Neutral Citation Number: **[2021] EWCOP 20**

Case No: COP13470990

COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 29/01/2021

Before:

MR JUSTICE WILLIAMS

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Between:

Royal Borough of Greenwich	**Applicant**
- and -	
EOA	**Respondent**
(By his Litigation friend of the Official Solicitor)	
South East London CCG	

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Ms Jemimah Hendrick (instructed by Legal Services) for the applicant
Mr Ian Brownhill (instructed by Duncan Lewis) for the respondent
Mr Adam Fullwood (instructed by Ward Hadaway) for South East London CCG

Hearing dates: 25-28 January 2021

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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.

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MR JUSTICE WILLIAMS

If this Judgment has been emailed to you it is to be treated as 'read-only'. You should send any suggested amendments as a separate Word document.

Williams J:

Introduction

1. The Court is concerned with EOA. EOA was born on 5 August 2001 and is therefore 19 years old. EOA and his twin brother D were removed from the care of their parents in December 2015 and were made the subject of full care orders on 21 June 2016, together with their two other siblings. They were removed from their parents' care as a result of ongoing concerns about the parents' treatment of the children, which included keeping them isolated from the rest of society, not allowing them to attend school or receive any medical treatment and subjecting them to extreme religious and anti-social indoctrination as well as emotional and physical abuse. Their parents played no part in the care proceedings and did not seek to have any contact with them; effectively they abandoned them.

2. EOA and D were both placed together in a Local Authority foster placement. During the care proceedings psychological assessments of the brothers were undertaken and concluded that EOA might have a learning disability, autistic spectrum disorder and that he was very much under the influence of DOA. The assessments were tentative because EOA declined to engage to any great extent and that has remained a feature of his presentation ever since. On reaching his 18th birthday DOA who was assessed to have capacity, unlike EOA left the foster placement on 5 August 2019 at 6.30am without EOA and his whereabouts are still currently unknown, although there has periodically been reports of sightings of him in the Bromley area.

3. In anticipation of EOA reaching the age of 18 on the 5 August 2019 on 23 July 2019 the Royal Borough of Greenwich ("the Local Authority") applied to the Family Division under the inherent Jurisdiction and to the Court of Protection for a personal welfare order in respect of EOA. The Local Authority initially sought the following declarations; (a) That EOA lacks capacity to litigate; (b) That EOA lacks capacity to make decisions about his care and treatment (c) That EOA lacks capacity to decide where he should live; (d) That it is in EOA's best interests for him to reside at a supported living placement identified by the Local Authority; (e) That the placement and care plan proposed by the Local Authority are lawful and in EOA's best interests.

4. Following the commencement of proceedings various Judges made interim orders in respect of EOA including interim declarations as to capacity. EOA case first came before me on 16 October 2019. He attended and spoke of his very strong desire to be free of court proceedings and his wish to make his own choices in relation to where he lived and with whom he spent his time, in particular his brother but also his wider family. On that occasion I decided that EOA should move to live from his foster placement in a residential placement. The nature of EOA's life at that placement was such that it would amount to a deprivation of his liberty and I made further interim declarations and a deprivation of liberty order.

5. On the 16.12.20 I heard the case again. Both EOA and his brother POA attended that hearing and I considered issues to do with EOA's contact with his family. I made final declarations in relation to EOA's lack of capacity:

    i) To conduct litigation.

ii) About his care and support.

iii) Where he should live and

iv) In relation to his property and affairs.

6. I made provision for the obtaining of expert evidence in order to determine further issues in relation to EOA's capacity in relation to contact, foreign travel and use of the internet and social media and Dr Layton was instructed to prepare an assessment of EOA. An assessment early in 2020 concluded that EOA was unlikely to meet the diagnostic criteria for an autistic spectrum disorder rather than having a complex attachment history and learning difficulties which led to his local ASD service not agreeing to provide treatment.

7. At that stage there were some concerns about EOA's placement and in particular there was considerable uncertainty as to the nature of the care and treatment that would best this meet EOA's welfare needs given the complex interweaving of issues relating to the impact of his upbringing, his possible learning disability and his possible autism. Although the issue of EOA's capacity to make decisions about his care and support and where he should live had been made, the determination of what was in his best interests and in particular whether a deprivation of liberty order should be authorised made remained very much alive. There has been some debate in the course of these proceedings as to how one should characterise or describe EOA's experience of life in his family up until his removal into care. Neglect, radicalisation, coercion and control, undue influence and duress have all featured, but it seems to me that the phrase proposed by Dr Layton and adopted most recently by Dr Dubrow- Marshall, namely indoctrination seems the best fit for the totality of EOA's experience in the family environment provided by mother and father.

8. The Local Authority and the Official Solicitor had resolved many issues in this complex case prior to the commencement of the hearing. It is agreed that EOA lacks capacity to;

i) Conduct these proceedings.

ii) Make decisions about his care and support.

iii) Make decisions about where he should live.

iv) Make decisions about his property and affairs.

v) Make decisions as to his foreign travel.

9. At this final hearing, the Local Authority are seeking final declarations that EOA lacks capacity to make decisions in relation to;

i) Foreign travel and holding a passport.

ii) Use of social media and the internet.

iii) Contact.

The Local Authority also seek determination that it is in EOA's best interests that a care and support plan dated 13 January 2021 is implemented, and in consequence of the nature of that care and support plan that the Deprivation of Liberty is authorised for a period of 12 months.

10. The following additional issues also emerged;

    i) The framework for the psychological/ de-indoctrination treatment plan,

    ii) Whether a litigation friend is required for EOA for the duration of any deprivation of liberty which is authorised and if so, who that should be.

    iii) Potential issues in relation to contact with JOA (OS wishes to explore this).

    iv) The appointment or otherwise of a personal adviser.

    v) The Official Solicitor identified a potential issue in relation to the Jurisdictional framework under which aspects of the case should be dealt. The issue raised was whether the evidence demonstrated that in respect of the various declarations sought a causal nexus was established between an impairment or disturbance in the functioning of the mind or brain and the inability to make a decision or whether the evidence demonstrated that EOA was a vulnerable adult over whom undue influence was exercised and who ought properly to be protected under the Parens Patriae Inherent Jurisdiction.

11. In advance of the hearing the Local Authority represented by Ms Hendrick, the official Solicitor represented by Mr Brownhill and the CCG represented by Mr Fullwood submitted written position statements. I formally Joined the CCG at the commencement of the hearing. I'm grateful to the advocates for their assistance in their written and oral submissions.

12. I was provided with a bundle on Caselines and I heard evidence from;

    i) Dr Layton, Consultant Psychiatrist.

    ii) Ms Meehan, Assistant Director of Commissioning.

    iii) Ms Aroyewun, Social Worker.

