of his role. Within that letter dated 3 August 2020, he set out that his role is that of an independent medical expert giving advice to the Court:

> "With my responsibilities set out within the relevant practice guidance, my duty is to the Court as opposed to any specific party within any proceedings. My advice in any case is founded upon clinical observations and assessment and set in the context of the agreed letter of instruction that set out the relevant case law upon which I must frame my views. Accordingly, my opinion is precisely that, an opinion set within the legal framework. The decision-maker within these proceedings is a sitting Judge and thus, respectfully, any decision to revoke or return the LPA will sit with them with the decision made on the basis of the law."

I read that out specifically because his understanding of his role within the proceedings is correct. Dr Ince is the expert in relation to capacity, but it is the Court which decides upon the basis of all the evidence before it. I have heard Dr Ince give oral evidence upon FP's capacity in this case on two occasions. I am satisfied that he is a careful and highly experienced expert. He is a respected assessor of capacity in the Court of Protection. His written evidence is comprehensive, cogent and his analysis follows the principles set out at Sections 1, 2 and 3 of the Act to which I have already referred.

64. I appreciate that the issue of capacity is not straightforward and that it is sometimes difficult to someone without a legal or medical background to understand the complexities but neither RT or ST, I find, have any real understanding of what it means to either have capacity or lack capacity. I am well aware that neither RT or ST will accept this opinion of the Court. I do not want to be patronising but the understanding of the application of the Mental Capacity Act by RT and ST is limited.

65. Dr Ince initially interviewed FP on 15 November 2018. FP's very first exchange with Dr Ince is recorded as being without prompting and: "I don't know if I would like to live here or elsewhere but I would like to live with my mother". FP has at various times told various professionals that she would like to live with her mother. RT told Dr Ince: "All she needs is medication. FP is who is going around neglected and abused, yes, abused, and that is another matter, sodium docusate, I said to the doctors I didn't want her medication changed".

66. Dr Ince sets out his opinion at I23 within the bundle.

> "The letter of instruction raises a number of issues and as such it would appear prudent to address each in turn. With regard to any assessment of capacity, it is necessary to note the specifics of the Mental Capacity Act wherein the overarching principles of Section 1(1)-(6) states that a person must be assumed to have capacity unless it is established that she lacks capacity".

67. He then goes on to deal with those matters which I have just set out. Dr Ince states that:

> "The available information confirms that FP has a long history of complex delusional beliefs, has been prescribed numerous anti-psychotic medications and displays recurrent and rapid deteriorations within her mental state. She has previously required inpatient psychiatric care and detention under the Mental Health Act. FP has invariably been afforded diagnoses of psychosis, non-organic psychosis and paranoid schizophrenia. It was clear at assessment and noted within the mental state examination that FP continues to present with a range of delusional beliefs, primarily relating to the harvesting of her internal organs. There is no evidence that FP suffers from any other mental illness. There is no evidence that FP would meet the criteria for any degree of learning disability. I do note her significant care needs that exceed her own appraisal of necessity of input and would ascribe these deficits within her adaptive functioning and the dual comorbidities of epilepsy and cerebral palsy. She has significant continence needs and there are further concerns regarding her behavioural presentation, with the provided documentation particularly referencing agitation, physical assaults, e.g., grabbing at both staff and RT, self-harms and breaking, swallowing objects.

Despite these factors, there's no evidence of global developmental delay and she presents with the cognitive impairment that is often present in individuals with multiple neurological conditions to include previous meningitis with concurrent chronic psychosis. There is no evidence that FP suffers from a pervasive developmental disorder, there's no evidence that FP would meet the criteria for any disorder of adult personality. Overall, there is clear evidence that FP suffers from an impairment or disturbance in the functioning of the mind or brain based upon the *International Classification of Diseases*, 10th edition, a diagnosis of F20 schizophrenia is the most applicable terms given that she displays persistent delusions of other kinds that are culturally inappropriate or implausible, such as religious or political identity, superhuman powers and abilities etc. that have been present for most of the time during an episode of psychotic illness lasting at least one month.

FP suffers from epilepsy, however, whilst an impairment or disturbance in the function of the brain or mind, this condition is not relied upon within the substantive assessment of capacity as set out below.

With regard to the impact of FP's underlying psychotic illness upon her level of cognitive functioning, and aside from the general impairment as set out above, her presentation at assessment demonstrated a gradual demonstration within her performance that was notably exacerbated following the telephone call from RT. I would also note the longitudinal continuation sheets and other care records provided by [the] Care Provider that set out rapid fluctuations within the presentation of FP often during the course of a single day with a tendency towards deteriorations in her mental state, mood and global presentation in the evenings and with it suggested that these correlate with telephone calls from RT.

