Neutral Citation Number: [2024] EWCOP 53 (T3)

Case No: COP14101431

IN THE COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 18/10/2024

Before :

MRS JUSTICE THEIS SITTING AS THE VICE PRESIDENT OF THE COURT OF PROTECTION

- -

Between :

	Leicestershire County Council	**Applicant**
	- and -	
	P	**1st Respondent**
	- and -	
	NHS Leicester, Leicestershire and Rutland ICB	**2nd Respondent**

- -

Mr Conrad Hallin (instructed by **Leicestershire County Council**) for the **Applicant**
Ms Victoria Butler-Cole KC and Mr Alexander Campbell
(instructed by **EMG Solicitors Limited**) for the **1st Respondent**)
Mr Sam Karim KC (instructed by **Mills and Reeve**) for the **2nd Respondent**

Hearing dates: 5th – 7th August 2024; 13 August 2024
Judgment: 18th October 2024

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Approved Judgment

This judgment was handed down remotely at 10.30am on 18th October 2024 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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MRS JUSTICE THEIS VICE PRESIDENT OF THE COURT OF PROTECTION

This judgment was delivered in public, but a Transparency Order dated 7th August 2024 is in force. This version of the judgment is published on condition that (irrespective of what is contained in the judgment) in any published version of the

judgment the anonymity of P must be strictly preserved. All persons, including representatives of the media and legal bloggers, must ensure that this condition is strictly complied with. Failure to do so may be a contempt of court.

Mrs Justice Theis DBE :

Introduction

1. The central issue in this case is whether P has capacity to make decisions about her care and contact with others. There is no issue that P suffered significant trauma in her early life within her family and, possibly, later involving others. The consequences of this on her mental and psychological health have been significant. She has at times been detained under the Mental Health Act 1983 (MHA) and has had extended periods in specialist placements. More recently she has been living in her own home, with care and support provided or arranged by the local authority and the Integrated Care Board (ICB) in accordance with MHA.

2. P suffers from Dissociative Identity Disorder (DID) although in her oral evidence the jointly instructed expert, Dr Camden-Smith, (Consultant Psychiatrist) said a more accurate description is Complex PTSD (CPTSD) with dissociative characteristics.

3. These proceedings were commenced in June 2023 by Leicestershire County Council (the local authority). Interim declarations were made under s48 Mental Capacity Act 2005 (MCA) that P lacked capacity to make decisions about her care and accommodation and did not have litigation capacity.

4. The other parties to the proceedings are P and the Integrated Care Board (ICB). At the start of this hearing P made an application to discharge the Official Solicitor as her litigation friend as the expert, Dr Camden-Smith, had concluded that P had litigation capacity to conduct these proceedings, save when she dissociates. P's solicitor and Ms Butler-Cole KC considered P did have litigation capacity. As a result, I discharged the Official Solicitor as P's litigation friend. P attended the hearing with support and remained in court for most of the hearing.

5. I heard oral evidence from P's psychotherapist, ZX, the allocated social worker, Ms S, and the jointly instructed expert, Dr Camden-Smith. Due to the complexities in this case Dr Camden-Smith listened to the evidence of ZX and Ms S before she gave oral evidence.

6. At the end of the oral evidence all parties agreed that when P does not dissociate she has capacity. The issue between the parties is what the position is when P does dissociate, whether

    (i) If P lacks capacity when she dissociates the court can or should make an anticipatory declaration that in that situation P lacks capacity and best interest decisions will need to be made, or

    (ii) The evidence demonstrates at most of the times that occurs P is able to manage the situation, for example by going to her bedroom, and is unlikely to be making decisions then or being asked to make decisions then about her care. In the relatively rare circumstances when P may be putting herself at risk of harm when she dissociates there are sufficient safeguards in the existing statutory framework under s 5 and 6 MCA.

7. With the agreement of the parties I met P with her solicitor at a video meeting prior to this hearing. A note of that meeting was circulated to the parties.

Relevant background

8. P had a difficult background, her parents separated when she was young. She remained in the care of her mother and was removed from her care before she was a teenager. P went to a residential school for girls. After leaving school she had specialist support for Obsessive Compulsive Disorder (OCD). In her mid-twenties she was admitted to a therapeutic community for people diagnosed with a personality disorder. During her time there P reports being groomed to take part in a sexual relationship with a male staff member. In her twenties P was able to secure a job but continued to self-harm and had a number of hospital admissions when her diagnosis was Borderline Personality Disorder (BPD) (now known as Emotionally Unstable Personality Disorder, EUPD). P made attempts to take her own life.

9. In her thirties P was diagnosed with Fibromyalgia and had regular psychiatric support for a period of about eight years.

10. In her early forties P was diagnosed with Bilateral Polyradicular Neuropathy. During that period she had a number of admissions to a psychiatric hospital, one of which followed an admission for assessment pursuant to s 2 MHA. P also made a further attempt to take her life by way of an overdose.

11. In her early fifties P was referred by the community mental health team to the Clinic for Dissociative Studies (CDS) to engage P in the specialist long-term psychotherapy the mental health team considered she required. Following further suicide attempts and being detained in hospital pursuant to s 3 MHA CDS informed the local mental health team of the outcome of a multidisciplinary assessment undertaken by CDS that P's symptoms are consistent with a primary diagnosis of DID. As a result of that, CDS were commissioned by the ICB (then the Clinical Commissioning Group) to undertake work with P, which started in December 2019.

12. Since 2019 P has been the subject of further admissions to hospital either under s 2 or 3 MHA. P has made further suicide attempts and serious self-harming. In addition, P has disclosed that she was the subject of sexual abuse by a staff nurse whilst she was an inpatient at one of the psychiatric hospitals.

13. In August 2022 CDS reported that P disclosed in therapy that she was involved with an abuse group and that one of her identities was being contacted alongside other identities to attend meetings where she was subject to abuse that her main identity (referred to as 'Z') was not aware of, as her main identity had returned home on occasions with injuries consistent with possible sexual and physical assault. The police investigated three incidents but were not able to pursue investigations due to lack of evidence.

14. Following a further suicide attempt P agreed, on the recommendation of CDS, to move to a specialist unit, GH, in September 2022. This is a 24 hour placement with onsite therapy.

15. A report in September 2022 from CDS regarding P's psychotherapy noted P was working within Phase 2 (i.e. working through trauma and abuse) of 3 within the International Society for the Study of Dissociation Guidelines (ISSD). At that time P was receiving twice weekly support therapy sessions and thrice weekly support therapy sessions for a particular identity.

16. GH reported an incident of self-harm by P in November 2022. P reported that she was further assaulted when left unattended by GH staff when she visited an acute hospital. P left the hospital and was found five hours later with injuries and complaining of pain to her vagina.

17. In December 2022 P stated she no longer wished to remain at GH. The local authority and the case manager on behalf of the ICB looked for alternative options. There was a further incident of P seeking to leave GH.

18. In February 2023 GH served a 28 day notice and P moved into an offsite bungalow with 1:1 24 hour supervision.

19. In March 2023 P's face to face therapy with CDS stopped due to poor health of her therapist. CDS expressed concern that P was planning to return to live in her own property.

20. In late March 2023 P returned to her home with a support package in place to commence from KG provider from early April 2023 with 24 hour 1:1 support, 7 days per week.

21. In mid-April 2023 P left her home and drove her car in the night without support staff. When P returned she had injuries consistent with previous reports of rape. P stated she could not recall anything and that another identity must have been present at the time. The matter was referred to the police.

22. At a subsequent professionals meeting, it was decided a mental health assessment was not required and follow up actions included looking at possible residential options and adult social care pursuing risk mitigation plans, such as Ring doorbell technology.

23. The following week, in late April 2023, there was a further incident when P left her home just after 8pm without a support worker and drove her car. When she returned staff reported she did not respond to her name and was constantly blinking. No injuries were reported but the following day P expressed via email to the CDS therapy team that she was experiencing (unspecified) pain. Five days later she reported she had been bleeding from her vagina.

24. At a professionals meeting in late April 2023 the police reported ongoing investigations were closed. All professionals agreed P was at significant risk within her home and the case manager on behalf of the ICB agreed to contact P's consultant psychiatrist for views regarding use of the MHA, attendance at professionals meetings and alternative options.

25. In May 2023 a further professionals meeting considered placement options if P's current care package broke down.

26. In early May 2023 an ambulance was called due to support worker concerns about P, who was assessed but not admitted to hospital. P did not disclose that she had taken an overdose the previous day. Two days later an ambulance was called again, P was taken to hospital for assessment and discharged after observations.

