[2024] EWCOP 42 (T2)

Case No: 14032126

IN THE COURT OF PROTECTION

The Sessions House,
Lancaster Road,
Preston
PR1 2PD

Date: 16 August 2024

Before :

HIS HONOUR JUDGE BURROWS
Sitting as a nominated judge of the Court of Protection at Tier 2

- -

Between :

PS	**Applicant**
(by her litigation friend, Cecilia Walsh)	
- and -	
(1) A LOCAL AUTHORITY	**Respondents**
-and-	
(2) WP	
-and-	
(3) DT	
-and-	
(4) RS	

PS: SEVERE SHORT TERM MEMORY LOSS: CAPACITY TO ENGAGE IN SEXUAL RELATIONS

Neil Allen (instructed by **Irwin Mitchell LLP**) for the **Applicant**
Dr Barbara Green (instructed by **the Local Authority Solicitor**) for the **First Respondent**
WP, DT and RS (Second, Third & Fourth Respondents) all appeared in person.

Hearing date: 19 June 2024

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JUDGMENT

HIS HONOUR JUDGE BURROWS:

INTRODUCTION & OUTLINE

1. This case is about a lady I will call Patricia, or PS. She is 79 years of age. Sadly, in recent years she has suffered the effects of memory impairment, which have become extremely serious. There is a diagnosis of alcohol related impairment and associated alcohol misuse and amnesiac syndrome related to alcohol use.

2. For most of her life, PS has lived independently. She has had two great relationships in her life. She was married to LS for many years. She also knew William (WP), and they were friends since their teenage years. After LS died, PS and WP started a relationship, and they lived together as partners for the best part of two decades. They had a sexual relationship. It is unchallenged that both want that relationship to continue even though PS is now in residential care.

3. The issues with which this Court is concerned in this case are whether, and to what extent PS lacks the capacity to make certain decisions. According to the instructions given to the expert in this case, the decision-making issues I am concerned with are:

    (a) Decisions regarding residence;

    (b) Decisions regarding the care she receives;

    (c) The decision to consume alcohol;

    (d) Decisions about contact with others;

(e) Capacity to engage in sexual relationships.

4. I have benefitted from professional advocates in the form of Neil Allen and Dr Barbara Green, as well as WP, DT (who is one of PS's property and affairs attorneys) and RS (who is PS's son). With the exception of RS, all those mentioned above as well as the expert, attended the hearing in person. RS lives abroad, and he attended by way of video link. I was greatly assisted by all parties. In particular, the non-professional participants were extremely sensible and focused on PS's best interests in the way they approached the case.

5. The case has not been without some difficulty, for reasons I will outline. However, I have reached the conclusion that PS lacks the capacity to make all decisions with the exception of engaging in sexual relations. I will explain my reasons and the difficulty in the decision I had to make as succinctly as I can.

6. I would also add that I have decided not to go into the minute detail of PS and WP's relationship. Nothing would be gained by a detailed exposition of their relationship both in the past, the present and the future. I will have to make some limited comments, but I will keep them to a necessary minimum.

THE FACTS

7. The following unchallenged facts are taken as uncontroversial for the purposes of my task in this judgment.

8. First, PS and WP's relationship appears to have been framed within a culture of alcohol use and, it appears, overuse.

9. Secondly, although there were times when they lived together that there were concerns over WP's ability to look after PS, leading to concerns about neglect, this

appears to be due to her increasing needs and WP's inability to meet them, rather than any deliberate neglect or abuse on his part. I note that PS's son has said that WP was (and maybe is) financially dependent on his mother. That may have been so, however there is no doubt on his or any other person's part about one feature of their relationship, namely that it has been a loving and caring relationship and PS still benefits to the extent she can from it.

10. Thirdly, there have been some "safeguarding" concerns raised and investigated by the Local Authority. On the first occasion, when it seems PS was not assessed as lacking capacity, she and WP were found together in her locked bedroom. This caused a "safeguarding" alert when staff were not let in the bedroom. It seems this "incident" was reported to the police.

11. As a result, and due to what was described as "concerns about mental capacity" a protocol or "protection plan" was put in place.