FP is further noted to struggle with external stresses and high express emotion and whilst not the sole trigger, I would, again, note the consistent references within the

care records to her becoming agitated, verbally hostile and distressed during visits or following visits from RT. I would also note that the detailed care records corroborate the statements of GR, social worker, and the safeguarding alerts and are further triangulated within the comprehensive report prepared by [the] independent investigating officer, regarding the latter.

In referencing the documentation and the comments of RT, the reference to FP having capacity relate to aspects of self-care and her ability to decide whether to take prescribed oral medication, I would also note that the provided records from March 2017 referenced that she was deemed not to meet the criteria for detention under the MHA as opposed to her having capacity and that she was subsequently released as not being able to consent to admission to or discharge from hospital and, thus, made subject to detention under Section 2 of the MHA.

I would further note, both within this and previous assessments, that FP's presentation gradually deteriorated and that her responses became more confused and contradictory. I would suggest that she presents with a substantive picture of fluctuating that regularly impacts upon her ability to make decisions regarding a number of issues and that such deteriorations can be rapid and significant".

68. Dr Ince in his oral evidence confirmed his opinions as set out within his report and stated:

> "In broad terms, I would conclude FP lacks capacity with regard to treatment of her mental disorder. Her view in respect of blood tests was to check if her organs had been harvested. She fails to understand the purpose of monitoring for medication and the treatment she is on."

He described his view: "There is a deference by E to at least some of the views of RT and not an objective weighing of those views as to a positive or negative impact". Dr Ince referred in his oral evidence, to FP's complex delusional belief system. He told me that: "FP doesn't accept she has a mental health condition. She fundamentally disagrees with the diagnosis of schizophrenia. Her understanding is inextricably entwined with her delusional belief system". Dr Ince described that FP's schizophrenia was within the 25% of persons with the condition who would suffer ongoing symptoms of illness despite treatment.

69. I am satisfied that FP suffers from schizophrenia which amounts to an impairment in the functioning of the mind or brain for the purposes of Section 2(1) of the Mental Capacity Act 2005. It seems that RT and ST accept that FP has a diagnosis of paranoid schizophrenia.

70. In his report of 7 January 2019, Dr Ince concluded: "FP lacks capacity to make decisions regarding accommodation and residence". During the course of his assessment, Dr Ince noted that FP's mental state, as set out within his report, was subject to a significant change following the telephone call from RT. Dr Ince has taken the view that FP expressed views which were not her own and believed that she was unable to objectively weigh information

provided to her. In his addendum report, Dr Ince is clear that the telephone call did not cause FP to lose capacity but more wholly identified her deficits and produced a degree of distress that further impaired her global development.

71. Dr Ince was clear that FP's inability to make a decision is attributable to her schizophrenia. Dr Ince set out that FP was unable to consistently understand, retain and weigh information relevant to the decisions on care and, therefore, lacked capacity to make decisions regarding her care and support needs.

> "Overall, FP lacked an awareness of the nature and extent of her care needs due to the lack of insight into her underlying psychiatric illness and her refusal to accept the role the care staff played in keeping her safe and maintaining her mental health. FP further lacked any understanding of the triggers to deteriorations within her mental state and that the care staff were there to provide and did provide a protective factor to minimise the risk of harm to herself and others."

72. Mr O'Brien in his final submissions refers to Dr Ince setting out that FP further lacked any awareness that RT would not be able to solely care for her or that there have been previous significant risk incidents.

73. Dr Ince was satisfied that in relation to contact with others, FP was unable to weigh information relevant to the decision and that her inability to weigh the validity of the views of others negatively impacts upon her ability to understand and retain Information As such, she lacked capacity to make decisions as to with whom she should have contact. Finally, Dr Ince set out that FP is unable to understand, retain, use or weigh information relating to the issues before the Court.

74. In relation to contact with others, and, similarly to other decision-making, I am satisfied that FP is unable to weigh information relevant to the decision that she is required to make. Her inability negatively impacts upon her ability to understand and retain information. In Dr Ince's opinion, FP is unable to understand, retain, use or weigh information relating to the issues before the Court upon which declarations are sought. Dr Ince identified that there were times when FP was wholly unable to make decisions by virtue of an inability to understand, retain and weigh the relevant information, however, there were times when FP was able to understand and retain certain aspects of the information but her inability to appraise the source of the information and its validity meant that she could not weigh the information in order to arrive at a capacitous decision. Dr Ince concluded that FP currently lacks capacity at all times, but the reasons and the extent differ depending on her mental state.