27. In early June 2023 P stopped letting care staff into her home. Two days later KG care provider stopped providing support. P received two calls per day from the local authority crisis response service (CRS). There were two occasions in June 2023 and one in August 2023 when the police were called due to concerns about P's welfare.

28. The local authority issued these Court of Protection proceedings in June 2023.

29. In early July 2023 PQ became the main therapist from CDS and face to face therapy recommenced. In late July 2023 CDS informed the local authority about P reporting injuries to her arm.

30. HHJ Redmond ('the Judge') made directions in August 2023 for the filing of an expert report by Dr Camden-Smith regarding capacity, further evidence and the next hearing to be in mid-September 2023.

31. In late August 2023 P was found by PQ in distress and expressing pain in her head and neck. P expressed her belief that she had been sexually assaulted, that she had pain and discomfort in her vagina and believed a urinary tract infection had developed. AB reported to the police that P believed she had been visited by people who may be abusing her.

32. P saw Dr A, her treating psychiatrist, on 30 August 2023 which resulted in a plan for P to continue with her current treatment as commissioned from CDS and an outpatient appointment in 12 months' time. Dr A's letter notes that the lead professional is the CDS, that P's current presentation is *'in keeping with DID. The nature of this condition is complex and there has in the past, and continues to be, a lack of consensus between professionals, hence varying diagnoses have been used in the past to describe the symptoms that [P] experiences'*.

33. The police were called in early September 2023 as P's car was not at her home, a neighbour reported to the local authority that she returned at 9pm. When P met with Ms S the following day she did not recall leaving the home the previous day and reported the car had done 180 miles. P did not want to talk about injuries or pain but was described as being visibly in pain when sitting. P agreed with Ms S to additional welfare calls.

34. At a therapy session in early September 2023 P informed the therapist that she had attempted to hang herself that morning and reported similar suicidal thoughts a few days later.

35. In mid-September 2023 the police were called as the local authority had not seen P for 24 hours. P presented as very distressed and had red marks round her neck. An ambulance was called. The following day CDS contacted the local authority to raise concerns regarding P's continued suicidal ideation. There was a plan for assessment under the MHA if P did not attend her next face to face therapy session.

36. Two days later CDS contacted the local authority again to express concern for P's mental health and suggested a MHA assessment. This followed P stating in online therapy sessions that she had attempted suicide three times over the preceding weekend. A MHA assessment was undertaken and concluded P was not detainable under the MHA. A further assessment conducted the following day came to the same conclusion.

37. In mid-September 2023 the police and local authority attended P's home. P had called the police. A ladder was in the hallway under the attic opening. A MHA assessment was requested but was not done as P's presentation was the same as the previous two assessments. An CSU case manager requested additional support over the weekend. The following day the local authority attended P's home where she presented as hysterical. A MHA assessment determined she was not detainable but P agreed to informal admission to B mental health unit on 16 September 2023.

38. At the hearing before the Judge in September 2023 he directed a s49 report from CDS.

39. PQ stopped working with P in September and October 2023 due to a breakdown in the therapeutic relationship and face to face therapy stopped.

40. In early October 2023 B mental health unit requested deprivation of liberty (DoL) authorisation, which was granted on 19 October to 30 November 2023.

41. In November 2023 CDS provided a s49 report and gave responses in December 2023 to further questions from the parties.

42. ZX took over as P's main CDS therapist in December 2023.

43. In late December 2023 P left the B mental health unit and returned to her home with a package of support by Q care providers. Care provider R have ceased to provide a service to P.

44. On 27 May 2024 the Judge agreed a staged reduction in the 1:1 24 hour care so care was removed from 10pm to 8am on Monday, Wednesdays and Fridays. At a review two weeks later it was noted there were no incidents and P reported that the removal of nighttime care had been beneficial. It was agreed there would be a further reduction with the removal of care from 7pm to 9.30 am on Tuesdays, Thursdays and Sundays. The review following this reduction again reported no concerns.

45. The proceedings were re-allocated to this court in June 2024 when I made directions fixing this hearing to determine the issue of P's capacity.

46. At the review in early July 2024 a further reduction in care was agreed, including evening care to finish at 7pm each evening and to look at arrangements during periods of increased risk to manage safety planning for P.

47. In mid-July 2024 CDS contacted the local authority asking for evening support to be reinstated for each evening until 10pm. At a multi-disciplinary meeting (MDT) on 22 July 2024 the additional evening support was agreed, as well as increasing the support to 24 hour support over dates of increased risk, for example around public holidays and P's birthday.

Evidence

Psychotherapist

48. ZX, a psychotherapist with CDS, has been P's main therapist since December 2023 although had been involved in, and known of, P's involvement with CDS since 2019.

49. When pressed by Mr Hallin, on behalf of the local authority, about the evidential basis for the frequency of DID, how it manifests itself and what, if any, literature base there is ZX was unable to produce any references and said he would '*have to think about that'*. He said CDS have 65 cases of DID and under 10 are of the same severity as P. He said he had seen 7 or 8 people as a psychotherapist with DID over the last 20 years. CDS also treat other people who do not have DID.

50. Since December 2023 ZX has seen P for face to face therapy for three hours each week, together with a weekly online therapy for one and a half hours with P's other identities. In addition, CDS provide online support therapy for P with another therapist on three separate occasions for an hour and a further fortnightly face to face session with a CDS specialist support worker for six and a half hours once a week.

51. ZX confirmed he was a co-author of the s 49 report and agreed that P experiences all five symptoms of DID on a severe level, including dissociative amnesia (significant loss of memory for past or present events), depersonalisation (a sense of disconnection with bodily feelings and sensations), derealisation (a sense of disconnection or disorientation with one's external environment), identity confusion (a profound sense of feeling unknown to oneself and/or confusion about who one really is) and identity alternation (the presence of one or more altered identities or identity states). He confirmed that CDS are also of the view that P presents with a form of DID known as 'installed DID', where they understand that some or all of P's altered identities have been created by methods of mind-control, torture, and coercive control in an attempt to manipulate, abuse and control her. ZX initially said the account of her family history in the s49 report would have come from P although recognised that later in the report it was said P had no or limited memory of her childhood, so he agreed the history could have come from other reports which are not listed.

52. CDS provide a team of three therapists (consisting of a main therapist, two support therapists who deliver specialist psychotherapy in person, online, and by phone) as well as a support worker, who provides practical support. There is a case manager who oversees the treatment package. CDS have been providing this therapy since 2019.

53. He confirmed CDS follows the International Society for the Study of Trauma and Dissociation (ISSTD) guidelines for treatment (as there are no NICE guidelines), which describe three phases; phase 1 – stabilisation and safety; phase 2 – working through trauma and abuse; phase 3 – establishing cooperation and communication. Although there is linear progression he said there can also be an element of moving backwards and forwards between phases, which is often connected with external circumstances. He considers P is currently between phase 1 and 2.

54. As regards relevant risks now to P he considered the risk of self-harm and suicide to have generally decreased although rises around high risk periods, such as P's birthday. ZX said whilst these risks were connected with DID they are also a result of P's childhood trauma. When asked about the risks of physical or sexual abuse and the evidential foundation for that he said P's different identities had reported different abusive experiences in relation to the family and others, he said he did not know who makes up these groups although there is some consistency of stories related to Y religion. He considered there was nothing to suggest this was fictitious or not a current concern and had featured in what he described as his recent contact with two of P's other identities when they talked of the WiFi being switched off and the front door being left open. In his view some of P's identities have been trained to do certain things. He recognised in the answers to questions about the s49 report that CDS were not able to judge the accuracy of some of the recollections.

55. Whilst ZX made it clear that his role as a psychotherapist is not to become an investigator the court was provided with the CDS safeguarding flowchart that set out the system in place to report any safeguarding concerns.

56. As regards the frequency and duration of when P switches to another identity ZX was unable to say although was able to identify some triggers, such as cigarette smoke. He agreed with the s49 report that P's amnesia was described as large gaps in her everyday memory on a daily basis that *'can last anywhere between a few minutes and 2-3 days'*. He said that had improved, is less likely now and the *'other parts'* tend not to be present when the carers are there. He described how P has developed a way of managing distress over what she perceives as criticism, such as going up to her bedroom.

57. ZX did not agree with Dr Camden-Smith's view that when P dissociates she lacks capacity to make decisions, as in his view some of P's other identities have capacity. He referred to that as his impression but accepted he had not assessed capacity.

58. ZX's view is that any package of care for P needs to have inbuilt flexibility to manage periods of time when P is more vulnerable (P's birthday, Christmas, Easter and Halloween) and any necessary changes should be discussed with P. Whilst he acknowledges the difficulties there have been with carers ZX said the CDS support worker has been with P for over 3 years and been able to maintain an effective relationship as did P with some of the staff at her previous placements. In ZX's view it requires the carer to respond to P's emotional state; silence is very difficult for P.