The Parties Submission

13. The Local Authority's position in respect of the remaining issues is as follows;

    i) The Local Authority maintained that the evidence of Dr Layton established a causal nexus between the autism and EOA's inability to make a decision in the relevant domains. That being so the issue of undue influence and the Parens Patriae Jurisdiction did not require detailed consideration.

    ii) Dr Layton engaged with EOA with the assistance of placement staff in respect of this decision and concluded that EOA would not be able to understand the

financial aspects of foreign travel, nor understand the risks associated therewith and thus he lacks capacity in this domain.

iii) In relation to social media and internet usage the Local Authority's initial position was that they accepted that consideration of his capacity to use social media was distinct from the general consideration of contact. As the case progressed their position developed such that they accepted that the issue should properly be bifurcated to recognise that EOA's general usage of the Internet plainly fell into one domain whereas his ability to contact family members in respect of whom he lacked capacity in the domain of contact fell into another.

iv) In relation to contact the only individual that EOA was seeking to see was J. He stopped having contact with P and with T and neither of them wished to see EOA. He continued to express a wish to be reunited with his mother, father and brother DOA. The Local Authority accepted Dr Layton's conclusion that EOA lacked the capacity to make decisions in relation to others and the reasons that he gave for it. In relation to family members who remained aligned to the doctrine and thus potentially posed a risk they accepted that EOA was unable to weigh relevant information about the risk they posed to him. In relation to T & P who were not aligned to the doctrine but rather were hostile to it they also accepted that he lacked capacity due to his fixed thinking in relation to them and his inability to weigh information. Finally, in relation to strangers they accepted Dr Layton's formulation that currently EOA was unable to weigh information relevant to the risk of interactions with strangers and his lack of recognition that they may have interest adverse to his or that they were seeking to take advantage. They accepted that in this respect EOA might regain capacity with relatively limited support and education on the particular area of risk.

v) The emergence of further evidence from the CCG as to the nature of the 'three-pronged 'treatment package that could be commissioned established a sufficiently clear treatment plan that together with the care and support plan provided a framework for EOA's care that was in his best interests. The Local Authority accepted that the order should not be finalised until such time that the professionals meeting had occurred, and the treatment plan had been reduced to a choate black and white proposal. In relation to the care and support plan in closing submissions Ms Hendrick identified a number of amendments that would be required to it covering;

a) A request to the GP for a practice nurse to undertake a Cardiff health assessment with EOA to be followed up by a general practitioner desktop assessment or a private assessment. The plan would also need to refer to undertaking desensitisation work in particular in relation to health issues but also more broadly in relation to EOA's resistance to interaction with agencies of the state and authority figures. The Local Authority also invited me to request that the GP cooperate in the implementation of this. I am happy so to do.

b) The details of the contact plan in relation to JOA.

c) The development of a dynamic Positive Behaviour Support plan as part of the psychological intervention.

d) The permanency of his current placement and the fact that he will not be moved from it.

vi) The nature of the care and support plan plainly amounted to a deprivation of EOA's liberty as he would continue to reside at TOA where he was not free to come and go, where his trips into the community were supervised and where he would be required to return to T were, he to seek to leave. It was accepted by the Local Authority that any deprivation of liberty order did not need to authorise any physical restraint of EOA as not having been required over the 15 months old that he had resided at TOA. An unexpected emergency which arose which might require the use of physical restraint would be covered by the provisions of the Mental Capacity Act without express incorporation into the order. The Local Authority submit this order should be made for a period of 12 months running from the date that the court finally approves the finalised care, support and treatment plan. They submit that those around EOA and importantly EOA himself needs to be free of the prospect of further court hearings in order for the implementation of the plan to gain the best foothold. Imminent court proceedings are a distraction both for those caring for EOA and for EOA. The process is likely to be a slow one in any event and so a review in 12 months would provide a timescale which both enabled those concerned to focus on the work and also for the work to have a reasonable period within which to take effect.

vii) In relation to a personal adviser, EOA's children's services social worker had remained allocated to him and he had not been transferred to the care leavers team. As a result, his children's social worker had continued to work with him providing the sort of services a personal adviser under a pathway plan would have. He could not enter the care leavers team because of a lack of capacity. His pathway plan was reviewed as required albeit the Local Authority accept, he had not received visits as a result of his children's social worker being away for an extended period. The Local Authority objected to a declaration that they had failed to comply with their statutory duties in relation to the pathway plan and personal adviser both because it had not been formally applied for but also substantively because they maintained that a pathway plan and personal adviser had been in place albeit there may have been some technical or minor failure to comply with the strict statutory requirements.

14. At the conclusion of the evidence and in submissions the Official Solicitor submitted as set out below.

15. Having heard the evidence of Dr Layton the official solicitor accepted that the causal nexus between EOA's autism and his inability to make decisions in the relevant domains (primarily arising out of his inability to use or weigh the information due to the rigid thinking associated with autism)was established and any need to consider whether he was a vulnerable adult requiring protection under the inherent jurisdiction had abated. The OS also accepts that the indoctrination continues to play a role and that after the psychological intervention to address issues of indoctrination and autism have had some time to impact on EOA's functioning that a further assessment of his

capacity will be required. The MCA is therefore the correct framework as opposed to the inherent jurisdiction.

16. However, Mr Brownhill submitted that when the psychological treatment has been carried out it will still remain necessary to unpick what the effect of the indoctrination was, and care will need to be taken to ensure that he is not regarded as incapacitous indefinitely either because of the diagnosis of autism or because of the undiagnosed consequences of indoctrination

17. She accepts that on the evidence the Court is able to declare, pursuant to Section 15, that, EOA lacks capacity to;

    i) Make decisions in respect of foreign travel given his inability to understand or weigh information in relation to various aspects of travel as established by Dr Layton.

    ii) Make decisions as to his contact;

        a) With DOA, JOA and his parents;

        b) With POA and TOA;

        c) Make decisions as to his contact with strangers.

    The official solicitor having heard Dr Layton's evidence also accepted that EOA lacked capacity and that three declarations in respect of the three categories of individual decision-making could properly be made. Mr Brownhill submitted that on the facts of this particular case, such an approach is permitted by the decision of the Court of Appeal in PC & Anor v City of York Council [2013] EWCA Civ 478 at paragraph 35 which supports the court focussing (where the facts permit it) on the actual decision to be made rather than a notional or generic decision . The declarations it was submitted should be tailored to reflect the particular issues with decision-making in relation to each of the three categories. In relation to family members who subscribe to the doctrine the official solicitor accepted that it to enable EOA to make a competitor's decision he would need to understand and to weigh the fact that he would be subject to undue influence, the pernicious effects of exposure to the doctrine and the fact that his family members might have adverse interests to his. In relation to family members who did not subscribe to the doctrine he would need to be able to understand the issues relating to the family dynamic and the doctrinal differences. In relation to strangers the classic formulation set out in the Jurisprudence would be appropriate, and, in this regard, he would need to be able to recognise the risk of third parties posed and the fact they may have their own adverse interests. In this regard the Official Solicitor submitted that the effect of section 1 (3) was relevant because the work in order to give him capacity in relation to strangers has not been undertaken and so all practicable steps to help him to make a capacitous decision had not been taken and thus the appropriate declaration is an interim order rather than a final declaration.

iii) Internet and social media access: The Official Solicitor also initially took a similar position to the Local Authority in relation to social media and internet usage. Their position also adapted to recognise that whilst generic issues of internet usage and social media could properly be fitted within the jurisprudence in this field that if one considered the particular decision in relation to use of social media and the Internet in relation to contact with family members it could not properly be distinguished from the issues of EOA's capacity to have contact with them. The Official Solicitor thus submitted that an interim declaration was appropriate in relation to generic Internet and social media issues to enable support to be given to EOA to enable him to make capacitors decisions in this regard by giving him information as to the risks of exploitation by third parties via the Internet. In relation to issues of internet and social media use for the purposes of contact they accepted that a final declaration could properly be made but that it should be made in the domain of contact making specific reference to social media and Internet in that regard.

iv) Health matters: The Official Solicitor does not seek any declarations of EOA's capacity in this regard but agrees with the Local Authority that there is significant doubt that EOA has capacity to consent to a physical medical examination. The Official Solicitor understands that the court will not be able to make a declaration in this regard. However, the Official Solicitor would invite the court to comment on this issue in the Judgment. In particular, that EOA's capacity in this regard requires careful consideration. In respect of the coronavirus vaccine, the Official Solicitor accepts that EOA's capacity has not been assessed in this regard, nor has it been offered to EOA as of yet. However, the Official Solicitor would again invite the court to comment on this issue in light of Dr Layton's clear evidence.