12. It is important to quote what that "agreement" says because it may form the backbone of any visiting regime in the event I find that PS lacks capacity to engage in sexual relations, and until a new plan can be put in place if I find the other way. It says (as if it is written to WP):

    (1) WP to contact the home to book in for a visit.
    (2) WP to visit between the hours of 8am – 5pm to enable more staff presence.
    (3) All visits to take place in communal areas. If more privacy is required for example, too much noise etc. other rooms can be accessed such as the music room, just ask a member of staff.
    (4) If PS is asking for you to attend her bedroom with her or is making advances which become uncomfortable. Please consult staff for direction.
    (5) No outside visits to take place.
    (6) Under no circumstances are any visits to take place in PS's bedroom, this is to Safeguard yourself as well as PS.

13. That last point is intended to prevent WP being accused of rape or indecent assault should sexual activity take place when PS is assessed as incapable of consenting to it.

14. There were, however, two "incidents" in breach of this agreement. These caused concern to the management of the care home and the Local Authority. WP was told not to breach the agreement again. As I understand it there has been no sexual activity between the two since then.

15. Although PS's son seems very supportive of the relationship between WP and his mother, he was unambiguous when asked during the hearing, that she is incapable of consenting to further sexual activity.

THE LAW

16. The basic law on capacity is straightforward.

17. The first four sections of the Mental Capacity Act 2005 (MCA) are foundational to the jurisdiction. Section 1 lays down the principles. It establishes the presumption of capacity (sub-s 2) and the obligation to ensure that a person is not to be regarded as lacking capacity to make a decision until "all practicable steps to help him to do so have been taken without success" (sub-s 3). This is a particularly important provision on the facts of this case.

18. P making an unwise decision does not mean she lacks capacity (sub-s 4) (at least not without more).

19. Finally, any act done, or decision made on P's behalf where she lacks capacity must be made or done in her best interests (sub-s 5).

20. Sub-section 6 states the principle of least restriction.

21. Sections 2 and 3 of the Act deal with the diagnostic and functional "tests" for incapacity. This means that 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".

22. Section 3 should be laid out in full. It provides:

> (1) For the purposes of section 2, a person is unable to make a decision for himself if he is unable to-
>
> (a) To understand the information relevant to the decision,
>
> (b) To retain that information,
>
> (c) To use or weigh that information as part of the process of making the decision, or
>
> (d) To communicate his decision (whether by talking using sign language or any other means).
>
> (2) A person is not to be regarded as unable to understand the information relevant to a decision if he is able to understand the information relevant to a decision if he is able to understand an explanation of it given to him in a way that is appropriate to his circumstances (using simple language, visual aids or any other means)
>
> (3) The fact that a person is able to retain the information relevant to a decision for a short period only does not present him from being regarded as able to make the decision.
>
> (4) The information relevant to a decision includes information about the reasonably foreseeable consequences of-
>
> (a) Deciding one way or another, or
>
> (b) Failing to make a decision.

23. In relation to sections 2 and 3 a number of authorities now make it clear that the functional exercise needs to be considered first (i.e. whether P can make the

decision) before moving on to consider the diagnostic test (i.e. is that inability due to a disturbance in the functioning of the mind or brain). I will address this later in the circumstances of this case.

24. Section 4 deals with best interests. In the case of most areas of incapacity, a decision can be made on behalf of P. However, in the case of sexual relations, s. 27(1)(a) MCA intervenes, which prohibits the making of a best interest decision to enable P to consent to sexual relations. As Sir Brian Leveson, President QBD put it in IM v LM [2014] EWCA Civ 37, where P lacks capacity to consent to sexual relations the LA must do everything it can to ensure she does not engage in sexual relations.

25. The controversial issue in this case concerns PS's capacity to engage in sexual relations. The statutory provisions are the same, but there is authoritative guidance on the approach to be taken from the Supreme Court in A Local Authority v JB [2021] UKSC 35, which is as follows. The information P must be able to understand, retain, use and weigh (before communicating his decision) is:

> (1) the sexual nature and character of the act of sexual intercourse, including the mechanics of the act;
>
> (2) the fact that the other person must have the ability to consent to the sexual activity and must in fact consent before and throughout the sexual activity;
>
> (3) the fact that P can say yes or no to having sexual relations and is able to decide whether to give or withhold consent;
>
> (4) that a reasonably foreseeable consequence of sexual intercourse between a man and woman is that the woman will become pregnant.
>
> (5) that there are health risks involved, particularly the acquisition of sexually transmitted and transmissible infections, and that the risk of sexually transmitted infection can be reduced by the taking of precautions such as the use of a condom.