75. When Dr Ince gave evidence on 20 August 2020, he said that he had revisited the issue of FP's capacity. RT and ST had been very anxious, as their view had not altered that FP had capacity, that a further and up-to-date consideration of capacity should be undertaken so that the Court had before it the most recent assessment of capacity. Dr Ince told me that on consideration of the records created since his last report and upon the additional evidence sent to him, he had found no evidence that FP's mental presentation or her fundamental

abilities for the purposes of Section 3 of the Mental Capacity Act had improved to an extent that she may have acquired capacity to make the relevant decisions as to residence, care, support and contact. It was, he said, not a serious possibility.

76. Mr Fullwood, on behalf of RT, submitted that RT accepted the diagnosis of paranoid schizophrenia. In addition, he sets out that it is also accepted that when her condition is not treated properly and she is unwell, she may temporarily lose capacity, although I note that that was not the evidence at times within the oral evidence of RT. Mr Fullwood submits that it cannot and should not lead to a final decision that FP lacks capacity, that those concerned with FP should ensure she receives the correct care and treatment and should wait until she recovers, when, it is argued on behalf of RT, that FP is perfectly capable of making her own decisions. I disagree.

77. To complete RT's position, Mr Fullwood submits that RT completely disagrees with Dr Ince's opinion about her daughter's capacity to make her own decision. RT does not accept FP is unaware of her mental health needs or otherwise lacks sufficient insight into the same. There is a concern that Dr Ince has imposed a very high threshold in terms of what relevant information he expects FP to understand, retain, use and communicate. Mr Fullwood submits that the Court must be careful to ensure that the bar is not set too high, see *LBX v K, L, M* [2013] EWHC 3230 (Fam).

78. I have considered the issue of capacity very carefully and, of course, whether or not the bar has been set too high. It is not my view that it has been. The approach of the Court must be that a person has capacity to make their own decisions unless proven otherwise. In this case, the burden is upon the Council to establish lack of capacity. RT very strongly takes the view, as does ST, that the Council has failed to discharge that burden and no declaration that FP lacks capacity can be made. I am satisfied on the evidence before me and with careful consideration and analysis that FP does lack capacity in relation to her care and support needs, residence and contact.

79. In addition, I am satisfied that FP does not understand the effect of RT's behaviour upon her mental state and does not understand that RT's behaviour has the potential to undermine her care and placement. Dr Ince confirmed in his oral evidence that FP does not understand the extent to which the high expressed emotion, to which he refers, with which RT presents and the stress RT causes FP may precipitate or elongate relapse in her mental health. I will refer to some examples of RT undermining FP's trust in those supporting her when I come to consider the Schedule of Findings. I am completely satisfied that FP does not understand how the stress RT causes impacts upon her and also those persons around her who are tasked with supporting and caring for FP. Thus, such lack of understanding must support the view that FP lacks capacity to make decisions about contact with RT. Further, Dr Ince concludes that overall, his view is that:

> "RT, knowingly or otherwise, seeks for her view to be put forward by FP and that she cannot accept that FP is able to hold contradictory views or that others involved may similarly hold conflicting views or be seeking to advance the autonomy of FP to put forward her own views".

80. I am satisfied that RT does not regard any views about FP and her requirements other than her own, whether it be a professional with a certain expertise, such as Dr Ince, or the responsible clinician or the mental health social workers or indeed the care staff. If their opinions in respect of FP and her care differ from those of RT, then, in RT's view, they are wrong and RT expresses her view stridently that she is right and she knows her daughter. It is a very small point, but it is illustrative of RT's approach: RT was concerned that [the placement] staff were washing FP's bedding on the 60-degree programme, which is a usual programme for sheets and bedding, however, more particularly, it is a requirement, as far as those operating [the placement] were concerned, to ensure hygiene and safety rules were complied with. It was a source of complaint for RT, who wanted them washed on a 40-degree wash because her view was that the higher temperature was unnecessary and ruined the bedding. RT was critical of the staff and would not accept that there was a valid reason for their actions.

81. In her oral evidence before me, RT made her views clear. She told me: 'FP has been tortured and abused for years', that the fluctuation in FP's mental state was because her medication was not properly reviewed. RT referred to the conspiracy between the doctors and the nurses to experiment with FP's medication. She told me the Social Services influenced the hospital:

> "The social worker interferes, tittle tattle again, turning the nurses against me. I've been through so much. They are just bullies. They put me through daily stress. I have been deliberately aggravated. I have been excluded. I have had aggravation since day one. I don't know why. Statements by the social workers are not accurate; they are just not. They are a lot of lies. I just try my best for my daughter. I have not done anything wrong".

There is no recognition of the effect her behaviour has upon other people, including FP, or any acceptance of any responsibility for the distress occasioned to FP by reason of the high expressed emotion, referred to by Dr Ince, on RT's behalf.