59. In his view he thought there could be up to 50 different identities, some of which he describes P having scheduled time with. When asked by Mr Hallin how a carer would be able to know if P has switched ZX recognised the difficulties. ZX considered that the best way is to ask P if she is distressed on the basis it is necessary to address the emotional state first. ZX agreed P had variable knowledge of the other identities, that some he had not told her about and has instigated a communication book to try and assist with this.

60. Mr Hallin took ZX to the November 2023 statement of one of his colleagues at CDS where he said in relation to risk from others *'CDS UK are aware that the reports of third-party abuse given by [P's] altered identities could at times be recollections of past, rather than current, traumas and there remains the possibility that some*

reported abuse and injuries which might be consistent with third-party abuse might be self-inflicted. However, in therapy [P's] altered identities have demonstrated a level of consistency in what they are reporting in respect of alleged current abuse, which leads us to believe third-party abuse is likely to be orientated to the present rather than the past. As noted in the s49 report, on many occasions medical examinations have not been provided or permitted and so an opinion on the possible causes of injuries may not be able to be determined in all cases'. ZX said that in his experience P is able to make the distinction between what happened in the past and the present. He said P's identities describe the abuse happening now but give no more details in terms of location. He recognised P could be reliving the past but did not think so due to the way the past and present is distinguished. ZX said he had recently been given a leaflet by P and was going to pass that on as it raised safeguarding issues. ZX agreed P is not in a position to know the full extent of what is being alleged by her other parts, so that makes it hard for P to weigh that up. In answer to Ms Butler-Cole KC, ZX agreed that P was not aware of any current abuse risk until psychotherapy started and that treatment is being provided to P on the basis that there is a group there intent on causing P harm. He agreed P finds it difficult if she considers she is not being believed. In particular, as a psychotherapist he believes what P reports but the public bodies may consider something has not been established. He agreed with Ms Butler-Cole that whether the abuse group is real or not there are times when P feels unsafe, P reports that and requests more support.

61. ZX agreed with Ms Butler-Cole that there has been an improvement in that P is a lot more knowledgeable, there is an increased communication with her other parts and P has a better understanding of her past. ZX said the level of harm to P's body has *'radically reduced since 2018'* and P's ability to understand that *'has progressed a lot'*. When she switches out and freezes he says those periods now are *'very short'* and he has seen no reports of more than a day since he has been providing therapy.

62. ZX agreed that P is at risk of harm when she meets people who pose a risk and when she leaves her home at night.

63. When Ms Butler-Cole took ZX through the recent examples the local authority relied upon regarding P's dysregulated behaviour ZX considered they required more planning beforehand and encouragement and to avoid P becoming stressed and distressed.

64. Mr Karim KC explored with ZX what the risk factors are after 10 pm and how they could be mitigated.

Social worker

65. Ms S has been the allocated social worker for P since September 2022. In her eleven statements she outlines her involvement with P. She has had regular meetings with P including monthly and other meetings with the professionals involved with P, including CDS. The mental health service will always be invited, the case manager attends but no one attends who has direct contact from the mental health service with P.

66. Ms S referred to the difficulties in managing P's care as P has fixed ideas as to how the care can be provided, which makes it difficult to have flexibility and she can be

critical of staff if things, such as provision of medication, are a few minutes late with P reporting she has not been prompted to do care when the notes record otherwise. Ms S considers one of the reasons why care packages have broken down is that P feels the care workers are not doing what they are required to do, she will send the care workers to the kitchen for long periods which causes difficulties for them both. Ms S acknowledged there are real difficulties in providing overnight care due to the conditions put down by P about how the care workers should behave (not go to the toilet, not make a drink etc). Ms S considers there is a lack of awareness by P of how her behaviour impacts on the carers. Ms S agreed there was a tension between what the local authority can provide and what P wants. Ms S would welcome more active participation by the mental health team.

67. Ms S was asked about the capacity assessments she undertook in April 2023, and she said she wanted to hear the evidence of Dr Camden-Smith before reaching a conclusion now about P's capacity.

68. Ms Butler-Cole asked Ms S about the Care Act assessment in January 2024 and the conclusion that P's budget was for 24 hours of care per week when P currently receives about 55 hours per week. Ms S agreed the reduction had not been implemented, the plan is to do so over the next 8 weeks and agreed it would have flexibility to provide periods of 24 hour care if the need arose, in consultation with the ICB. Ms S said she considered the local authority role under the Care Act is to build peoples strengths to be as independent as possible and to build up autonomy. Ms S agreed there was no assessment under s 117 MHA to reduce P being re-admitted to hospital and agreed that needs to be done, she hopes with more involvement of the mental health services.

Expert Consultant Psychiatrist

69. Dr Camden-Smith provided her main report on 14 March 2024 and responded to questions from the parties on 21 April 2024. She interviewed P on two occasions for a total of about four hours. One meeting was via Teams and the second when Dr Camden-Smith saw P at her home. P reported to her she feels she is starting to make progress. Dr Camden-Smith said she found P to be *'thoughtful, reflective and open'*. P feels the risks have not changed, she has been managing them for her entire life and the purpose of the current restrictions is *'defensive practice by the statutory bodies'*.

70. In her report Dr Camden-Smith records that P has a *'confirmed diagnosis of [DID] as a consequence of severe, sustained trauma since childhood. As such she has periods of dissociation in which she switches to different personalities both at times of stress and at other times because different personalities may be better placed to deal with the circumstances. It is not known how many different identities she has. Some of her identities are children, whilst others are adults…[P's] difficulties are adequately explained by her experience of childhood trauma which is known to significantly and substantially affect brain development. Her need for control and order is a common feature of childhood trauma. [DID] is an impairment or disorder in the functioning of the mind and/or brain for the purpose of the Mental Capacity Act 2005.'*

71. In her oral evidence Dr Camden-Smith considered a better description of P's diagnosis is CPTSD with dissociative characteristics. She accepted this results in the causal nexus as required by s 3 MCA.

72. In her written report Dr Camden-Smith concluded that P had capacity to conduct proceedings, make decision about her residence, care and support, contact with others, internet and social media usage, sexual relations and use of her mobile phone, however she may lose capacity when dissociated or another identity.

73. In relation to capacity to conduct proceedings Dr Camden-Smith stated *'I note this [dissociates or another identity] has not happened in the substantial length of time that the case has been ongoing and consider it unlikely that this will become a critical factor during the course of proceedings'.*

74. As regards residence she said *'There maybe occasions on which this capacity is lost, such as when she is a dissociated state or one of her other identities is present, however decisions about capacity are usually discrete decisions made at a point in time, and it is entirely possible to make sure that it is [P] that is present before any decisions about residence are made'.*

75. Turning to care and support Dr Camden-Smith stated in her report *'I have given significant thought as to the approach to take in this case and it is my view that it is one in which anticipatory declarations would be workable. The periods of loss of capacity are concrete, discrete, easily identified and follow a predictable pattern. Therefore it would be eminently workable for a care plan to be in place in which support workers simply ask P 'Is [J] present' and then follow a care plan for when she isn't. There may well be periods in which this doesn't work or in which [J] herself still acts in a way that may be risky or unwise, however, [P] is willing to accept this level of risk in balance for the increased quality of life (and therefore recovery) that independence will give her.'* Dr Camden-Smith felt that contact with others could be dealt with in the same way.