18. One of the principal submissions of The Official Solicitor at the commencement of the case was that the lack of a clear treatment plan should cause the court to pause long and hard before making any long-term orders. However, the late provision of evidence from the CCG, from DR Thomson and from DR Dubrow- Marshall together with the oral evidence of Dr Layton and Ms Meehan satisfied The Official Solicitor that an embryonic but satisfactory treatment plan had now emerged. It now required to be reduced to writing in or following the professionals meeting. On the basis that this judgement would set out my conclusions in relation to what was required and that this should then via the prism of the professionals meeting find its way into a concrete treatment plan The Official Solicitor was satisfied that the overall package proposed both in terms of care and support and treatment was in EOA's best interests. The Official Solicitor will propose that the public bodies have a month to hold the necessary meetings to formulate a plan informed by today's evidence and the court's judgment.

19. The Official Solicitor submitted that the restrictions in the care plan are necessary, save that the permission in respect of physical restraint is no longer necessary and should be removed. I was invited to reflect in its judgment that ABA and PBS ought not be used and instead that the bespoke "management" or "dynamic PBS" should be developed and put before the court. The Official Solicitor proposes that a separate

care plan is devised in respect of EOA's contact with JOA, with the input of those providing the tripartite treatment plan.

20. The Official Solicitor submitted that the court should continue to authorise the deprivation of liberty in the next month, under section 48 as an interim order. Then, once the overall plan is choate, the court could determine the length of the authorisation and who acts as r.1.2 representative for that authorisation period. The Official Solicitor initially pressed for a six-month deprivation of liberty order on the basis that the care and treatment plan was so inchoate and its implementation so uncertain that the court should be in a position to review progress but also that the prospect of a further hearing would provide a stimulus to ensure that good intentions were acted upon. However my indication that I would not finally approve an order until after the professionals meeting proposed by Ms Meehan my confirmation that I would reserve all further applications relating to EOA to myself satisfied the official solicitor that there was a sufficient mechanism in place to ensure both that the plan became choate and that stumbles in the implementation could be addressed in a swift resort to the court satisfied The Official Solicitor that period free of litigation justified the making of a deprivation of liberty order for 12 months.

21. The Official Solicitor's position remains that through 2020, EOA was not given the support he was entitled as a care leaver and this ought to be reflected in a declaration. The OS accepted that the principal responsibility for a failure to progress EOA's education might lie with children services rather than with the current team but still maintained that the issue had been these proceedings and had not been adequately addressed.

22. The clinical commissioning group were joined as parties and provided the court and the parties with assistance in the form of information and evidence. Mr Fulwood on behalf of the CCG did not advocate for any particular outcome but emphasised the framework within which the CCG operated and emphasised that whilst it could commission services it could not determine precisely how they were delivered. Those were clinical judgements not commissioning decisions. The CCG accepted that an appropriate order should not emerge until the professionals meeting had been undertaken and produced a plan. One of Miss Meehan's colleagues would be delegated the task of coordinating the meeting and the provision of services.

The Legal Framework

23. The Mental Capacity Act 2005 sets out the statutory scheme in respect of individuals aged over 16 who lack capacity. Section 15 gives the court the power to make Declarations as to whether a person lacks capacity to make a specified decision and the lawfulness or otherwise of any act done or to be done in relation to that person. Section 16 gives the court the power to make an order and make the decision on a person's behalf. Section 48 gives the court discretion to make an order on an interim basis and in particular if it is in the person's best interests to make the order without delay.

24. Section 2(1) of the Act provides that a person lacks capacity 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.*'

It does not matter whether the impairment or disturbance is permanent or temporary. The determination of whether a person lacks capacity is to be made on the balance of probabilities.

25. Section 3 provides that 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 a way 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).

    The section goes on further to provide that a person is not to be regarded as unable to understand information relevant to a decision if he is able to understand an explanation given in a way appropriate to his circumstances. It also provides that a person who is able to retain information relevant to a decision for a short period of time does not prevent him from being regarded as able to make the decision. Information relevant to a decision includes information about the reasonably foreseeable consequences of deciding one way or another or failing to make the decision.

26. Thus, the act provides a diagnostic threshold where the court must identify and impairment of or disturbance in the functioning of the mind or brain and this must be the cause of the functional criteria namely the inability to make a decision. In *NCC v PB (By her litigation friend the Official Solicitor), TB (By his litigation friend the Official Solicitor) [2014] EWCOP 14* Parker J considered the issue of combined causes of decision-making inability and concluded:

> *"86. It seems to me that the true question is whether the impairment/disturbance of mind is an effective, material or operative cause. Does it cause the incapacity, even if other factors come into play? This is a purposive construction."*

27. Mr Brownhill referred me to two decisions of Cobb J in the linked Judgments of A (Capacity: Social Media and Internet Use: Best Interests) [2019] EWCOP 2 and B (Capacity: Social Media: Care and Contact) [2019] EWCOP in which he set out an approach to the assessment of capacity in relation to social media and internet use and contact. These were endorsed by the Court of Appeal in B v A Local Authority [2019] EWCA Civ 913. That approach was reflected in Dr Layton's approach.

28. Section 1 of the Act sets out the principles applicable under the Act. The section provides that

    i) A person must be assumed to have capacity unless it is established that he lacks capacity.

ii) 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.

iii) A person is not to be treated as unable to make a decision merely because he makes an unwise decision.

iv) 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.

v) Before the act is done all 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.

29. Section 4 of the Act deals with 'Best interests'

(1) In determining for the purposes of this Act what is in a person's best interests, the person making the determination must not make it merely on the basis of —

(a) the 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 what might be in his best interests.

(2) The person making the determination must consider all the relevant circumstances and, in particular, take the following steps.

(3) He must consider—
(a)whether it is likely that the person will at some time have capacity in relation to the matter in question, and
(b)if it appears likely that he will, when that is likely to be.

(4) He must, so far as reasonably practicable, permit and encourage the person to participate, or to improve his ability to participate, as fully as possible in any act done for him and any decision affecting him.

(5) Where the determination relates to life-sustaining treatment he must not, in considering whether the treatment is in the best interests of the person concerned, be motivated by a desire to bring about his death.

(6) He must consider, so far as is reasonably ascertainable—
(a) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity),
(b) the beliefs and values that would be likely to influence his decision if he had capacity, and
(c) the other factors that he would be likely to consider if he were able to do so.
(7) He must take into account, if it is practicable and appropriate to consult them, the views of—
(a) anyone named by the person as someone to be consulted on the matter in question or on matters of that kind,
(b) anyone engaged in caring for the person or interested in his welfare,
(c) any done of a lasting power of attorney granted by the person, and

> *(d) any deputy appointed for the person by the court, as to what would be in the person's best interests and, in particular, as to the matters mentioned in subsection (6).*
>
> *(8) The duties imposed by subsections (1) to (7) also apply in relation to the exercise of any powers which—*
> *(a) are exercisable under a lasting power of attorney, or*
> *(b) are exercisable by a person under this Act where he reasonably believes that another person lacks capacity.*
>
> *(9) In the case of an act done, or a decision made, by a person other than the court, there is sufficient compliance with this section if (having complied with the requirements of subsections (1) to (7)) he reasonably believes that what he does or decides is in the best interests of the person concerned.*
>
> *(10) "Life-sustaining treatment" means treatment which in the view of a person providing health care for the person concerned is necessary to sustain life.*
>
> *(11) "Relevant circumstances" are those —*
> *(a) of which the person making the determination is aware, and*
> *(b) which it would be reasonable to regard as relevant.*

30. The courts have emphasised in a variety of contexts that 'best interests' (or welfare) can be a very broad concept.

    a. *Re G* (*Education*: *Religious Upbringing*) [2012] EWCA Civ 1233, 2013 1 FLR 677.
    b. *Re A (A Child)* 2016 EWCA 759.
    c. *An NHS Trust v MB & Anor* [2006] EWHC 507 (Fam).
    d. *Re G (TJ)* [2010] EWHC 3005 (COP).
    e. *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67, [2014] AC 591.