82. During the course of his interviews, Dr Ince noted that when FP took a telephone call from her mother on 15 November 2018 during his assessment, there had been a notable change with the posture and manner of FP and she became more tense and abrupt. I am satisfied that FP's lack of understanding of the impact of high expressed emotion, which RT initiates, means that FP lacks capacity to make decisions about contact.

83. FP, in her discussion with Dr Ince, did not believe she required support in relation to her mental illness and had no understanding or awareness of the necessity for compliance with medication and the risks arising from non-compliance. She was unaware of RT's actions in relation to reducing and discontinuing medication without medical advice, in circumstances where RT said that the doctor was unavailable. FP had no understanding that she required the assistance of care staff to keep her safe and assist with her day-to-day living. I am satisfied FP lacks capacity in making decisions in respect of her care. FP, while expressing a wish most of the time to live with RT, is unable to understand that RT, prior to her move to [the placement], was unable to meet her needs, whether at home, or present much of the

time at FP's accommodation and that FP was assessed as requiring an independent supported living placement.

84. Therefore, taking account of all the evidence, I am satisfied FP lacks capacity in respect of care, support and contact.

85. I turn then to the Schedule of Findings. I have extensive evidence from the carers at [the placement], the social workers involved with FP and had access to the records which were compiled by a number of different caregivers and healthcare professionals. The consistent theme throughout these documents is the inappropriate manner in which RT engages with professional carers and health and social care staff. The evidence is from different sources but is remarkably similar in content. RT told me that it was all lies but, apart from referring to a conspiracy, RT did not provide to me a logical explanation for the vendetta against her.

86. ST, in his submissions, questions that FP's own legal representatives do not report her complaints to the Court. It is apparent that ST does not regard FP's representatives as acting in FP's best interests. He states: "Why are they not working towards E's best interests instead of merely attacking RT without justification?"

87. Unfortunately for FP, and despite RT's avowal of just doing her best for her daughter, FP has been caught up in RT's complaints and battles with the social workers and [the placement]. [the placement] gave notice to FP. I was told it was the first time [the care provider] had served notice to a tenant because of the behaviour of a relative. It was not a snap decision or without significant reason, namely the effect of RT's behaviour on the staff at [the placement] and, as responsible employers, [the placement] had to take that into account, and the anticipation that a complaint would be made by RT against the staff at [the placement], I was told that they walked on eggshells, which affected their care of FP.

88. ST, in his oral evidence, made the point that most of the time, altercations took place when he was not present. I am satisfied that ST has not full knowledge of all that occurred in his absence. However, he has had the opportunity to consider, as has everybody else, the records which have been provided. ST questioned whether the accounts and allegations about RT's behaviour were exaggerated and said to me in oral evidence: "I still question whether it really happened". ST did seem to act, at various junctures during the hearing, as though he had some understanding and appreciation of the difficulties RT's behaviour could cause. However, his written submissions repeat a catalogue of complaint and accusations. His views and complaints mirror those of RT. He has set out that: "At no time have the Council or their Social Services department ever come close to providing the safe and proper care they promised or claimed would be provided by [the placement]". He makes no criticism of RT and, it seems, accepts without question what he has been told by her and dismisses the evidence and expertise of Dr Ince and other witnesses, preferring his own interpretation of the application of the Mental Capacity Act 2005.

89. The Court must assess the evidence before it, both written and oral, and the credibility of the witnesses must be carefully evaluated, particularly, as in this matter, when there is dispute as to which is the true account in respect of a number of occurrences and incidents.

90. RT gave lengthy evidence. I give due consideration to the stressful and emotional task of giving evidence, particularly in a language which is not her first language. An interpreter was present throughout the hearing and I am grateful to the interpreter for her careful

assistance to RT in the court. It was demonstrably difficult to get RT to answer the questions put to her and to refrain from lengthy excursions into detailed accounts and complaints which she decided to raise. RT's complete unwillingness to recognise that her behaviour, on any occasion, has been unacceptable, derogatory and, at times, distressing to FP and contrary to FP's best interest, undermines her credibility.

91. Mr Garlick, in cross-examination, took RT to numerous examples of the care provider and medical care provider's records and medical records which describe RT behaving in an abusive or negative way towards professionals. All these examples are recorded and set out by Mr Garlick at paragraphs 14 and 15 of his final submissions to the Court. I use them as examples of behaviour in that the Court saw and heard RT giving responses to them: RT behaving in a highly intimidating way towards nurses on 22 June 2017, RT abusive and swearing at [the care provider] staff on 4 January 2018, RT abusive and swearing at [the care provider] staff on 7 April 2018, RT swearing about FP's care to [the care provider] staff on 23 April 2018, RT telling the contact supervisor that she was "a snowflake, a chav and sly" on 8 September 2018, RT telling the supervisor that she is a "shit carer" on 30 October 2018, RT calling supervising staff "liars" and "ginger bitches" on 14 March 2019, RT accusing carers of writing lies, RT mimicking JR and speaking to her in a deplorable manner. All these examples were put to RT and denied.