76. Turning to internet use Dr Camden-Smith stated *'I would suggest an approach in which it is declared that [P] has capacity to access the internet, and that it is accepted that other identities may not, but that accessing the internet is largely in their best interests and is therefore in the best interests of the system as a whole. There is currently no evidence that [P] is placing herself at risk online other than by potentially contacting the abuse organisation. In so far as she is contacting the abuse organisation, it is not known how she is doing this, as scrutiny of her phone by carers and therapists has not found evidence of this (although it is thought likely that it is happening)'.*

77. Regarding sexual relations Dr Camden-Smith said P is *'very clear that she has the main identity and she as a system do not consent to having sexual intercourse and she wishes to be protected from those who seek to access her for the purposes of abuse.'*

78. Turning, finally, to the question of capacity to access her mobile phone Dr Camden-Smith stated that whilst recognising P may lose capacity when dissociated or another identity she agreed with P that depriving other parts of access to her mobile phone was likely to be more damaging than beneficial and may impact on her ability to use and engage in therapy *'Therefore, whilst there may well be times in which [P] lacks capacity to make decisions about the use of her mobile phones, I would not recommend that any restriction on its use be put in place.'*

79. In her written response to further questions Dr Camden-Smith said she was not aware of any case law or guidance as to how to assess capacity in someone with DID. She said her approach was a pragmatic one in which she considers Z to be the primary identity and therefore any decisions taken by identities other than Z are taken when Z is not consciously present. *'If [Z] is not consciously present, then she cannot be said to have capacity at that material time, irrespective of the identity and knowledge of any of the other identities. Thus, the approach I have taken is that only [Z] can have capacity, and therefore any assessment of capacity can only be undertaken with [Z].'* A little later she states *'[Z] has lived with the consequences of trauma and dissociation her whole adult life, she is aware there are risks when in an dissociated state and that the biggest risks are that of self-harm and potential death and abuse by others…the analogy I have used is of someone in alcoholic blackouts – they cannot remember what happened at the time of the blackout, but they are aware of the consequences…in my opinion it is not necessary to know the details of what happened during that period, it is sufficient to know what led to the period of lack of awareness and what the consequences were or may be. So someone with alcoholic blackouts would not have capacity at the time of being intoxicated, but would potentially have capacity when sober to make decisions about, for example, using alcohol.'* Dr Camden-Smith recognised the issue regarding capacity is a legal one but states *'It is my opinion that [P's] capacity fluctuates, however there is a counter argument that the periods of change of identity are frequent and unpredictable enough for it to be considered that she lacks capacity.'* She said she deferred to CDS regarding the DID diagnosis.

80. In her oral evidence, having had the benefit of hearing the oral evidence of ZX and Ms S, Dr Camden-Smith stated that DID is *'highly controversial'*. Dr Camden-Smith has no doubt P is distressed, there are periods when she dissociates and she divides it between when P is Z and when she dissociates. P is the first person she has met with DID in over 20 years of practice. She said that *'mainstream psychiatrist thinking is it is part of dissociation attached to trauma part of PTSD'* and is highly sceptical of any claims as to how many people are said to have DID. She expressed concern that CDS is a charity with no outside input from a doctor, in her view what is lacking is psychiatric orthodoxy to ground some of the assertions. P is hugely vulnerable and Dr Camden-Smith does not believe there are other identities, she considers there is a dissociative state. Dr Camden-Smith's concerns is that DID is a self- perpetuating diagnosis; there is little benefit in getting better. P has had four years of therapy and CDS report six years lay ahead. Dr Camden-Smith knows that P is very aware of the scepticism regarding DID. What is required is a 'critical friend' as CDS and the local authority are not equipped to discuss this with P. In her view it is plausible that some of what is being said is not real but P may still be abused. Dr Camden-Smith did not think P was lying.

81. When asked about the various incidents referred to by the local authority, such as throwing the table, Dr Camden-Smith said *'[J] lives in a permanent state of high arousal – fight, flight or freeze – this is as a result of her past trauma and she can lose control more easily.'* Dr Camden-Smith was clear that when P was in this state she would not be asked to make decisions. She agrees P can be angry without dissociating but P is asking care workers to prevent her leaving the home. Dr Camden-Smith acknowledged that it is difficult to know whether P is dissociating and accepted that they should not ask 'Do I have Z present ?'. In her view Z is able to

fully understand she puts herself at risk, it is not necessary to know the details. The question for a carer could be changed to 'Are you dissociating?' which would be demonstrated by her inability to weigh information. She accepted that if it is frequent and unpredictable that may support a more longitudinal view regarding capacity.

82. In answer to questions from Ms Butler-Cole, she agreed in the last year there have been three occasions when P put herself at risk of harm and whatever the legal outcome there is a need for carers to feel able to stop P putting herself at such risk. She agreed when it was suggested to her that it was important to maintain P's autonomy and there is a risk if a longitudinal approach to capacity is taken that defensive decisions will be taken, which will have an adverse impact on P's mental health.

Social worker's further evidence

83. Ms S returned to give evidence having heard Dr Camden-Smith and outlined the local authority's position in an email confirming that the local authority's view on capacity is that P has capacity regarding care and support. She agreed with Dr Camden-Smith's evidence that P's presentation is more consistent with someone who has experienced severe trauma and has CPTSD and dissociation. Ms S said that the symptoms of hyperarousal and dissociation are more consistent with what she had observed in the past. Ms S continued in the email *'the description of hyperarousal would in my view fit with the behaviours that are present when [P] is involved with the care and the high levels of distress, frustration and dissatisfaction that is experienced by [P] when receiving care.'* She agreed with Dr Camden-Smith that when P dissociates, it is part of P and not another identity and that dissociation is not a linear state. Also, that P behaves in this way as a result of trauma and CPTSD. When P dissociates at home the records suggest she will go to her room and P does not pose a risk to herself during this time, on the contrary P reports this is useful to her. Ms S considers that on the infrequent and rare occasions when P puts herself at risk from harm related to going out or seeking out people and then having some form of physical and possible sexual injuries this would not constitute a lack of capacity on a longitudinal basis. Ms S considers, if required, the powers under s 5 MCA could be used to support P at times when staff are aware of that risk. Ms S went on that she did not consider anticipatory declarations would be workable as the carers cannot be expected to determine whether P has dissociated or, if she has, whether that means she necessarily lacks capacity.

84. Dr Camden-Smith briefly gave further oral evidence when she confirmed her position that when P dissociates she lacks capacity.

Legal framework

85. The MCA sets out the statutory framework for dealing with capacity with the important fundamental principle enshrined in s 1(2) that *'a person must be assumed to have capacity unless it is established that he lacks capacity'*. Section 2(4) MCA makes clear that is to be established on the balance of probabilities. Sections 1 (3) – (4) MCA provide further general principles relevant in considering the question of an individual's capacity:

'(3) A person is not to be treated as unable to make a decision unless all practicable steps to help him do so have been taken without success.

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

86. Section 2(1) MCA defines a person who lacks capacity as *'…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'.*

87. Section 3(1) MCA provides that for the purpose of s2(1) a person is *'unable to make a decision'* if they are unable to:

a. Understand the information relevant to the decision.

b. Retain that information.

c. Use or weigh that information as part of the process of making the decision; or

d. Communicate that decision.

88. Section 3 (2) – (4) MCA outlines further guidance on the application of the 'functional test' in section 3(1) as follows:

'(2) A person is not to be regarded as unable to understand the information relevant to a decision if he is unable to understand an explanation of it given to him in a way that is appropriate to his circumstances (using simple language, visual aids or any other means).

(3) The fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him from being regarded as being unable to make that decision.

(4) The information relevant to a decision includes information about the reasonably foreseeable consequences of: a deciding one way or another; or b. failing to make the decision'.

89. The material parts of sections 5 and 6 MCA provide:

's 5 (*1) If a person ("D") does an act in connection with the care or treatment of another person ("P"), the act is one to which this section applies if—(a)before doing the act, D takes reasonable steps to establish whether P lacks capacity in relation to the matter in question, and (b)when doing the act, D reasonably believes—(i)that P lacks capacity in relation to the matter, and (ii)that it will be in P's best interests for the act to be done.*

(2)D does not incur any liability in relation to the act that he would not have incurred if P— (a)had had capacity to consent in relation to the matter, and (b)had consented to D's doing the act…'

's6 (1)If D does an act that is intended to restrain P, it is not an act to which section 5 applies unless two further conditions are satisfied.

(2)The first condition is that D reasonably believes that it is necessary to do the act in order to prevent harm to P.

(3)The second is that the act is a proportionate response to—

(a)the likelihood of P's suffering harm, and

(b)the seriousness of that harm.

(4)For the purposes of this section D restrains P if he—

(a)uses, or threatens to use, force to secure the doing of an act which P resists, or

(b)restricts P's liberty of movement, whether or not P resists…'

90. In the recent Court of Appeal decision of *Hemachandran v University Hospitals Birmingham NHS Foundation Trust [2024]* EWCA Civ 896 King LJ set out the following regarding determination of capacity at [42] – [46]

42. In A Local Authority v JB [2021] UKSC 52; [2022] AC 1322 ("JB"), the Supreme Court considered the proper approach for [or to] determining capacity. Lord Stephens, with whom Lord Briggs, Lady Arden, Lord Burrows and Lady Rose JJSC agreed, set out at [56] onwards the general approach to be adopted in relation to an assessment of capacity. He emphasised at [65] that section 2(1) is a single test "albeit that it falls to be interpreted by applying the more detailed description given around it in sections 2 and 3".

43. Lord Stephens went on at [66] to say that section 2(1) MCA requires the court to address two questions which, he says at [79] are to be approached in the following sequence: i) Whether P is unable to make a decision for himself in relation to the matter [65]- [77] (section 3: the functional test). ii) Whether that inability to make a decision is "because of" an impairment of, or disturbance in the functioning of, the mind or brain (section 2(1): the diagnostic or the mental impairment test): "78. The second question looks to whether there is a clear causative nexus between P's inability to make a decision for himself in relation to the matter and an impairment of, or a disturbance in the functioning of, P's mind or brain."