26. What I must point out at this stage, before considering the expert evidence is the following.

27. First, the threshold for capacity for this decision is set deliberately low. The level of understanding is not high or elaborate.

28. Secondly, the second limb of the test requires P to be able to retain the understanding that the other person may change his mind as to sex and that means P no longer can have sex with that person. Equally, although the language used is subtly different, the same applies to the third limb. Clearly, if P must understand that she can say yes or no to the act of sexual relations, she must also be able to understand that she can withdraw her consent at any time during the act. This may be the critical issue in this case.

29. Thirdly, two matters that have arisen during the questioning of the expert is the place of memory and understanding of the identity of the sexual partner in the issue of capacity. These are issues I will deal with a little later on.

30. Fourthly, there is the issue of the overlap between various domains of decision making. In particular, there is a problematic relationship between capacity to make decisions concerning contact with people on the one hand and making decisions about sexual relations with people on the other.

31. As Mr Justice Poole put it in Hull CC v KF [2022] EWCOP33 (at [24]): "Decisions about capacity must be coherent and allow those responsible for caring for and safeguarding KF to make practical arrangements". It may be thought that if P lacks the capacity to decide whether to have contact with a person she also lacks capacity to engage in sexual activity with that person. Certainly, those managing P's care in a situation where contact is regulated, but sexual activity is permitted have a very difficult job when formulating what is (in effect) an "intimacy care plan".

32. That being said, there is no reason in principle why a person may lack capacity to make decisions with contact with a person or persons in general but have capacity to engage in sexual activity with a person or persons. In Manchester City Council v LC and KR [2018] EWCOP 30, albeit the P in that case was in a very different situation than PS in this case, this issue arose. Mr Justice Hayden said that "though it may not be intuitive, it is perfectly logical, looking at capacity in an issue-specific context (as the MCA requires), to possess the decision-making facility to embark on sexual relations whilst, at the same time, not being able to judge with whom it is safe to have those relations". In that case the care planning was exceptionally challenging for those responsible for P. However, whilst I have expressed some misgivings about the circumstances of that case in A Local Authority v ZX [2024] EWCOP 30, LC is still a decision that may support a similar finding in PS's case.

THE EXPERT EVIDENCE

Generally, and not including contact and sex

33. Dr Catriona McIntosh, is a Consultant Clinical Neuropsychologist. She provided a substantive report (1 August 2023) and responses to questions (31 October 2023). She also attended Court and was asked questions. I am grateful to Dr McIntosh for her clear evidence in a complicated case.

34. I do not intend to go through Dr McIntosh's written evidence in detail. Some issue was taken in the written questions as to why she did not approach the capacity assessment with the functional test before the diagnostic one/mental impairment (as the Courts specify). Nothing turned on that in this case, and I will not be disregarding her evidence because of that, although, in fact she should approach the matter as the Courts have specified in the future.

35. There is no doubt in her mind, nor in mine, that PS suffers from a disturbance in the functioning of her mind or brain. The relevant diagnosis is of alcohol related amnesia. That is, it seems, permanent but not necessarily deteriorating.

36. There is no doubt in Dr McIntosh's view that this has and continues to have a devastating impact on PS's short-term memory. That has a dramatic effect on her ability to understand things. She lacks the ability to make decisions as to her residence or care. That is because, putting it in simple terms, she has no real concept of where she is or what her care needs are.

37. Although there were some differences in the wording to be used in relation to PS's capacity to make decisions as to consuming alcohol, I am satisfied that she is unable to assess the risks associated with the consumption of alcohol and this needs to be regulated in her best interests by others.

The issues of contact and sexual activity

38. The issues in this case centred on PS's capacity to make decisions about contact and to engage in sexual relations.

39. As I understood the case, the issue of contact is complicated by two factors. The first is PS's inability to assess any risks that a person with whom she has contact with may present to her. That is further complicated by evidence that, because of her damaged memory, PS is liable to misidentify people. She has, it was said, mistaken other men for WP in this case. This may have implications for her decisions on contact generally but also on sexual relations, in particular.

40. Dealing firstly with contact, in her report at 3.7.8, Dr McIntosh concludes:

> "that PS was unable to understand, use or weigh, nor retain the relevant information to have capacity for contact. It is my opinion that she lacks capacity for contact with males in general and not specifically with her long-term partner. It is my opinion that her difficulty in these areas is directly attributable to the cognitive impairments as a result of her alcohol related amnesia, and therefore that the causal nexus requirement is met".