31. The weight to be attributed to P's wishes and feelings will differ depending on such matters as how frequently they are expressed, how consistent the views are, the complexity of the decision and how close to the borderline of capacity the person is. (See [35] *RM, ITW v Z* [2009] EWHC 2525(COP) [2011] 1WLR 344). In *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67 the Supreme Court made it clear that the court below had been wrong to focus on what "the reasonable patient" would decide, and emphasised that the patient's own wishes and feeling must be properly considered: "the things which were important to him… should be taken into account because they are a component in making the choice which is right for him as an individual human being."

32. Deprivation of liberty is addressed in section 4A MCA 2005. That provides that P may be deprived of his liberty if by doing so the person is giving effect to a relevant decision of the court. A decision by an order under section 16 thus authorises a person's deprivation of liberty. There is a distinction between a deprivation of liberty and a restriction of liberty. In the case of *Storck v Germany*, the court said that there

are three broad elements to consider when determining whether or not a person is deprived of their liberty.

i) The objective element of a person's confinement to a certain limited place for a not negligible length of time.

ii) The 'additional subjective element that they have not validly consented to the confinement in question'.

iii) The confinement must be 'imputable to the state'.

In the 'Cheshire West' case, the Supreme Court confirmed that deprivation of liberty involves a factual assessment of whether the conditions imposed cross the threshold of 'continuous supervision and control and lack of freedom to leave'. Continuous does not mean 24-hour presence of a person but is in the nature of the conditions. The difference between restriction and deprivation of liberty is 'nonetheless merely one of degree or intensity, and not one of nature or substance. Although the process of classification into one or other of these categories sometimes proves to be no easy task in that some borderline cases are a matter of pure opinion, the Court cannot avoid making the selection upon which the applicability or inapplicability of Article 5 depends. In determining whether a decision within section 16 MCA should be made by the court with the consequent effect that it will deprive P of his liberty the court must only do so where it is necessary and proportionate. A conclusion that a care package is in P's best interests and which incorporates within it provisions which amount to a deprivation of liberty will meet this test although the court will of course scrutinise such a plan with great care and in particular those elements which take the plan over the threshold from restricting P's liberty to depriving him of his liberty.

33. Therefore, a host of matters must all go into the balance when the Judge seeks to arrive at his objective assessment of P's best interests

Care Proceedings

34. In his Judgement delivered on 21 June 2016 District Judge Alderson said as follows:

The position is quite clearly that these children have led a nomadic lifestyle, that the parents have not looked after them in any appropriate or satisfactory manner, in terms of schooling, in terms of bringing them up in a hygienic and a proper way. They have not been involved properly with medical services, community services, and educational services. They have moved around from county to county, to Ireland as well and to Nigeria at times, without any thought for the children in terms of continuity of education or medical care. 8. I was very distressed as well on seeing the children to understand how bad their education had been. Indications that the parents have given to the Local Authority, with regard to homecare being done in a proper and organised way, were manifestly and clearly exaggerated and overblown. These children are, educationally, at a very young age, many years younger than they should be. The only education, if you like, or element of education which they have had of any note is that of Bible studies. Quite clearly, they have been brought up in an environment, which really revolves around purely Bible studies and church issues to the exclusion of nearly every other aspect of their education. It is pleasing to see that

they are now coming round, that POA, particularly, is embracing with enthusiasm the educational opportunities that have been put his way and pleasing to hear that the other three are beginning to follow suit. 10. In terms of the threshold document which has been placed before the court on behalf of the Local Authority, quite clearly every aspect of that is made out and I have no difficulty in finding threshold criteria, and that the children have manifestly suffered harm, significant harm, as a result of the neglectful parenting provided by the parents…. The only parents they have, Mr and Mrs A, have failed to work with the court in any way whatsoever. They have failed to work with the social services. They have failed to work with the guardian and, indeed, it appears that they have left the country and certainly taken no steps to follow up a very reasonable and limited requirement to speak to the social worker to try and arrange contact. In other words, it appears that they have given up on their children, which is sad indeed.

35. Dr Sophia Jansen an educational psychologist saw EOA and DOA in April 2016. She noted that he appeared to be very vulnerable and easily influenced by his brother. She found it difficult to interact with him or to engage him. She thought he was very dependent upon his brother and vulnerable to influence by him. She was unable to reach a clear view on his level of learning disability. Dr Halari, a chartered consultant clinical psychologist provided a detailed report on the sibling group in May 2016. In relation to DOA she concluded that his '*experiences of being parented, the negative influences of his parents in relation to education, religion, professionals and society in general, his lack of engagement in education and socialisation is likely to have had a significant detrimental impact on his psychological cognitive, behavioural, social and emotional development.* I refer to DOA because she goes on to say in respect of EOA that he was quite strongly influenced by DOA's presents his views and opinions and that he had a tendency to copy and mimic his brother's views and beliefs. EOA refused to engage in the cognitive assessment. She was of the view that EOA '*suffers from neurodevelopmental difficulties such as learning difficulties, social and emotional communication/developmental difficulties'* and that '*the lack of adequate educational/social emotional behavioural support, the parenting that he has received in particular teachings relating to people, systems and society is likely to have had a negative impact on EOA.*

Dr Layton's Evidence

36. Dr Layton is a consultant psychiatrist with particular specialisation in autism. The questions he was asked and the substance of his report and evidence in respect of them is as follows;

    i) Does EOA have an impairment of, or disturbance in the functioning of the mind or brain? When answering this question please include information about: a). Any relevant diagnosis; b). Prognosis insofar as is material to the capacity questions.

    Think that is likely that EOA has a diagnosis of Autism. Taking account of the 1. limited information available 2. that some of these symptoms would resolve

with age in more able people like EOA, 3. the definite presence of some of the symptoms set out above, alongside the possible presence of many other symptoms, 4, and the complicating effect of abuse and neglect, which cannot wholly account for EOA's Autistic Symptoms I think that EOA does have Autism.

I do not think he has Learning Disability. EOA has had an eligibility assessment for learning disability services. These have looked at his cognitive and practical functioning. EOA's IQ has been measured to be outside of the learning disability range. (b) His functional ability has also been assessed as outside the learning disability range. Both assessors recognise that the validity of their assessments is limited by EOA's non-engagement with formal assessment and his unusual overall presentation. (c) I have review Dr Joel Parker's report in detail and find his logic compelling and his conclusions consistent with this. (d) In addition to the points that DR Parker raises, most of the factors that I can identify within support the view that EOA functions just above the learning disability range, and that there may be other reasons for this than an intrinsic impairment of cognitive functioning: 1. Whilst EOA clearly has a wide range of skills deficits, many of them may be explained by lack of educational or practical opportunity, or by his Autism. In spite of his qualitative communication difficulties, EOA is said to be bilingual which suggests a significant level of baseline cognitive function 3. In spite of his entrenched opposition to any form of (re)- habilitation, EOA shows good evidence of skills acquisition which appears slowed by a combination of impaired theory of mind and rigid thinking due to autism, alongside an entrenched reluctance to work with staff to do things that professionals think are beneficial for him.