44. In relation to the first question, the functional test, Lord Stephens said at [68] that as the assessment of capacity is decision specific, "the court is required to identify the correct formulation of "the matter" in respect of which it must evaluate whether P is unable to make a decision for himself." He went on at [69]: "The correct formulation of "the matter" then leads to a requirement to identify "the information relevant to the decision" under section 3(1)(a) which includes information about the reasonably foreseeable consequences of deciding one way or another or of failing to make the decision: see section 3(4)."

45. Lord Stephens said at [76] that, once the information relevant to the decision had been identified, then: "P is unable to make a decision for himself in relation to the matter (section 2(1)) if, for instance, he is unable to understand the information (section 3(1)(a)) or to use or weigh that information as part of the process of making the decision (section 3(1)(c))." It should be noted that whilst reference is made to the statutory requirement to understand the information, no reference is made by the

Supreme Court to it being a necessary ingredient for P to believe the relevant information in order for him or her to be regarded as having understood it or to be able to use or weigh it. Lord Stephens relies simply on the words of the statute for his analysis.

46. In Kings College, MacDonald J said this in relation to a person's ability to use and weigh information:

> *"38. It is important to note that s3(1)(c) is engaged where a person is unable to use and weigh the relevant information as part of the process of making the decision. What is required is that the person is able to employ the relevant information in the decision making process and determine what weight to give it relative to other information required to make the decision. Where a court is satisfied that a person is able to use and weigh the relevant information, the weight to be attached to that information in the decision making process is a matter for the decision maker. ...If P is unable to make the decision his or herself in relation to the matter then the court moves to the second question namely whether the inability is "because of" an impairment of, or a disturbance in the functioning of, P's mind or brain."*

91. *Hemachandran* made clear the absence of belief in relevant information is not determinative of the question of capacity. An absence of belief may but not inevitably will, on the facts of a particular case, lead to a clinician or a court to conclude that the functional test in section 3(1) is not satisfied and that the person in question does not have the ability to make the decision in question.

92. In *North Bristol NHS Trust v R (by her litigation friend, the Official Solicitor)* [2023] EWCOP 5 MacDonald J usefully summarised the principles that flow from sections 1- 3 at [41].

93. The concept of fluctuating capacity has arisen in a number of cases in circumstances where it is said that there are times when P has capacity and times when P lacks capacity.

94. There are two ways in which a court has been prepared to make capacity declarations in such circumstances. By either taking a longitudinal approach to capacity or by making anticipatory declarations at a time when P has capacity in relation to a matter, to cater for a time when P is predicted to lose capacity.

95. In *A,B&C v X, Y & Z [2012] EWHC 2400 (COP)* Hedley J took a longitudinal approach when dealing with a person with fluctuating capacity in relation to a range of areas. He sought to draw a distinction at [41] between isolated decisions, such as making a will, and cases where decisions may regularly have to be taken, sometimes at short notice, where he found P lacked capacity. Hedley J took a similar approach in *PWK* [2019] EWCOP 57 at [19]-[21].

96. In *A Local Authority v AW* [2020] EWCOP 24 Cobb J concluded on the facts of that case even though there was evidence which suggested some fluctuation in AW's level of understanding or ability to use or weigh the relevant information it was not a case of fluctuating capacity. At [38] he stated *'I have reached the conclusion that this is not a case in which AW fluctuates in his capacity to decide on the issues under*

consideration. I accept that there is a basic and profound lack of understanding, and that, by reason of the deficits in his executive functioning, he has a pervasive inability to use or weigh information. I accept Miss Thomas' submission that his level of understanding and engagement with relevant issues do vary from time to time, but never to a point where it could be said that he is capacitous.'

97. The cases that have considered anticipatory declarations since the MCA have all been at Tier 3 level. Prior to the MCA the Court of Appeal in *Re MB* [1997] EWCA Civ 3093 considered an appeal by the Official Solicitor where the court had determined MB lacked capacity in circumstances where she was 40 weeks pregnant and had been admitted to hospital with the baby in a breech position. MB was unable to consent to the caesarean section due to needle phobia preventing the necessary anaesthesia being provided. The appeal was dismissed. At [30] the court confirmed MB consented to a caesarean section but was unable to accept the anaesthetist's needle at that moment of panic, her fear dominated all and she was not capable of making a decision at all.

98. S 15 MCA provides power for the court to make declarations as follows:

(1)The court may make declarations as to—

(a)whether a person has or lacks capacity to make a decision specified in the declaration;

(b)whether a person has or lacks capacity to make decisions on such matters as are described in the declaration;

(c)the lawfulness or otherwise of any act done, or yet to be done, in relation to that person.

(2)"Act" includes an omission and a course of conduct.

99. In *United Lincolnshire Hospitals NHS Trust v CD* [2019] EWCOP 24 Francis J held that CD had capacity to make decisions about obstetric care at the time the application was made but there was a substantial risk that she would lose capacity when the time came for key decisions to be made. Francis J made declarations that a contingent care plan was lawful pursuant to s 15(1) (c) MCA. He stated at [16 (iii)] *'...I acknowledge that I am not currently empowered to make an order pursuant to section 16(2) because the principle enunciated in section 16(1), namely incapacity, is not yet made out. However, as I have already said, there is a substantial risk that if I fail to address the matter now I could put the welfare, and even the life, of CD at risk and would also put the life of her as yet undelivered baby at risk. As I have said, I am not prepared to take that risk. I am prepared to find that, in exceptional circumstances, the court has the power to make an anticipatory declaration of lawfulness, contingent on CD losing capacity, pursuant to section 15(1)(c).'*

100. In *Wakefield MDC v DN and MN* [2019] EWHC 2306 Cobb J considered a case where the local authority sought anticipatory declarations to provide authorisation for care staff to intervene at times when P suffered 'meltdowns'. He was described in the judgment at [1] as having *'...a severe form of autistic spectrum disorder [ASD], together with a general anxiety disorder, and traits of emotionally unstable personality disorder. That said, he is not significantly intellectually impaired, and he*

is capable of clear thinking'. The evidence was when P goes into 'meltdown' he loses capacity to weigh up information given to him, that is attributable to his state of arousal caused by his ASD, at that moment the parties proposed that the court can and should make anticipatory declarations under the MCA which would authorise the local authority to deprive P of his liberty. The basis of the jurisdiction was not in issue between the parties and Cobb J made the orders sought stating it would [51] *'... provide a proper legal framework for the care team, ensuring that any temporary periods of deprivation of liberty are duly authorised and thereby protecting them from civil liability'.* He set out the declarations he made at [51].

101. In *Guys and St Thomas' NHS Foundation Trust v R* [2020] EWCOP Hayden J was dealing with an urgent application concerning P who was 39 weeks pregnant. She had a diagnosis of Bipolar Affective Disorder which is characterised by psychotic episodes. All the treating clinicians agreed P had capacity to make decisions as to her ante-natal and obstetric care, there was a substantial risk of a deterioration in P's mental health, such that she would likely lose her capacity during labour and there was a risk to her physical health in that she would require an urgent caesarean section for the safe delivery of her baby but might resist. He set out the risks at [4].

102. In the judgment given after the event Hayden J recognised the intrusive nature of the orders being sought [17] and that it was not possible to make decisions under s16 MCA as the jurisdiction to make a decision under that section is triggered by incapacity in relation to that decision to be determined by the application of ss1-3 MCA [26]-[28].

103. Hayden J considered he could make the contingent declarations sought pursuant to section 15(3) and set out his reasoning as follows [29]

'In contrast to section 16(2), the power to make declarations of lawfulness, pursuant to section 15 MCA, is not expressly curtailed by any requirement of incapacity. Section 15(1) (see paragraph 23 above) enables the Court both to determine whether an individual has or lacks capacity and the lawfulness of any act done or 'yet to be done'. The wording here contrast markedly with Section 16 and cannot be said to be explicitly confined to those lacking capacity. On the contrary, this section contemplates consideration and determination of the issue of capacity. Furthermore, there is nothing in Section 15 (1) (c) which inhibits or restricts the Court's declaratory powers to those individuals assessed as lacking in capacity (i.e. on any particular issue)'.

104. Hayden J took the position that his decision had the potential expressly to override the capacitous person's wishes about her medical treatment in the future, albeit on a contingent basis. He did not restrict himself to authorising the care plan agreed by the capacitous mother to be (see [61] – [63]). In that case the Official Solicitor acted as advocate to the court and did not take issue with the jurisdiction.