41. Earlier in her report, Dr McIntosh had considered the guidance given by Mrs Justice Theis in LBX v K & Others [2013] EWHC 3323 as to the relevant information needed in order to assess capacity as to contact. This included, although was not restricted to: who the person was and in broad terms the nature of her relationship with them; the sort of contact she could have with each of them, including different locations, differing durations, and differing arrangements regarding the presence of a support worker; and, the positive and negative aspects of having contact with each person as well as the relevant risks of contact with that person. The instruction letter was not initially person (i.e. WP) specific, although it was later modified to include him.

42. It seems to me there is a need for clarity here, particularly since we will be moving on to a consideration of sexual relations after this. There is no doubt that PS is unable to understand/use and weigh the information relevant to decide on contact with people in general. In very simple terms, PS is incapable of understanding/using and weighing the matters listed in LBX and quoted above.

43. What about WP? It seems to me that even if we treat him differently, because he is PS's partner of many years and she has a strong sense of memory of him at a very deep level, it is clear from what Dr McIntosh told us, and the rest of the evidence, that PS does not know how to make decisions about contact with him taking into account the LBX features summarised above. She cannot put their contact into the context of her needs and the fact she now resides in residential

care. During oral evidence Dr McIntosh focused on any risks WP may pose to PS and that she would have no ability to assess those risks. Actually, leaving risk to one side, PS has no ability to initiate or refuse contact within the context of her relationship with WP, other than simply following her basic feeling that she knows him, and he is her husband/partner.

44. Whether WP poses a risk to PS of which she is unaware is a different issue. If there had been evidence that WP had, throughout his relationship with PS, abused her and regularly sexually assaulted or raped her, the risk would be obvious, and it would be relevant information for her to have in order to assess contact with him. However, no one suggests WP has ever been anything other than a loving partner to PS. The risk identified is the risk that he will not follow a care plan put in place to keep PS safe. Experience shows that there is a risk that he may do that, and it is a risk that would be relevant to PS's decision-making if she were able to do so.

45. Consequently, I determine that PS lacks capacity to make decisions as to her contact with others, including WP. I would add immediately that I can think of no circumstances as matters stand why WP should ever be prohibited contact with PS (or her with him).

46. The issue of PS's capacity to engage in sexual relations has been difficult. Dr McIntosh described it as finely balanced. Although she was extremely clear and insistent that the presumption of capacity in this area is a matter of law and that people have the right to have sexual relations with whoever they wish unless it can be established that they lack capacity, Dr McIntosh has obviously toiled anxiously over this question. This is no criticism of her at all. Indeed, I would have been very critical of her if she had not found the issue somewhat difficult.

47. When considering the question of "relevant information" as in JB, Dr McIntosh approached the matter this way. The relevant information depends on the circumstances and must be modified accordingly. So, in the same way as sexual relations between two members of the same sex cannot result in children, neither can sex involving a woman way beyond her child-bearing years. The need to understand that risk, question (4) in JB, is irrelevant.

48. The need to understand that sexually transmitted diseases may be spread by intercourse is something PS is unable to understand according to Dr McIntosh. That would of course be a crucial problem when considering sex relations with men in general. However, during her evidence, it was put to Dr McIntosh that we are concerned in this case with PS having sexual relations only with WP. Her response was that was not necessarily so because there were other men in the care home who she could have sexual relations with, perhaps even in error (her error, that is). However, it was then suggested that the overwhelmingly likely outcome of this hearing if the Court were to find that PS did have capacity is that any sexual relations would be carefully risk assessed. Amongst those issues that would have to be considered would be to ensure that PS only ever had the opportunity for sexual relations with the man she says she wishes to have them with, and that is WP.

49. Since WP and PS are within a monogamous and long-standing relationship it was asserted that the risk of STD could be ruled out. Whilst I am not sure one can be so confident that one party in a stable relationship will not acquire an STD, I am willing to accept that within the context of such a relationship it is not the risk factor that a young person wishing to explore sexual experiences in a distributive rather than focal way would have. On that basis Mr Allen, Dr McIntosh and the

Court accepts that for PS to be unable to meet requirement (5) is also not a bar to her having capacity.