92. In dismissing most of the examples, RT said to me: "If in any way, I have offended someone, I would be first to apologise and say sorry". I am not aware that any apologies have been forthcoming from RT to any of the caring staff. RT told me that sometimes she reacted, my words, because she was deliberately aggravated by the care staff or social worker.

93. RT was asked about the letter she sent to the social worker in which she described the carers as "miserable, lazy, bad attitude", which I find at L40 within the bundle. This is an email sent by RT at 18.04 on 3 December 2017.

> "I honestly can go on about washing again and other unpleasant things happening, which we can discuss at any time if you wish, but the problem is I face the same miserable, lazy, bad attitude people I named in my previous letter who will not change their attitude despite I asked to isolate E from them, because they are not just neglecting FP they are proved to be dangerous, not in one occasion, now. I said in my previous letter that I have no problem with care E received from M but not anymore. Please let me remind you while FP was on sodium docusate, on the night before the meeting was held, FP was sick. I saw M in the morning at FP's apartment. She said nothing about FP being sick, but when I took washing out after washing machine stopped working, I found that",

and she attaches a photograph.

> "Unfortunately, M is still bossing around with her stinking attitude with her

> favourite phrase at the moment of time that "we cannot force FP". I would like to advise her to read [the placement] brochure, what they are promising. I still wait to see any of it. On Thursday, FP had a fall. I caught her in time, and it was more like a slide. It happened in front of the office. FP was trying to turn around. Her shoulder was a little bit red because she slid by the wall but no bruises or anything like that but suddenly, no, not suddenly, next day, M became concerned and sent FP to hospital for all day. At first, I thought it is FP's idea because it is usually her initiative but when I came to the hospital and asked FP if she is in the hospital mood, she said no, it was not her idea. Urine infection found. I do not believe FP has urine infection. I am more inclined to believe that FP was neglected as usual and was not properly washed. Now, she is on antibiotics again. She just finished a short course of them for the same problem. I am a little bit disappointed in A, to whom I praised in my previous letter. It seems to me that she took the attitude of the bad company, "cannot force FP", because I came on Saturday, 2 December, at 11.20, FP was still in bed, wet through with urine. I see it as laziness because if she approaches FP in the right way, there will be any of what happening right now".

The email contains more criticism of the staff.

94. It was put to RT that the descriptions she gave in that letter were unnecessary and inflammatory. Her response in evidence was that they were not nice to her or FP. RT told me that she had used words like "fishfaced" and "two-faced" and had used them for comparison. I am not clear what she meant by 'comparison'. She accepted that to call somebody a "fishwife" was insulting.

95. On 20 March this year, RT was described as becoming very agitated, saluting and said, "*Sieg heil*". She then told me: "I didn't behave in that way. There was no agitation at all. The social worker was abrupt in a commanding voice". When it was put to her: "Did you make a gesture?", she said: "I did. It was a Russian salute". She admitted that she said: "*Sieg hei*l", but she maintained when asked about what she meant by it, that it was just a salute. I am conscious that she has gone on to make more explanations within the annex to Mr Fullwood's submissions, but I go from the evidence which was presented to me. When pressed and asked was she aware it was highly evocative and insensitive, she responded, "I think it was silly of me, but the reasons are there". RT at no stage in her evidence accepted that she was unreservedly wrong.

96. In looking at credibility, the evidence the care provider support workers gave, for example, about RT's behaviour towards M, including mimicking her, her reference to staff as "M's soldiers" all tie in with RT's admissions about these events and the records before the Court. I am satisfied that RT is not always truthful and is not a credible witness. When there is a factual dispute between RT and professionals or carers for FP, I prefer the evidence of the carers. They have, indeed, no axe to grind. They have no reason to lie. I am not even sure whether RT recognises that she is lying. If the account of facts do not match up with the way that RT wishes to see things, she presents her own desired scenario.

97. In respect of the Schedule of Allegations, some of the matters to which I have already

referred support the findings which the Council seeks.

98. Finding one: "RT lacks a basic understanding of how FP's mental disorder affects her".

99. It is clear from both RT's and ST's response to Dr Ince's evidence that they do not accept FP has a treatment-resistant forms of paranoid schizophrenia, even if RT accepts FP's diagnosis of paranoid schizophrenia. RT believes that given the correct medication, FP will become symptom-free and achieve complete resolution of the condition. This belief underpins the claim that the social workers, nurses and doctors are conspiring to give FP drugs which are not prescribed and that if FP was receiving the proper treatment, she would not be experiencing any symptoms of mental ill-health.