105. Lieven J considered the issue of 'contingent declarations' in *A Local Authority v PG* [2023] EWCOP 9. This case concerned P a 34 year old woman with moderate intellectual disability and ASD, who also had been diagnosed with trauma based mental illness with EUPD traits and mild learning disability. Issues arose regarding P's capacity regarding her care and contact with others including at times of heightened anxiety. The local authority had significant concerns regarding P's safety.

Lieven J considered the case on the basis of the available options regarding longitudinal capacity or anticipatory declarations. Lieven J's findings and analysis is at [34] – [44]. She concluded that the appropriate approach in that case was to take the longitudinal view as *'An anticipatory order would in practice be close to impossible for care workers to operate and would relate poorly to how her capacity fluctuates. The care workers would have to exercise a complicated decision making process in order to decide whether at any individual moment PG did or did not have capacity. This might well vary depending on the individual care worker, and how much of the particular episode they had witnessed or not. The result would fail to protect her, probably have minimal benefit in protecting her autonomy and in practice make the law unworkable.'* [43].

106. In a further case, *The Shrewsbury and Telford Hospital NHS Trust v T [2023]* EWCOP 9 Lieven J considered anticipatory declarations where she refused to make one as there was nothing more than a 'small risk' that P might lose capacity which Lieven J considered was [24] *'...insufficient to justify an anticipatory declaration in a case such as this. There is a serious risk in a case such as this that a woman's autonomy will be overridden at such an important time, because of an assumption that she has lost capacity'.* Lieven J considered there were other ways of managing the situation as set out at [25]. In *North Middlesex Hospital NHS Trust v SR* [2021] EWCOP 58 Ms Gollop KC found that although P had capacity to make decisions about her obstetric care, there was a 'real risk' [44] that she may lose capacity [45] and P's circumstances were 'exceptional' so as to justify the making of anticipatory declarations as to the lawfulness [47].

107. In *An NHS Foundation Trust v Amira* [2023] EWCOP 25 Mostyn J in obiter comments doubted the existence of the court's jurisdiction to make anticipatory declarations under s15(c) stating that provision [35] *'...can only be made in relation to a person who, at the time the declaration is made, lacks capacity as regards the subject matter of the declaration. In my judgment, the court cannot make a proleptic finding of incapacity, saying, pursuant to s2(4), that it is satisfied that it is more likely than not that at some point in the future that person will lose capacity, This is because Part 1 of the Act only applies to persons who are presently incapacitated, not to persons who are not incapacitated but who might become at some point in the future incapacitated.'* Mostyn J continued that even if he is wrong in that analysis there are practical difficulties in managing the declaration sought, as set out at [38] – [41] and considered that the powers in ss4B, 5 and 6 MCA could be used. In the event the updated evidence supported his conclusion that P lacked capacity so the application for anticipatory declarations was not pursued.

Submissions

108. On behalf of the applicant local authority Mr Hallin submits the court does not need to make any declarations as to capacity in this case. Having heard the evidence the local authority accept P has capacity regarding her care, support and contact with others. He takes issue with any jurisdiction to provide 'anticipatory declarations' to govern the best interests of a person with capacity for times when he or she might come to lose capacity and, in any event, submits it would not be of any practical benefit in this case.

109. The local authority submit one of the difficulties in this case is that there has been an abdication by mental health support services to provide a framework for P's care and support, they have effectively delegated that function to her treating therapists, CDS. The mental health service involvement has been limited to an annual appointment with P's clinical psychiatrist and no involvement from the mental health service in the regular ongoing meetings, other than by a case manager, who has no clinical responsibility. Mr Hallin submits this has put the local authority in an invidious position and that the key to unlocking greater stability is the greater involvement of the mental health team.

110. Mr Hallin is critical that Dr Camden-Smith had not stated in her written reports earlier that the appropriate diagnosis for P is CPTSD as a result of her history of abuse, not DID. The local authority accept the evidence of Dr Camden-Smith that P has capacity about care, support and contact with others and contend that the suggested possibility that she might in the future dissociate or suffer from such dysregulation so as to lose capacity does not prevent her from making decisions about her care, support and contact with others on a day to day basis, as she currently has capacity. The local authority do not accept Dr Camden-Smith's evidence that when P dissociates she loses capacity. According to CDS P dissociates every day but not always loses capacity. They submit it would be virtually impossible to expect domiciliary care workers to be able to know when P has dissociated and input is required from orthodox mental health treating clinicians on the ground to assist as to diagnosis and care planning. The involvement of Dr A, the treating psychiatrist, appears to be no more than an annual review and there is no evidence that CDS have been providing ongoing evidence to Dr A.

111. Having heard the evidence the local authority considers the presumption of capacity has not been rebutted. Mr Hallin submits *'There is no evidence that [P] cannot on a day to day basis, understand information relevant to her care needs, cannot retain it, cannot weigh it or cannot communicate her decisions. In so far as CDS have given evidence that [P] 'dissociates' on a daily basis, this is in the context that they themselves encourage such 'dissociation' for the purposes of speaking to identifiable 'parts'…some of whom have capacity to make decisions and some of whom do not. Dr Camden-Smith rejects this diagnosis and approach, suggesting that [P] is a person with one identity who 'dissociates'…'*.

112. At the start of the case the local authority submitted that the longitudinal approach to capacity was an option. Having heard the evidence that is no longer pursued and is not supported by the evidence or any party.

113. As regards anticipatory declarations Mr Hallin submits that such declarations cannot be made in relation to a person who currently has capacity and considers such declarations are outside the proper ambit of the powers of the Court of Protection, relying in particular on the rationale set out by Mostyn J in *Amira* at [27] – [41], in particular the availability of ss 5 and 6 MCA. He submits Tier 3 cases where such a jurisdiction has been used have been in circumstances where the legal jurisdiction to make such declarations has not been in dispute.

114. Mr Hallin submits that even if there is jurisdiction to make anticipatory declarations they would not be workable in this case as capacity is time and decision specific and it would be difficult to predict the circumstances reliably to bind carers to a certain

response. This is illustrated by the cases where such declarations have been made on the basis that there is a predictable time in the future where a person will lose capacity. As Mr Hallin submits *'There is no such predictable defined moment in this case'* and Dr Camden-Smith acknowledged that it would be *'virtually impossible'* for care workers to assess whether P has lost capacity by reason of dissociating. In any event, Mr Hallin submits, there is an element of speculation as the court is trying to crystalise triggers when P could be said to lack capacity in the future so as to make best interest decisions on uncertain events and would be doing so without any proper orthodox mental health involvement in this process.

115. In the light of the evidence Mr Hallin outlines the local authority's proposed approach to care planning. It will seek urgent involvement of the local mental health services with the support of the ICB. Subject to any different determination by the court the local authority will plan on the basis that P has capacity and the package of care will reflect that including managing any periods said to be higher risk for P including a crisis plan.

116. Ms Butler-Cole, at the request of the local authority, provided a summary of relief sought by P which can be summarised as follows:

(1) P has capacity on a global basis to make decisions about her care arrangements.

(2) P has a mental disorder that satisfies the requirements of s2 MCA, namely DID.

(3) When P dissociates, on the balance of probabilities, she lacks capacity to make decisions about her care.

(4) When P is putting herself at risk of harm, and a carer or other person with caring duties towards P forms the view that she lacks capacity to decide what care she should receive at that time, it will be in P's best interests for a plan to be followed which permits carers to override P's presently-expressed wishes. A proposed protocol was produced to support this which includes trying to persuade P not to leave the house and following her if she does.

(5) The crisis plan should be reviewed and modified by agreement as required.

117. Ms Butler-Cole submits if these conclusions were reached then either the court makes a declaration pursuant to s15 MCA that in the event P lacks capacity to make decisions about her care and support it is in her best interests for the crisis plan to be implemented or no declarations are made but the local authority or ICB give undertakings that the crisis plan will be implemented and provided to staff (subject to any amendments following further discussion). She submits Ms S accepted a crisis plan was in place and an aftercare assessment under s117 was required.

118. Ms Butler-Cole's proposed way forward was rejected by the local authority on the basis that the carers can rely on s5 MCA. It transpired the only crisis plan in place was that put in place by Dr A and on further investigation the care plan made by the current carers had never been provided to P or her representatives. Ms Butler-Cole is critical of the local authority in not engaging with the proposed crisis plan and describes it as *'fairly low-level – seeking to persuade [P] to stay at home, or following her if she leaves'*. In addition, she submits that instead of trying to be

solution focussed the local authority seek to over complicate matters and defer from making any decisions until more active involvement from the mental health team. As was made clear in *Hemachandran* a formal diagnosis is not required, there is evidence in this case where the court can find that there are times when a disturbance in P's mental state (for example by dissociation) prevents her from making a decision. Ms Butler-Cole relies upon Dr Camden-Smith's evidence that the diagnostic label that is attached to P's position is not a critical issue in terms of care planning and any changes in care support would need to be very carefully managed. Dr Camden-Smith accepted there were times when P dissociates and there is common ground that P is traumatised, lives daily with the consequences of trauma and there are periods of dissociation. The focus, she submits, needs to be on securing the most appropriate care package with the objective of reducing P's reliance on care.