EOA's overall presentation since coming into care is not consistent with an intrinsic psychotic illness….exposure to staff and professionals has diminished his paranoia towards them. This suggests to me that his paranoid and conspiratorial views, whilst extreme and unusual, are not delusional36, as they are gradually eroded by positive experiences of particular people. The slow rate of change probably reflects a number of factors related to autism: 1. Rigid thinking 2. Lack of theory of mind leading to difficulties understanding social rules and social context 3. A subgroup of individual with ASD are also predisposed to a more paranoid world view because of their problems with theory of mind. I suspect this has been further reinforced in EOA by his father's extreme views. I think that his family experiences (in the context of EOA's autism) are the major drivers of his paranoia and conspiratorial worldview, though he may have some additional genetic predisposition to paranoia.

Developmental factors related to abuse, neglect and indoctrination. (a) As highlighted by DR Rippon, children exposed to abuse and neglect can have increased levels of symptoms of autism. (b) The impact of indoctrination and very limited access to the wider community would further intensify any the rigidity of thinking seen in Autism. (c) EOA's experiences of abuse, neglect and indoctrination may well have wider effects on his personality and resilience. However, fortunately the reports from staff and within the bundle suggest that

he is both prosocial and resilient. He does not show evidence of personality disorder or mental illness.

ii) Does EOA have capacity within the meaning of the MCA 2005 to make decisions about: a). Have contact with others; b). Make decisions regarding any foreign travel; c). Make decisions regarding his internet and social media use.

In terms of a causative nexus, the presence of Autism, in the wider psychological context of this case as discussed above, has the potential to affect capacity. EOA's baseline level of understanding and practical functioning means that understanding is less likely to be an issue in this case. The presence of rigid thinking, lack of theory of mind and paranoia means that impaired weighing up / using of the relevant information is most likely to be at issue. EOA's reluctance to engage means that understanding, retention and weighing up can only be inferred by observation rather than formal testing. The evidence suggests that EOA may have some difficulties with social learning and learning practical tasks.

I think EOA lacks capacity with regards to contact, foreign travel and internet and social media use. I think this is based primarily on impairments of weighing up the relevant information due to his autism. These, along with his lack of life experience, have affected his ability to engage in education about the relevant information as well.

Contact

The information from his carers described a rigidity in thinking, and a paranoia about how any such discussions would be used against him. This would strongly suggest that EOA is unable to use information in regard to these family members. The alternative interpretation is that these same mental phenomena prevent him from believing the relevant information which then precludes him from using it. On the basis of this analysis, I think that EOA lacks capacity with regards to contact with his parents and siblings DOA and JOA.

EOA is in an entrenched position with professionals and care staff. He does not engage with discussions about his own vulnerability. He does not openly accept any of the concerns about his lack of social awareness, social naivete and that his symptoms of Autism and wider lack of experience make him vulnerable to exploitation and abuse. This entrenched position appears to be a function of his Autism (related to his rigid thinking, lack of wider social awareness and problems with theory of mind, including paranoia). It has been compounded by his upbringing and the family doctrines. EOA appears able enough to understand the risks strangers pose in theory, and practice putting this knowledge into action during trips out with staff. However, the entrenched position described above appears to prevent him using this information. This suggests that he is unable to use the relevant information in this case. Therefore, I am of the opinion that he lacks capacity with regards to contact with strangers.

Travel

The report (apparently at the request of the parties) descends into immense detail about the various aspects of travel including booking tickets, accommodation having an itinerary in advance, travel insurance, the need for immunisations etc. Dr Layton's observations in relation to the totality is that EOA would not be able to understand various aspects of the issue and would not be able to weigh up the relative risks; these being aspects of his broader functioning in particularly being unable to weigh information because of preconceived ideas or rigid thinking arising from his autism.

Social Media

He understands much related to this field. It seems likely that his current level of social naïveté means that he does not understand the more sophisticated ideas about deception online. However, I think it is likely that he could learn this information with some education and support. I base this on his paranoid and conspiratorial views, which require a similar level of cognitive ability. It is of note that EOA understood some of the benefits of internet use such as connecting with family, shopping online, looking at things that interest him (cars and cartoons). He can also use Skype independently to speak to his brother. Overall, I think that EOA lacks some areas of understanding in relation to the use of the internet. These deficits are a product of his Autism and family circumstances, especially his lack of wider social experience. On this basis EOA lacks capacity with regards to internet and social media use.

Unless capacity for contact is considered to be linked to capacity for internet and social media use in EOA's case, then EOA's capacity for internet and social media is not tied to any contentious or secretive areas. Therefore, it would be relatively easy for him to be given additional education to learn the relevant information.

37. Dr Dobrow-Marshall is a consultant psychologist with particular interest and expertise in issues relating to involvement with new religious movements and cult membership. She offered to work as a consultant to the practitioner psychologist, an expert in autism., In her communications she expresses her views as

i) *In this case, there appears to have been a blending of religious ideas and psychotic thinking that the patient was exposed to in his upbringing which would have led to feelings of paranoia and other deleterious effects of neglect. These would presumably best be dealt with within a trusting psychotherapeutic relationship which would take some time to develop.*

38. The way she formulated the approach would be;

i) *There would be many psychotherapeutic tasks to attend to before working with the patient to consider his religious indoctrination and the subsequent neglect on the part of his parents.*

ii) *These would include establishing a therapeutic relationship and a sense of safety for the patient in his housing and overall care. I could help the*

psychologist to identify the right timings and best way to approach the patient to begin to be able to express any mixed emotions or conflicting ideas about his religious upbringing, while supporting him to explore his feelings about how this may have affected his relationship with his parents, his self-concept and identity, and his relationship with the world.

39. Following further consultation between DR Dubrow- Marshall, Dr Layton, Collette Meehan of the CCG and DR Graham Thomson of the Oxleas NHS Foundation Trust a more detailed treatment plan was formulated which would bring together components including.

i) The staff at EOA's accommodation who would be given bespoke training and Psychological education over a period of about six months to enable them to understand how to interact with EOA and to avoid common pitfalls in working with individuals exposed to similar experiences to EOA. She would also provide a consultation service to enable staff to seek her input on an ongoing basis and to continue to support staff. My understanding of this segment of the treatment plan is that in effect this would involve a period of normalisation or normalisation and desensitisation in which EOA would be supported to feel safer in that environment and to help him to engage in exploring other interests and activities besides his religious ideas. This period would seek to lessen EOA's rigid thinking and opposition to ideas or experiences which do not conform to his current worldview which remains largely fixed in that which he was indoctrinated into in his family. This could involve an extensive period before EOA would be ready to engage in psychological treatment.

ii) The autistic spectrum disorder service at Oxleas, headed up by consultant psychologist Dr Centonze. This service would in effect be the lead clinical input covering the period of stabilisation and would supplement the advice given by Dr Dubrow- Marshall in relation to indoctrination issues by providing training and support to the staff in autism -related issues.

iii) The ADAPT (anxiety, depression, affective disorders, personality and trauma team) at Oxleas headed by consultant psychologist DR Thomson. At a point when EOA was considered to be sufficiently open to psychological intervention following a period of stabilisation and support for his autism this team would (assuming they assessed him as being appropriate for treatment) provide treatment focused on addressing the consequences of EOA's indoctrination. This stage might involve between 24 to 48 weekly sessions of individual psychotherapy with some specific sessions with Dr Dubrow-Marshall but the precise form would need to be determined at the time and might involve longer term work up to 18 months in duration. The precise nature of the therapy would be determined at that time.

iv) Dr Dubrow -Marshall would remain available as a consultant to the ASD and the ADAPT teams.