100. This misplaced belief leads to continuing complaints. Mr Garlick has referred to RTs complaint, which was provided to the Court at lunchtime on 17 August 2020. It is one of many complaints to the CQC. In RT's complaint to the CQC dated 13 August, which was sent to the Court at lunchtime on 17 August, RT says:

> "The question to ask why is my daughter screaming again? She should not be screaming because Clozapine should and was taking all the unwanted effects. Today, she is very distressed again and was crying for help again and this is in the new ward at the new hospital. What is happening now? Is she suffering from maladministration of medicine again or something interacting with her treatment? Why would she be absolutely fine and not in any distress and then become severely affected?"

I am satisfied that finding one is made out.

101. Finding two: Over a period of many years, FP and RT have had an enmeshed relationship in which FP is exposed to high expressed emotion.

102. RT, I find, has a tendency to over-care and micromanage FP's life. I will not speculate upon what past life events have prompted this circumstance. I have no doubt, whatsoever, that RT loves FP and that such love is fully reciprocated. I have no doubt that RT worries about the welfare of FP but RT's highly emotional presentation and her inability to allow FP to be supported by others than her is a source of high expressed emotion and the dynamics of the relationship contribute to an unhealthy cycle of FP and RT's level of emotion and distress, increasing distress in the other and, in FP's case, leading to increased agitation and a decline in her mental health. There are examples throughout the written evidence of FP and her mother fighting in a physical way, inappropriate displays of kissing, touching and physical affection, verbal altercations and of screaming and shouting.

103. The examples in the schedule provided to the Court were put to RT. The oral evidence of RT was that she could not recall biting FP and that she did not hit FP over the head in Tesco but pushed her shoulder. RT described FP grabbing her by the hair and attacking her. The description, whatever way one looks at it, is of a high-octane emotional relationship with FP, arguments and overwhelming physical emotion being a feature.

104. The examples in the schedule are set out by Mr Garlick at paragraph 24 within the submissions. I do not intend, in this judgment, to go through each and every example which has been provided but I am satisfied that Mr Garlick, in setting out the happenings, has taken them from the records and I am satisfied that they represent an accurate reflection of the relationship and the dynamics of that relationship. I find that the findings at finding two are made out.

105. In finding three, the Local Authority seeks a finding that: RT communicates negative and critical thoughts about FP's care to her and others, sometimes in abusive terms and in FP's presence.

106. In oral evidence, RT was adamant that she was not critical of FP's carers when FP was present, however, there are numerous examples in [the care provider's] records when RT has been unrestrained in criticising the care staff and in the presence of FP. I have no reason to doubt the accuracy of the records. DU, support worker, said: "RT tries to influence FP not to like the staff, which then makes the care of FP very hard". In the report of the independent investigator, the content of which RT and ST dismiss saying they are dissatisfied with it and taking it further to the Ombudsman, the complaints made by RT were not upheld, save for two minor matters. The independent investigator spoke to 11 staff members, nine of whom told her they heard RT being abusive and/or intimidating to staff members. Mr P, the Deputy Manager, said RT told him that: "English people cannot clean right", and accused him of poisoning FP. He said: "She becomes abusive and irate and knocks FP's confidence. She refers to 'silly busy bees' and staff as 'K's soldiers'". CA said RT was generally nice to him but called M "two-faced". He said: "She swears all the time". In his view, RT is intimidating. He said: "We daren't put a foot wrong as we know that there will be a complaint straight away".

107. RT's response in evidence was that the report of the independent investigator was based on lies. When asked why people are "lying about you", RT said that it was within the Council's agenda. It was put to her, in a question form, that: "They are telling lies to the independent investigator because they have been influenced by the Council?" RT responded firmly that: "I believe so".

108. Dr Ince records FP's comment that: "It was the social worker. My mum said she was lying", and talking of the support staff and social worker, FP said: "They lie. My mum says they lie".

109. I am satisfied that upon frequent occasions, as set out in the Schedule of Allegations, RT communicates negative and critical thoughts about FP's care to FP and to others and sometimes, in abusive terms in FP's presence.

110. In respect of finding four, that: “RT has often behaved towards care workers in an abusive and unpleasant fashion which may be intended and is likely to demoralise them”

111. Mr Garlick makes it clear in his final submissions that it is not the Council’s case that RT was never justified or had any justification for complaint in respect of FP’s placement at [the placement]. The Council accepts that for some time, it did not provide sufficient funding and care planning to enable staff at [the placement] to provide an acceptable level of one-to-one support beyond the necessary support which FP needed for her daily living activities and personal care. The Council has expressed its apologies.