119. Ms Butler-Cole submits that the court can make a declaration under s15 MCA that when she lacks capacity to make decisions about her care and support it is lawful for the crisis plan to be implemented even if she is objecting at the time. She submits there are two possible routes for the court to take under s15. One is to make a declaration as to capacity under s15 (1)(a) or (b) and then a declaration of lawfulness under subsection (c) and the other is just to make a declaration under s15(c). She submits in this case a declaration under s15(c) could be in the following terms *'In the event that [P] lacks capacity to make decision about her care and support, and specifically to decide whether to leave her house or to admit visitors to her house, it will be lawful for the crisis plan to be implemented'.* Ms Butler-Cole makes clear this declaration does not state P will always lack capacity when she dissociates, nor that dissociation is the only possible cause of her incapacity *'its purpose is to confirm the lawfulness of the crisis plan so that as and when a carer forms the view that [P] lacks capacity at a particular time, there is no doubt that the plan can be lawfully implemented'.*

120. Ms Butler-Cole submits the court could make a declaration under s15 (a) or (b) that P presently has capacity and then make the declaration outlined above under s15(c), which does not require as a precondition a declaration of present incapacity. She submits subsection (c) refers to 'that person' which is a reference to a person whose capacity has been determined under (a) or (b). As she submits *'Subsection (c) does not say that it can be invoked only if the outcome under (a) or (b) was a declaration of incapacity. And both subjections (a) and (b) envisage positive declarations of capacity.'.*

121. Ms Butler-Cole takes issue with the obiter analysis by Mostyn J in *Amira* for the following reasons. Whilst the heading in an Act can be considered it is a poor guide to the scope of the section (see Lord Reid in *R v Schildkamp* [1971] AC 1). S 5 and 6 MCA are not only to address emergency situations. In *N v A CCG* [2017] UKSC 22 [38] the Supreme Court confirmed s5 gives '*…a general authority, to act in relation to the care or treatment of P, to those caring or him who reasonably believer both that P lacks capacity in relation to the matter and that it will be in P's best interests for the act to be done'.* There are other provisions in Part 1 MCA that clearly apply to people with capacity (see ss22 and 24).

122. Ms Butler-Cole rejects the submission that anticipatory declarations are not workable in this case as the court cannot predict the circumstances in which a person will lack capacity or bind the carers to respond in a certain way. She submits that whether there

is a declaration or not carers will need to form a view on capacity and if she lacks capacity act in her best interests. P's capacitous wish for a crisis plan to be implemented will be a weighty and likely determinative factor. A declaration would confirm the lawfulness of the plan, provide a safety net for untrained carers, provide some certainty in circumstances where the local authority has not suggested that a crisis plan of this sort was not in P's best interests.

123. Ms Butler-Cole recognises that there needs to be caution in exercising the power to grant an anticipatory declaration. Dr Camden-Smith observed in her evidence that people usually get on with implementing crisis plans such as the one being discussed in this case without seeking a court order. If the local authority submissions are right it would have the consequence that where a period of incapacity is foreseeable and the statutory body and the person concerned disagree about what steps can be taken regarding that person's welfare during the period of incapacity there can be no recourse to the Court of Protection to resolve that dispute. So, Ms Butler-Cole submits, the person concerned will have to wait until they lose capacity and the statutory body's plans have been implemented against their capacitous wishes, and then somehow apply to the court.

124. Mr Karim KC, on behalf of the ICB, reminds the court that the issue the court is being asked to determine is whether P has capacity to make decisions about her care and contact with others. It is not disputed that P requires a package of care to meet her eligible needs which should include a crisis plan that may impose restrictions. The issue is what framework can be in place to authorise the crisis plan when P dissociates when certain risks are heightened and at a time when she objects, but consents to it when she has capacity. This is in the context of the evidence that there have been occasions when after periods of dissociation P has returned distressed and injured.

125. P is in receipt of aftercare funding under s117 MHA with commissioning responsibility shared between the ICB and the LA. The ICB works alongside the local Commissioning Support Unit (CSU) who have day to day management of the case on behalf of the ICB.

126. The ICB commissions the Leicester Partnership NHS Trust ('the Mental Health Trust') who are responsible in meeting P's mental health needs which the relevant Community Mental Health Trust ('CMHT') deliver. In his written submissions Mr Karim candidly recognises that the ICB is acutely aware that input from CMHT is needed, and imperative. He relies on the written evidence of Ms C regarding the attempts the ICB had made to involve the CMHT. In his written submissions he set out that the ICB have already contacted the Mental Health Trust to instigate the following steps:

(1) A reconsideration of the crisis plan.

(2) MDT meeting (to include CMHT) to take place every three months.

(3) To discuss plans for the CMHT to provide specific input into the diagnosis of DID and the suggested alternative diagnosis of CPTSD by Dr Camden-Smith; an assessment of risk from the mental health perspective; input/review of care provision including clinical oversight of what is commissioned by the ICB by way of therapy from CDS; to provide objective targets regarding future therapy with an

evidence base to determine progress; in conjunction with P and CDS the advice to be provided to domiciliary carers to identify when P is dissociated; and, ensure CDS complies with their safeguarding protocols.

127. Mr Karim submitted the ICB does not positively seek orders or declarations although would support the proposition that P has capacity to make decisions about her care and contact save for when she dissociates, and only in that circumstance it is in her best interests to be in receipt of a crisis plan (to be finalised). He confirmed the ICB does not support any proposition that P lacks capacity on a longitudinal view as the evidence suggests that the periods of dissociation, which leads to the risky or unusual situations, are able to be well-defined. The ICB submits the evidence does demonstrate that P's capacity fluctuates sufficient for it to make *'qualified declarations that P lacks capacity in certain* situations' following the approach taken by Lieven J in *A Healthcare B NHS Trust v CC* [2020] EWHC 574 [51] and Hayden J in *GSTT and SLAM v R* [2020] EWCOP 4 [35]. This would, Mr Karim submits, strike the right balance in promoting P's autonomy whilst protecting against the risks.

Discussion and decision

128. This is a complex case, both in terms of the factual background and the relevant legal framework. The court is extremely grateful to the respective legal teams for their detailed written and oral submissions.

129. I found the meeting with P prior to this hearing particularly helpful when she was able to explain with care the difficulties and frustrations she feels regarding the situation she is in. P showed great courage in attending this hearing which I recognise was, at times, very difficult for her. However with support, she was able to hear most of the oral evidence.

130. The ICB have been candid in their recognition of the urgent need for the Mental Health Trust to be actively engaged in this case. Whilst the local authority and ICB have joint duty under s117 MHA to provide after care services to P on the information this court has seen, which I acknowledge may not be the complete picture, there has been virtually no effective engagement by the Mental Health Trust and the CMHT. There has been no clinical input from them for a number of years apart from an annual appointment with Dr A, which appears to lack any effective engagement with CDS or the work they are undertaking with P. For the last five years CDS have effectively been left to manage the situation with no external more orthodox mental health input, not even in the role of critical friend. Over this extended period there is no evidence of any effective engagement between CDS and the Mental Health Trust. As far as the court is aware the Mental Health Trust are invited to all meetings concerning P but have attended none in any clinical capacity or demonstrated any effective knowledge or understanding of the decisions made in those meetings. The local authority have, in effect, been left shouldering the responsibility alone. The firm re-assurance given to the parties and the court by the ICB that this apparent abdication by the Mental Health Trust of their responsibilities is going to change is very welcome and should have taken place much earlier.

131. There is no issue between the parties, and the evidence establishes, that P has suffered significant trauma in her past and remains traumatised. As a consequence of that trauma she has an impairment of the mind which causes P to have periods of

dissociation. Up until Dr Camden-Smith's oral evidence the case had proceeded on the basis that P had a diagnosis of DID. Although not entirely clear, it appears that diagnosis was made by CDS and adopted by Dr A, P's treating psychiatrist, as her most recent report refers to that.