40. Ms Colette Meehan is the assistant director, integrated adults commissioning (Greenwich) south-east London clinical commissioning group. The CCG is

responsible for commissioning support for both autism and psychological therapy and she confirmed that they would deal with EOA on the basis that there was a confirmed diagnosis of autism and that the issues relating to indoctrination or de-radicalisation (which would not fall within the CCG's responsibility) were subsidiary. She confirmed that although the Local Authority would retain overall control for the case management of EOA the CCG would have responsibility for commissioning psychological therapies which would be delivered by OXLEAS, through the learning disability and autism program (formerly the transforming care programme which would deal with ASD issues and through the adapt team. The CCG would fund

i) Bespoke Autism Spectrum Disorder awareness training with Transforma. This will also be tailored around the specific needs of EOA.

ii) Time limited (three months after the conclusion of training sessions) bespoke advice and consultation to Transforma in order to further increase ASD awareness as needed and to further increase the understanding of ASD specific needs of the client.

iii) If needed provide support to psychological rehabilitation therapy provider with ASD specific adjustments to psychological approach and intervention.

41. She said that she would convene a professionals meeting including Dr Layton, Dr Centonze, Dr Dubrow-Marshall, Dr Thomson, the social worker and a staff member from T to draw up a detailed plan. I adopt the expression care and treatment plan for this. I was impressed by Ms Meehan and although she was not in a position to provide guarantees in relation to the precise level of funding or the precise treatment that would be provided, I'm satisfied that she was committed to ensuring that the best care and treatment plan was commissioned for EOA.

42. Precisely how the care and treatment plan is constructed from the elements set out at paragraph 25 above and the commitment offered by Ms Meehan set out at paragraph 16 of her statement and recorded at paragraph 26 above will need to be subject to detailed discussion at the professionals meeting. What all seem to be agreed upon though is that it must comprise the three essential elements of training and support for the staff of T provided by Dr Dubrow-Marshall and Dr Centonze to equip the staff with the necessary skills in the field of indoctrination and ASD to deliver the period of stabilisation; the element of treatment for ASD delivered by the ASD service and the element of treatment for indoctrination delivered by adapt. The lead psychologist is identified to be Dr Centonze but it will be a truly multidisciplinary team comprising not only the psychologists but also the care team, other specialists within the ASD and adapt teams, the social worker and others.

43. Ms Aroyewun filed the Care and Support Plan which sets out the detailed provisions proposed for EOA's continuing care at T. It is a detailed document. In short it proposes that EOA continues to reside at his current placement which he currently shares with two other individuals and the staff. He has his own room and his access to and from the house is controlled. Trips to the community are supervised. This will continue. The change to the arrangement centres around the extra training and support that the staff will be given in dealing with EOA's autism and the consequences of his indoctrination. EOA does not generally engage with his social worker but has

developed relationships with the staff at the placement. It is his engagement with those staff that reflects the progress that he is making.

44. Helen Cummings has filed a number of statements on behalf of the Official Solicitor. EOA generally declined to speak to her and so the information she gains is via the staff at his placement. That records that EOA is generally content in the placement, engages with the other resident and speaks with and speaks with staff. He has daily routine, he helps with cooking, cleaned his room looks after his personal hygiene and goes out shopping or for a walk twice a week he listens to music and watches You-tube. The star's view was that his ability to live independently was limited as he needed support with cooking and shopping. He would like his own laptop rather than using that of the placement. He won't see the GP although complains of back pain which limits his walking. He doesn't talk about his family much although looks forward to contact with JOA. He was asked if he wanted to attend the hearing but did not wish to do so.

Discussion and Determinations

45. The Applicant and the Official Solicitor have agreed many of the issues although that does not absolve the court of undertaking its own evaluation and reaching its own conclusions on agreed matters. In this case I have already reached final conclusions on important aspects of EOA's capacity to;

    i) Conduct these proceedings.

    ii) Make decisions about his care and support.

    iii) Make decisions about where he should live and

    iv) Make decisions about his property and affairs.

46. Nothing that has emerged in the evidence which has been produced since those decisions were reached undermines the validity of those decisions but rather Dr Layton's oral evidence reinforces them.

47. Despite the difficulties in carrying out a comprehensive assessment of EOA that Dr Layton, (as experienced by almost every other health professional) experienced as a result of the difficulties in securing EOA's engagement I am satisfied on the balance of probabilities that the diagnosis of autism is an accurate one. Dr Layton surveyed a broad landscape encompassing historic assessments of EOA, the views of his current carer's and EOA himself and given his degree of expertise in the area I accept his opinion. The particular feature of that condition which bears upon EOA's ability to make decisions is his fixed thinking which prevents him using or weighing information which is different to his preconceived and fixed ideas. This at the moment dominates his thinking in relation to very many important decisions that have to be made. That is not to say that there are not areas where he does show an ability to weigh and use information and where is thinking is not rigid but for the purposes of the decisions which have been put before me for adjudication it is this aspect of his condition which also in some contexts renders EOA unable to understand relevant

information but most importantly prevents him using or weighing it as part of the decision-making process. I am therefore satisfied that EOA has an impairment of, or a disturbance in the functioning of the mind or brain within section 2 (1) MCA.

48. Although I do not need to decide the issue as I am satisfied that EOA has an autistic spectrum disorder and that he lacks capacity in the relevant domains as a consequence of the fixed thinking associated with his autism and his consequent inability to weigh information it does seem to me that there is an issue which may at some stage need determining as to the role that other features of EOA's psychological condition may be playing in relation to questions of capacity and jurisdiction. Both Dr Jansen and Dr Halari identified that EOAs experiences had impacted on his psychological functioning or development. The definition of harm in the Children Act 1989 means ill-treatment or the impairment of health or development. Development means physical, intellectual, emotional, social or behavioural development and health means physical or mental health. District Judge Alderson accepted that EOA had suffered significant harm as a result of the abusive parenting he had experienced, and in particular the indoctrination into a way of life and belief system well beyond any norms in society; even giving due allowance for the very wide margins acceptable in a modern liberal society. It is well established that emotional abuse and neglect can have both physiological/neurological consequences in terms of brain development and psychological consequences. The absence of any specific diagnosis in relation to EOA of the effects of his neglectful and abusive childhood does not mean that they may not still be present and playing a part in his current functioning. In theory at least it seems to me possible that even if it were not possible to fit those consequences into any known diagnostic category that they would be capable of having caused an impairment of or a disturbance in the functioning of the mind or brain which would potentially bring them within the ambit of section 2(1) of the Mental Capacity Act. Of course, EOA's case is as a I have said far beyond any broad societal norms and within the spectrum where it can properly be characterised as indoctrination. Thus, even where the causes of incapacity caused by autism resolved that might still leave issues to be determined as to whether the consequences of his abusive indoctrination had consequences in terms of his capacity. Self-evidently it might also engage the protective Jurisdiction of the court in relation to vulnerable adults even if the consequences did not sound in capacity issues. However, given the evidence of Dr Layton that the autism itself is either substantially or entirely the source of EOA's inability to use or weigh information those are questions I do not need to resolve today. As Dr Layton said in evidence it is not possible to disentangle the effect of autism and the effects of the indoctrination in any way so as to quantify them but the fixed thinking which is a well-recognised aspect of autism, (but would also be consistent with indoctrination) establishes the causal nexus required by section 2(1) MCA.

49. In relation to foreign travel and possession of his passport I am satisfied that EOA lacks capacity to make decisions as to his foreign travel given his lack of understanding of various issues relating to the practicalities of arranging foreign travel including managing the funds and the risks associated with foreign travel and his inability to use and weigh relevant information.