112. While complaint in this regard may have been justified and gave rise to a degree of frustration, it does not, I find, justify the frequent abusive behaviour of RT to care staff including M and Ms R. It is unfortunate that, as RT said herself, that from day one, it seems that RT has found fault with the care being provided and upon no occasion has time been taken to discuss in a reasonable manner, and without recrimination and abuse, how the circumstances could be improved for the sake of FP.

113. The evidence makes it apparent that M was the focus of much of RT’s abusive behaviour despite the fact that FP liked M and expressed that like. There are records of RT swearing and CA told the independent investigator that: “RT swears all the time”. RT, in front of me, denied swearing and said that she never swore. I prefer the evidence of the staff, particularly CA. It was apparent in court that RT could become very agitated and voluble. I accept as an accurate description that, as CR told the investigator, he feels all the staff are constantly walking on eggshells. I find the criticism by RT was extreme and relentless. Experienced workers identified the behaviour as deplorable and outside their usual experience.

114. Finding five: ‘That RT’s contact, both direct and indirect with FP, whilst of importance and value to FP, is, on many occasions, associated with a decline in FP’s mental health and presentation’.

115. The support worker, DU, told the independent investigator that when RT visits, they see an increase in FP’s episodes. The support worker, JG, told the investigator that RT makes FP’s behaviour and mood worse. The team leader, M, told FP’s CPN in February 2018 that reading through the notes and discussions with staff, FP’s behaviour appears to change, and she becomes more agitated and aggressive around visits from her mother and in between visits with her mother, she generally appears in good spirits. The Deputy Manager, IP, told the CPN in April 2018 that FP’s ongoing mental health problems were influenced by the relationship with her mother, that usually, when not in the presence of her mother, she presents as stable in mood and pleasant and engages well with staff, however, problems relating to agitation and distress when her mother is present. In his statement to this Court, Mr G noticed that on limitation of contact between FP and RT, FP’s highly agitated behaviour completely changed.

116. Dr Ince noticed the consistent references within the care records to FP becoming agitated, verbally hostile and distressed during or following visits from RT. In his third addendum report, Dr Ince stresses his significant concerns as to the impact of the current level of contact between FP and RT upon FP's mental state. The changes in FP's presentation after phone calls were noticed by Dr Ince and Ms H. Association between FP's level of distress and agitation and night-time telephone calls was made by the staff at [the] Hospital. Ms H stated in her oral evidence that a similar association had been noticed by nursing staff at [the ward], where FP is currently a patient, and that staff suspect that there may be a behavioural element to this presentation.

117. RT has denied that her behaviour affects FP and ST in his written submissions queries why it is thought to be strange that FP is happy when her mother is there and sad when she leaves.

118. Unfortunately, the evidence is much more comprehensive than being explained by FP being sad when her mother leaves. I am satisfied that there is compelling evidence from a variety of sources over a period of time linking an increase in FP's distress and agitation with contact to RT. The increase in distress and agitation is in accordance with Dr Ince's concerns about high expressed emotion and criticism of staff and its effect on FP. I am satisfied that the finding that the Local Authority seeks is made out.

119. In relation to finding six: 'RT has sought to control FP's care and treatment and prevents FP expressing her own views',

120. Again, there are numerous examples within the documents and the concern that the Court has is heightened by the video which RT took or RT arranged and RT told FP to say within that video that she wants more contact with her mum, that she has the right to go to all of her medical appointments and she should be allowed back into FP's flat. The filming of FP on the two occasions, of which the videos were provided to the Court, raised considerable concern about the effect upon FP of her mother wishing to have FP videoed with the point of such videoing being to provide evidence to the Court and without consideration of any effect upon FP herself.

121. In relation to finding seven, that: 'RT attempts to challenge FP's medication and has interfered with FP's medication to her detriment'

122. I am satisfied that throughout the period covered by the medical notes, RT has demonstrated a fixation with medication which goes well beyond the normal concerns of a close relative. RT has involved herself very closely with FP's medication, demanding the medication be changed or stopped. RT admitted stopping FP's medication when she could not get in touch with the doctor and RT took the view that the medication should not continue. RT does not accept that her knowledge of the medication and its effect is not comprehensive enough to enable her to interfere with the medication, as she did in 2015.

123. It is not credible that it was FP who stopped the medication against her mother's advice and, indeed, in February 2017 on admission to hospital, FP told the clinicians that she had stopped the medication, "as mum asked me to stop them".

124. RT denies the allegations by the support staff that on 7 March 2019, RT gave a large quantity of laxatives to FP. I prefer the evidence of the support staff. There is no reason for them to make it up.