50. I am satisfied that PS is able to understand the issue in JB (1), namely the mechanics of the sexual act. It is clear from the evidence she understands what sexual relations are and involve.

51. I am also satisfied that she is able to understand and use and weigh JB (2), the fact that the other person must have the ability to consent to the sexual activity and must in fact consent before and throughout the sexual activity.

Memory, identity and consent

52. The remaining item of relevant information from JB proved controversial. This is (3), namely that the fact that PS can say yes or no to having sexual relations and is able to decide whether to give or withhold consent. Central to Dr Green's approach to this issue is PS's extremely damaged short-term memory. Her focus here was on PS's ability to change her mind. According to Dr McIntosh in her report, following a detailed examination of PS she did understand that consent was needed from both sides in order for sex to continue lawfully. If either WP or her changed their minds, the other should "pack it in" as PS put it.

53. Dr Green's argument, as I understood it went like this. Although she conceded that PS would be able to retain the relevant information to her decision to engage in sexual activity with WP long enough to agree to it, she would soon have forgotten that information and the decision she had made. Once sexual activity began, she would probably have forgotten what she had decided and why. Although Dr Green then went on to ask about what I consider to be a different issue, namely what would happen if PS changed her mind (which I will return to

shortly), in fact there is a serious issue about what happens to the decision she had originally made? Of particular importance here is the fact that sexual activity can only continue if both parties have consented, and maintain their consent or, perhaps more accurately do not withdraw their consent.

54. The answer is that if PS consents to sexual activity and it begins, her ongoing engagement with the activity will be determined by how she feels in the moment. If PS is happy to be engaging in sexual activity with her partner, then she will carry on. I pause here to note that Dr McIntosh was clear that when there was intimacy between PS and WP, she knew her partner was WP. There is no need for a periodic re-evaluation of the JB criteria in order for sexual activity lawfully to continue. If that was Dr Green's submission, I reject it. If PS does not want to continue or if, perhaps because of her memory difficulties she becomes confused, even afraid, then that will be clear through her behaviour including what she says. At that point, her partner WP will have to stop the activity.

55. It is hugely important in this case to emphasise that the sexual activity here is between established and loving partners. WP can be trusted to ensure that he behaves appropriately within the context of their relationship.

56. At the end of her evidence, Dr McIntosh had come to the conclusion that a proper care plan with a facilitative approach to consent would enable PS to make a capacitous decision about engaging in sexual activity with WP. For that reason, and in keeping with the regime of the MCA, steps ought to be taken to ensure such an approach is facilitated.

57. That approach was supported by and on behalf of PS and WP. It was opposed by RS and the Local Authority.

DISCUSSION & DECISION

58. I agree this has been a finely balanced decision. It is important to avoid the protection imperative in cases of this sort, where the easiest thing in the world is to prevent PS and similar people in her position from doing what they want because firstly, facilitating it is too complicated and secondly there will still be a risk. Neither of these arguments are what this Court is about.

59. That being said, I am mindful of the comments of Mr Justice Poole quoted above in which he cautions against making capacity decisions that are so artificial that they impose an unrealistic burden on those care planning to achieve something that cannot realistically be achieved.

60. However, I am also conscious of the need for the threshold for capacity to consent to sexual activity to be set low.

61. I have come to the conclusion that PS does not lack the capacity to engage in sexual activity with WP. The burden is on those asserting incapacity to displace the presumption of capacity, and I am not satisfied that has been displaced in this case.

62. That being said, the presumption or assumption of capacity only survives in the event that a proper protective care plan can be put in place to enable PS to enjoy sexual activity with WP if she (and he) want it. As I said using other words during the hearing, that will be a challenging TZ care plan. That will require a set of arrangements that enables the couple to have time together in privacy when they wish.

63. It is important also to make it clear that PS's best interests over care and contact are still extremely important and the TZ care plan will have to be created with

considerations for PS's wider best interests in terms of her care and residence. How any care planning can be managed and brought into effect remains to be seen.

64. I am grateful to counsel for their arguments and the conduct of the hearing. I am also grateful to DT, WP and RS the latter two of whom had to listen to detailed discussion of the very intimate details of his own in the case of WP and, in the case of RS of his mother.

65. The parties must now formulate an order encapsulating the above.

66. I would also add that the present LPAs in DT and the other attorneys' favour is defective, and the Court will make a deputyship order giving them identical powers.

67. That is the judgment.