50. In relation to the question of contact with others it seems to me that this issue does have to be broken down into separate compartments. First of all, there are issues of

capacity relating to family members; those who maintain the doctrine including the mother, father, DOA and JOA and those who have left the doctrine behind covering POA and TOA. Secondly there are issues of capacity relating to third parties or strangers. I agree with the Local Authority and with the Official Solicitor that it is appropriate to apply a different approach to questions of contact with family members to that which should apply to the generic issue of capacity to have contact with strangers or third parties. In relation to his capacity to make decisions about contact with family members who remain within the doctrine the evidence establishes that EOA understands the contact with family he does not understand the risk they pose to him and is unable to weigh that in any decisions about contact with him. This rigidity of thinking arises from his autism although may also be impacted by indoctrination. He thus lacks capacity to make decisions in relation to those family members. In relation to family members who are outside the doctrine EOA expresses no interest in seeing them. This may be because to do so he sees them in large groups which she does not like because of his autism but it may also be because they call into question his beliefs about the family. When POA attended court with EOA, he expressed his reluctance to see EOA because EOA's view of the family tended to undermine POA's separation from them. It seems to me that EOA lacks capacity in relation to these family members principally because he does not understand the benefits of seeing those who are outside the doctrine and he might be able to help him to understand the harm is indoctrination has done to him. As Mr Brownhill put it, he would need to understand something about the family dynamics and the differences that exist in order to make a capacitor's decision. Achieving this is part and parcel of the long-term three-pronged care and treatment plan. Thus, I am satisfied that EOA lacks capacity to make decisions in relation to contact with his family members. I'm satisfied that it is appropriate to make a separate declaration in respect of this aspect of contact with others because it is a fact specific decision which arises in this case and which has to be addressed. I will make declarations in this regard and am satisfied that they should address the issue of social media and Internet usage for the reasons set out below.

51. In relation to contact with strangers or third parties it is appropriate to consider the established formulation of the relevant information. Dr Layton identified EOA's lack of understanding of his own vulnerability arising from his lack of social awareness, social naïveté and autism which make him vulnerable to exploitation and abuse. His fixed thinking and unwillingness to consider these issues prevent him weighing issues relating to his vulnerability and he thus lacks capacity to make decisions about contact with strangers. There is an argument that in relation to contact with strangers that EOA might with the provision of information and support capacity to make decisions about contact with strangers in the way that he might with support regain be able to make capacitors decisions in relation to general social media and Internet use. However, I think there is a distinction. The issues of lack of understanding of his vulnerability and his susceptibility to exploitation by strangers in relation to contact our more profound than those which bear upon social media and Internet usage. There is some link in that one can lead to the other but the progress that EOA would need to make in understanding his vulnerability in face-to-face relationships with third parties or strangers are far more deep rooted and are likely only to be addressed through the three-pronged, long-term care and treatment plan. I am therefore satisfied that EOA lacks capacity in relation to making decisions about contact with strangers and that

the final declaration should be made in this regard. I do not consider that an interim declaration is appropriate in this regard.

52. I'm satisfied that in relation to general issues of access to the Internet and social media that decisions such as Re A (Capacity: Social media an Internet use: best interests) [2019] EWCOP 2 provide a proper route map to a decision in relation to this issue. The evidence establishes that EOA's capacity to use social media and the Internet is currently hampered by his lack of awareness of the possibility of deception and exploitation by third parties with interests adverse to his own. This in Dr Layton's view amounted to a lack of understanding which meant he lacked capacity. Dr Layton's thought he might gain capacity relatively easily with appropriate support and information in this area.

53. However, I am satisfied that this approach does not assist in relation to the particular decision which arises in relation to use of the Internet and social media for the purposes of searching for his family or contacting them. In this regard the issue is far more closely aligned with the approach to contact with other named individuals where the courts evaluation should be decision specific. The use of the Internet or social media is merely one vehicle by which EOA might seek or have contact with family members who pose a risk to him and in respect of whom he lacks capacity to make decisions as to contact. Social media and the Internet today are the modern equivalent of a telephone directory or a letter of a previous era; they are simply a means of gathering information or communicating and in this case where there are clearly identified individuals whom EOA lacks capacity to make decisions in relation to contact seems to me that this should be recognised. The danger of not dividing these domains into more specific identifiable decisions would be to either apply an approach which was too restrictive in that it would apply a high bar in relation to strangers which in fact was only relevant to family members or alternatively it would apply too low a bar relevant to strangers to issues of contact with high risk family. I am satisfied that the statutory scheme and the jurisprudence does not require such an approach but requires a tailored and decision specific approach where that is appropriate on the facts. Thus, the order in relation to general internet and social media use should be an interim order which reflects the fact that further practicable steps to enable EOA to make capacious decisions in this regard. In relation to social media and Internet usage in the context of contact with family members that should be incorporated in the declarations addressing contact.

54. Although EOA's capacity in relation to his physical health has not been expressly addressed, his reluctance to engage with doctors is a long-standing issue. This was noted during the care proceedings in 2016 and has endured down the years to his recent refusals to engage with the GP. As with other aspects of EOA's behaviour it seems probable that is refusal to engage with the GP is a complex interweaving of views derived from his upbringing and an inability to weigh information arising from that and from his autism. In relation to matters such as vaccination given to this. EOA is likely to refuse the vaccination as that has been his express position in relation to all forms of immunisation. It may be concluded at the relevant time that he lacks capacity in relation to vaccination but in welfare terms the issue of forcing a vaccination upon him would raise very sensitive issues of the balance between his physical health and the psychological impact which might be profound and would almost certainly have a significant impact on his trust in those around him and their ability to engage him in

the sort of normalisation and desensitisation on work as well as any autism related work.

55. In this highly unusual case, it is clear that the care and treatment of EOA needs to be bespoke. The complex interplay between the psychological consequences of EOA's upbringing and the impact of autism requires a bespoke approach which has now been identified. Approaches which might be well established for individuals with autism have to be re-evaluated in the light of the indoctrination elements of EOA's psychological make up. It is clear that ABA is inappropriate, and that PBS needs to be tailored specifically to EOA as an individual; dynamic PBS as suggested by the Official Solicitor. The care and support plan drafted by the Local Authority subject to the amendments outlined by Ms Hendrick provides an appropriate for EOA's medium to long term care. He has settled into that placement and has begun to develop relationships with some of the staff. It is important that the stability and security that brings EOA continues and that he is able to regard it as a home. The proposals that have been made in relation to the treatment plan with its three psychological components now provides an appropriate foundation for the treatment element of EOA's future care.

56. Taken in combination I am satisfied that the care support and treatment plans provide solid foundations on which EOA's medium to long-term future can be built. The two factors which weigh in the scales against the adoption of that care support and treatment plan as being in EOA's best interests are his own strongly held wishes to be reunited with his family and the prognosis.

57. EOA has consistently expressed the desire to be reunited with his parents and brother DOA. This has been a feature of his expressed wishes ever since he was removed into care. He is now 19 years old and has been consistent for some five years. He has expressed them firmly and articulately to me. The long held and firmly expressed wishes of a 19 year old young man warrant considerable attention. However those strongly held wishes remain very much a product of the indoctrination that led to EOA's removal into care and given that EOA lacks capacity to make decisions as to where he lives, his care and his contact with his family I am satisfied that those wishes must give way to the general welfare benefits that the care, support and treatment plan provide. I wonder whether EOA himself recognises or has some awareness of the benefits to him of his current living arrangements but is unable to express those because of the his indoctrination which have a firmer hold on him than they have for instance on POA or TOA. The other issue which bears upon the decision as to whether it is in EOA's best interests to approve the care support and treatment plan is whether it is likely to achieve its goals and thus whether it is necessary and proportionate for the court to make the order is sought. EOA has been in care for five years and there is only modest evidence of change. Thus, is it proportionate to keep EOA from his family against his wishes if there is only modest prospects of success. For reasons which have not been fully explored it seems that EOA has not been able to access the sort of treatment that is envisaged under the three-pronged treatment plan now proposed. It seems from reading about EOA as he was in 2016 and now that there have been modest changes in his presentation and that his experience of life with his foster carer and in his placement have had some beneficial impact. It therefore seems probable that the bespoke care support and treatment plan proposed is likely to have a beneficial impact albeit over an extended

period measured in years not months. Given the length of time EOA was exposed to indoctrination and the length of time that his autism has been untreated it may be that the changes that will be affected may be hard to predict and modest in extent but it is clear that the prognosis is positive if uncertain. That being so I am satisfied that and that it is a necessary and proportionate response to his situation. No lesser measure could be put in place to achieve the same ends.