132. In her oral evidence Dr Camden-Smith considered P's diagnosis is more accurately that of CPTSD which causes P to have periods of dissociation rather than different identities. It is unfortunate that view was not flagged up by Dr Camden-Smith earlier. When P dissociates Dr Camden-Smith agreed P can suffer from symptoms including amnesia, depersonalisation and derealisation. When that occurs P is unable to understand, retain or weigh up relevant information to make informed decisions about her care and contact with others pursuant to s3(1) MCA.

133. I agree with Ms Butler-Cole and Mr Karim that the uncertainty around diagnosis in relation to the impairment or disturbance of the mind has no material consequence, as there remains a causal nexus between the cause and the consequences namely, when P dissociates the symptoms outlined above are the same and may result in P losing capacity.

134. The difficult issue is whether P retains capacity when she dissociates. Dr Camden-Smith was clear in her evidence that P lacks capacity when she dissociates. ZX's evidence was less clear, albeit in the context of different identities, his view was that it was not as binary as that and P retained capacity when she was some identities other than Z but accepted there were times when she lost capacity.

135. The oral evidence painted a somewhat confused picture of how it can be established when P has dissociated and whether the carers will be able to recognise this. The evidence as to frequency of disassociation also varied. In 2018 the evidence refers to it happening multiple times a day, the July 2024 s 49 report states it occurs daily for variable duration. Dr Camden-Smith accepted that it would be difficult for domiciliary care workers to identify when P has dissociated, although later stated that dissociation would be apparent when P was putting herself at risk or acting in an unusual way.

136. The evidence establishes that the risks P has put herself at have decreased significantly in number, although the seriousness of the individual risk remains high. There have been three occasions in the last year when there is evidence that P has left her home during a period of dissociation and returned complaining of injuries to herself. When she is not dissociated P recognises the seriousness and significance of this risk and agrees there should be a crisis plan in place so steps can be taken to prevent her putting herself at such risk, such as to prevent tampering of the internet (so the Ring doorbell remains working) and of her being followed and/or prevented from leaving the property.

137. In drawing the evidential and legal threads together I have reached the following conclusions:

    (1) Whilst most of the time P is able to make decisions about her care and contact with others there are limited times when she is unable to do so when she dissociates in the context of leaving the property in certain circumstances or seeks to admit visitors to it. In particular, at those times she is unable to properly weigh

the relevant considerations, understand the significant risks and make decisions to keep herself safe which she recognises need to be made when she does not dissociate and has capacity.

(2) At those times the inability to properly weigh the relevant considerations is caused by an impairment of or disturbance in the functioning of the mind or brain which causes her to dissociate.

(3) No party submits that a longitudinal view of capacity should be taken in this case which I accept, as the evidence demonstrates that the relevant times when P is likely to lack capacity to make decisions regarding her care and contact relate to relatively infrequent isolated decisions.

(4) I accept the submissions of Ms Butler-Cole and Mr Karim that there is jurisdiction under s15 MCA that enables the court, in principle, to make anticipatory declarations. Such declarations, if made, are not dependent on P lacking capacity at the time such a declaration is made as s15 (c) refers to *'the lawfulness or otherwise of any act done,* ***or yet to be done****, in relation to that person'* (emphasis added), clearly referring to a future event. The reference to *'that person'* is to a person whose capacity has been determined under s15(a) or (b), which includes a declaration as to whether a person has or lacks capacity to make the decisions referred to in s15 (a) and (b). So, a declaration under s15 (c) is not dependent on a declaration of present incapacity, as submitted by Mr Hallin, as both subsections (a) and (b) envisage positive declarations of capacity. The heading to Part 1 of the MCA is only a guide, at best, and there are other provisions in this part of the MCA which concern those with capacity (e.g. ss22 and 24 MCA).

(5) Whether the jurisdiction to make an anticipatory declaration should be exercised will depend on the facts of each case. The court will need to carefully consider the underlying principles of the MCA which is to protect and, where appropriate, make decisions for those who lack capacity in relation to a matter, but take all necessary steps to preserve the autonomy of those who have capacity. In *The Shrewsbury and Telford Hospital NHS Trust* Lieven J refused to make such a declaration as there was nothing more than a 'small risk' that the woman might lose capacity which was *'insufficient'* to justify an anticipatory declaration, it risked the woman's autonomy being overridden and there were other ways of managing the situation, such as inviting the woman to enter into an advanced declaration or relying on necessity.

(6) In deciding whether to exercise the jurisdiction under s15(c) the court will need to carefully consider a number of factors, including:

(a) Whether there are other ways in managing the situation, for example whether s5 MCA can be utilised. As Lady Hale made clear in *N v A CCG* [2017] UKSC 22 [38] *'...Section 5 of the 2005 Act gives a general authority, to act in relation to the care or treatment of P, to those caring for him who reasonably believe both that P lacks capacity in relation to the matter and that it will be in P's best interests for the act to be done. This will usually suffice, unless the decision is so serious that the court itself has said it must be taken to court. But if there is a dispute (or if what is to be done amounts to a deprivation of liberty for which there is no authorisation under the "deprivation of liberty safeguards" in*

Schedule A1 to the 2005 Act) then it may be necessary to bring the case to court…'. This provision is not limited to only address emergency situations but there are clearly limits.

(b) The need to guard against any suggestion that P's autonomy and ability to make unwise, but capacitous decisions is at risk or any suggestion that the court is making overtly protective decisions.

(c) To carefully consider the declaration being sought, and whether the evidence establishes with sufficient clarity the circumstances in which P may lack capacity and in the event that P does the circumstances in which contingent best interest decisions would need to be made. This is to guard against the risk that if the facts on the ground were analysed contemporaneously the court may reach a different conclusion.

138. Having considered the evidence in this case I have, on balance, reached the conclusion that on the facts of this case the court should not make an anticipatory declaration for the following reasons:

(1) There remains considerable uncertainty on the evidence about how it is possible to establish when P has dissociated to the extent where she loses capacity to make decisions about her care and contact with others. Dr Camden-Smith accepts that could be difficult and whilst her evidence that P lacks capacity when she dissociates has the superficial attraction of simplicity it would, in my judgment, be virtually impossible to work in practice. There is evidence that supports the position that on many occasions when P may be said to dissociate she would not be making relevant decisions and is able to manage the position by taking steps herself, such as going to her bedroom. There is reference in the evidence to looking at when she acts in an unusual way, in a heightened state of arousal or puts herself at risk, however that could cover a myriad of different situations and it is recognised would be difficult for domiciliary care workers to assess in circumstances where P's Article 5 and 8 rights are affected.

(2) The focus of the declaration sought relates specifically to when P lacks capacity and decides whether to leave her house or to admit visitors to her home. On the evidence, whilst recognising the seriousness of each incident in the past, there has been a significant reduction in the number of such instances in part due to the consistency of the work being undertaken by CDS.

(3) P is very clear that she wishes to be protected from such risks and that her care package should include a crisis plan that covers this situation, including taking steps that would, for example, prevent her from disabling the internet and to follow her in the event she left the property.

(4) There is no significant dispute between the parties that a crisis plan should be in place, in broad terms what it should provide for and the court and the parties are assured (in particular by the ICB) that pro-active steps are being taken for that to be done which should be done with the Mental Health Trust and the local authority working with P.

(5) With the increased involvement and participation of the Mental Health Trust, which Dr Camden-Smith agreed was key, I am satisfied there are other ways, short of making an anticipatory declaration, of promoting P's autonomy and capacity to make these decisions herself with support. As Dr Camden-Smith observed *'CDS have become more of an advocate for [J] rather than what I would expect a treating clinician team to deliver'.*

(6) P remains protected by the existing statutory framework in s5 and 6 MCA that give general authority to those caring for P who reasonably believe both that P lacks capacity in relation to the matter and that it will be in P's best interests for the act to be done. Using this framework will have the advantage that decisions are taken contemporaneously both as to capacity and best interests, having up to date information on matters such as P's wishes and are more appropriate to guard against such infrequent occasions as in this case. I recognise that s5 and 6 may not have been intended to provide a complete catch all means by which carers can implement a care plan and are arguably more designed to provide protection from liability for carers to carry out certain but not all tasks, but on the particular and unusual facts of this case that legal framework better provides for P as it has the advantage of decisions being made contemporaneously, particularly where, as here, the risks being guarded against happen relatively infrequently so need to be considered in the context of an extended time frame. I fully take into account the submission that by making an anticipatory declaration it could provide more certainty for carers but there is nothing preventing the crisis plan including the same information, whether or not an anticipatory declaration is made, as, in effect, the carers or others are going to need to be making the same capacity assessment whether a declaration is made or not.

(7) It is clearly important that any order following this judgment accurately records the steps outlined above that are being taken by the ICB, in particular regarding the engagement of the Mental Health Trust and the CMHT, so there is a common understanding as to what action is being taken.