125. It is of considerable concern that RT has not been truthful in respect of her involvement with FP's medication. Her evidence before me made it clear that she thought she knew best in relation to her daughter's medication. She told me when she was asked if she had any idea how dangerous it is as a medically unqualified person to stop the medication, her response to me was: "I know my daughter. I spend a lot of time with her". Later, she said; "I try my best. Maybe I make a mistake but when something is not right". If RT was responsible for assisting FP with her medication, upon the basis of the evidence of past behaviour, if RT thought that the medication should be stopped or changed or was not the most efficacious for FP, I am satisfied that she would exercise her own choices without necessarily consulting with a doctor, not recognising how much of a risk she could subject FP to.

126. RT's response to the Court's requirement of an undertaking not to subject FP to any more videotaping is illustrative. While undertaking to the Court and it being explained to her the meaning of an undertaking, I find that RT breached the undertaking without a qualm, telling me she was justified in so doing because she had taken the view that the evidence of what FP wanted and how she was treated should be available in video form to the Court. She was largely unapologetic. She was in the right, entitled to do it, because she wanted to provide the evidence to the Court of FP in a distressed state. It was justifiable, according to RT, to prove the points that she wanted to make.

127. On 20 August 2020, the Court made an order with a penal notice attached, recording formal undertakings. I am satisfied, having reviewed all the evidence that the undertakings for the future should be in the form of an injunction, which this Court will make.

128. I turn then to the lasting power of attorney. Section 22(4) of the Mental Capacity Act 2005 empowers the Court to revoke an LPA if the Court is satisfied:

> (b) that the donee… of a lasting power of attorney
>
> (i) has behaved, or is behaving, in a way… that is not in P's best interests or;
>
> (ii) proposes to behave in a way… that would not be in P's best interests'.

129. Therefore, if the Court is satisfied that RT has behaved or proposes to behave in a way that is not in FP's best interests, it has a power to revoke the LPA and must exercise its discretion in deciding whether or not to do so.

130. Mr Fullwood, in his written submissions to the Court, invites the Court to find as a fact that RT has always acted in FP's best interests in relation to both her health and welfare. The fact that RT disagrees with the opinion of others as to FP's capacity and seeks to advance arguments why she has capacity cannot be seen as inconsistent with her role as LPA.

131. I disagree with Mr Fullwood. I am satisfied that RT has behaved in a way that is not in P's best interests as detailed within the body of this judgment and the evidence of past behaviour is indicative of future behaviour. The Council, supported by the litigation friend, invites me to revoke the LPA under Section 22(4). Dr Ince expressed significant concerns as to FP's ability to understand, retain and weigh information relating to the signing of documentation or that, on the balance of probability, FP understood the purpose of the document. However, it is under Section 22(4) that I am asked to revoke the LPA on the basis that the donee has behaved or is behaving in a way that is not in P's best interests or

proposes to behave in a way that would not be in P's best interests.

132. In the light of the findings I have made, the statutory criteria set out in Section 22(4) are established. The evidence leads me to a finding that RT has no insight into her behaviour and its effect upon the wellbeing of FP and, therefore, the prospect of any change in her behaviour is remote. Even now, RT has no understanding of the basic consideration of capacity. RT now believes the NHS and the Council are subjecting FP to a chemical attack by interfering with her medication. Those beliefs entirely prevent RT from acting in FP's best interests now or in the future. There is every sign that if RT has the power to do so, she will continue to make decisions contrary to FP's best interest.

133. In relation to contact, it is for the responsible clinician to make the decision in respect of contact. However, it is apparent from this judgment that the facts which have been determined upon hearing extensive evidence in this case must be relevant in considering contact. There is a need to regulate and supervise contact so that RT's highly expressed emotion and presentation, the strong negative and critical references to the support staff and carers and the conflicts in RT's own relationship with FP can be reduced and managed so that they do not detrimentally affect FP and contribute to the deterioration in her mental health. The issue of telephone contact and the removal of FP's phone at night needs careful consideration and Dr Ince's changing view between November, December and August requires careful analysis. I do not feel I am in a position to express any more concluded views on contact at this stage.

134. However, I am satisfied that I can express a view and make a declaration in the interim that FP should not live with RT. It would be potentially unsafe, not only in respect of possible interference with medication but also taking account of all the findings I have made based upon the evidence which I have read and heard and although it may well be a considerable period of time before FP is sufficiently well to be discharged from [hospital], I am satisfied that it is appropriate and within my power to make that declaration.

End of Judgment

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Ubiqus hereby certify that the above is an accurate and complete record of the proceedings or part thereof

This transcript has been approved by the judge.