58. The care, support and treatment plan continue the living arrangements for EOA which plainly constitute a deprivation of liberty given the limitations which are placed on his ability to leave the placement and the levels of supervision which are put in place both within the placement and when he ventures into the community. They are imputable to the state and EOA cannot consent to them. Although the risk of EOA absconding appears to be low the consequences of him being reunited with his family are extremely serious the risks to EOA in the community given his lack of capacity relating to contact with strangers also create considerable risks for him. I am therefore satisfied that the deprivation of liberty that the care plan represents is necessary and proportionate.

59. I agree that it is unnecessary to make express provision in the deprivation of liberty order authorising EOA's restraint. Although he expresses a firm wish to be reunited with his family so far as anyone is aware, he has not made any attempt to leave TOA or even to search for his family. When he has left the GP surgery unaccompanied, he returned to the house and did not abscond. Nor is his behaviour in the home such as to have required the staff to use any form of restraint. Although he may be assertive in expressing himself, he is not violent and is generally compliant with the rules of the placement. It is therefore neither necessary or proportionate to authorise the use of physical restraint. Given the difficulties that have been encountered during the course of these proceedings in tracking down EOA's mother and father for the purposes of notifying them of these proceedings it seems clear that were EOA to locate them and to that if he were successful it might prove impossible to find him again. The frequency with which the family move and their ability to evade detection would mean that the consequences were EOA to abscond would be likely long term and thus serious. The placement needs to be aware of this, as I'm sure they are, and to be vigilant to any sign that EOA might be seeking to locate them or even more seriously that he might have located them and was seeking to leave to Join them. However, as Mr Brownhill submits the statutory framework would permit the staff to take steps to prevent EOA absconding even without express to restrain him.

60. EOA lacks capacity to make decisions in relation to contact with JOA and it is proposed that he should continue to see him. The concern in relation to JOA is that he remains aligned with the family and there is evidence that he has made comments to EOA supportive of the family position and which would therefore have a tendency to undermine EOA's ability to disentangle himself from the family position. However, the Local Authority accept that EOA looks forward to his contact with JOA and that much of the content is appropriate as between brothers. EOA shares his drawings and the boys talk about cars and other day-to-day subjects. There is concern that terminating would be perceived by EOA as punitive and confirming his negative perception of the Local Authority thus further undermining efforts to normalise and stabilise EOA. The social worker gave evidence that following communications with

JOA's social worker that his foster carers had been alerted to this issue and were now monitoring the contact; albeit with a light touch and were primed to intervene if JOA said anything inappropriate. As a consequence, the contact between the brothers in recent weeks as not been tarnished by any inappropriate comments but has been innocuous. That being so provided he continues in the main to be positive it should continue. If there were a very dramatic change in JOA's approach that position would need to be revisited. I'm satisfied this contact is in EOA's best interests.

61. The Local Authority accepted that the making of a deprivation of liberty order and the necessity for a review meant that pursuant to COPR 1.2 a representative should be appointed. The Local Authority initially proposed that T's independent mental capacity Advocate be appointed on the basis that he knew the family well and was willing to act as EOA's litigation friend. The official solicitor did not take a firm position on this but remained willing to act as EOA's litigation friend. Given that T is regarded as an outsider by EOA it seems to me that appointing someone close to him, even if there is no overt conflict-of-interest, would find it difficult to engage with EOA who would be likely to reject him as tainted by association with T. Seems to me that the most appropriate litigation friend will be the continuation of the current arrangements.

62. The statutory scheme provides for the provision of a pathway plan to promote education and training for a care leaver. It emerged that unknown to EOA's current team that the children's team had in fact developed a pathway plan via his children social worker and they had monitored it. Although for a period of in excess of six months the pathway plan had not been reviewed as a result of the absence of the social worker seems to me that in reality this almost certainly had no impact on the ground. At present the benefit of a pathway plan is that if as a consequence of the treatment plan EOA expresses an interest in education or training that a pathway plan will mean there is a vehicle by which steps can be taken very rapidly to implement such a willingness to access education or training. Historically the evidence makes clear that EOA had almost no formal education. When he was received into care the educational psychologist suggested a special school for children with severe learning disabilities. I have not been able to unpick precisely what happened in relation to EOA's education between the making of the care order and his reaching his 18th birthday although it seems clear that home-schooling was attempted but was withdrawn when EOA did not engage. I entirely accept that for an individual in EOA's position nonengagement (as for autism itself) should not lead to the immediate conclusion that nothing can be done, and services be withdrawn. However, in EOA's case is nonengagement is not an aspect of his behaviour that is readily addressed; it permeates his whole personality and relates to far more than just education, but extends to health, engagement with almost any authority figure whether a social worker, a pathway adviser, his legal representatives or any other emanation of authority. Those who EOA engages with tend to be those he knows and has developed some trust in. A pathway plan and pathway adviser whether actively promoted or desultory promoted over the last 18 months would have gained no traction but would have represented another individual who EOA would have declined to engage with. I very much hope that the tripartite approach contained within the proposed care and treatment plan will open a window in EOA's mind to the potential benefits of education or training. Thus, the existence of a pathway plan which will allow rapid advantage to be taken of any such opening that the care and treatment plan creates in

EOA's attitudes to society and normative behaviours. Although the issue has been rumbling along in the orders and position statements and it is right that the official Solicitor has identified the issue I do not think in practice in this case it is of real significance in the way it was in Re ND where Mr Justice Keehan did feel it appropriate to make a Declaration that the Local Authority had failed to fulfil their statutory duty. It is of peripheral relevance in this case and I declined to make any declaration. I accept that those involved in these proceedings and on the ground have done their best (with occasional shortcomings) to deal with a situation and individual that does not fit into any readily recognised categories and that has taxed even the minds of experts in their fields such as Dr Layton and Miss Meehan.

Conclusion

63. I will therefore make declarations that EOA lacks capacity to make decisions in relation to;

    i) Foreign travel.

    ii) Contact with his family and others.

    iii) Social media and Internet usage.

64. In relation to social media and Internet usage this will be an interim declaration. I do not consider that a declaration in relation to EOA's capacity to consent to medical treatment can properly be made at this stage albeit I have recorded my views in that regard above. The previous declarations that I have made together with those set out above should be recorded in one order. I declined to make a declaration in relation to the issues relating to the pathway plan.

65. I determine that it is in EOA's best interests for the care support and treatment plan to be implemented. The care and support plan needs to be amended and the treatment plan needs to be set out in black-and-white following the professionals meeting.

66. The final order will not be made until the amended care and support plan and the treatment plan have been finally agreed and I will allow a period of six weeks for this to be finalised.

67. It seems to me that once approved the plan needs a period of a year at least to bed down without the distraction of litigation pending. It can therefore be reviewed by me one year on from the final order being made. I will reserve applications relating to EOA to myself. If it is agreed in a years' time that the plan is working and that it should continue the matter can be dealt with on paper. If substantive issues need determining, then I will hear the matter at that stage.

68. It seems to me that the Official Solicitor should remain as EOA's litigation friend for the purposes of the review of the deprivation of liberty and the care, support and treatment plan.

69. I will write a short letter to EOA to explain to him why I have reached these conclusions.

70. That is my judgment.