Neutral Citation No: [2015] NIFam 19 | *Ref:* **OHA9512**

*Judgment: approved by the Court for handing down (subject to editorial corrections)** | *Delivered:* **23/01/2015**

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

FAMILY DIVISION

IN THE MATTER OF CHILDREN (NI) ORDER 1995

BETWEEN:

A HEALTH AND SOCIAL CARE TRUST

Applicant;

-and-

P AND R

Respondents.

JUDGMENT ON CAPACITY

O'HARA J

[1] In order to protect the child who is the subject of these proceedings, nothing must be reported which would serve to identify the child or her parents or any of the parties.

[2] The issue at this stage of the proceedings is whether P who is the mother of an 18 month old child (M) has legal capacity i.e. whether she has the capacity to conduct litigation by instructing a solicitor and counsel, following the proceedings and making decisions on the basis of the evidence and the advice which she receives.

[3] A Trust has applied for a care order in respect of M. It has done so because of its concerns about the well-being of P who has significant and long established mental health problems. P and R, the child's parents, are unmarried but they have a continuing relationship. R's parents, the paternal grandparents, are currently the

main carers for M who is staying with them on an interim basis while the issues in this case are resolved.

[4] On 3 November 2014 Dr Fred Browne, consultant psychiatrist, reported on P. His extremely detailed and helpful 56 page report covers much ground which it is unnecessary (and impossible) to set out in detail in this judgment. Some of the areas on which he focused are:

(i) The breakdown of the relationship between P's parents when she was very young.

(ii) P being sexually abused by her maternal grandfather, by her mother's partner and by her mother with the result that she was taken into care when she was 13 or 14 years old.

(iii) P's own relationships as an adult and M's birth.

(iv) Her history of treatment for psychiatric problems in Scotland and in Northern Ireland – these problems include flashbacks, panic, self-harm and "losing time" as she moves from one persona to another.

(v) P's description of some of her different personalities of which there are about 19: "Sometimes she would tell that a switch … was going to come but mostly she was unable to tell that it was about to happen".

(vi) Her last two years working with a psychotherapist.

(vii) Her agreement with the Trust's concerns about continuity of care and lost time but her anger at social workers for not giving her a chance.

(viii) Her emphasis on the undisputed fact that she had never hurt or harmed M when M was in her care.

[5] In a long and worrying section in Dr Browne's report, extending to 24 pages, he went through extensive medical records showing how disturbed P has been and how much the abuses she has suffered have affected her. He reported his discussion with Ms C, the psychotherapist who has been working with P for about 2½ years. Ms C made a number of points:

(i) That she believed that P has Dissociative Identity Disorder (DID).

(ii) That the presentation of P's personalities could be very unpredictable and that M's presence seemed to be the one thing that helped unite P's personalities.

(iii) That P's attendance at weekly sessions with Ms C was good.

(iv) That even after 2½ years "it was very early days" in the course of the therapy.

(v) That Ms C would like to see the childcare system acting in a more supportive manner and that she did not how P could tolerate the involvement of childcare services.

[6] Dr Browne's own diagnosis was that P suffers from DID, from Borderline Personality Disorder and from Factitious Disorder. Of these three, the first is the most significant in the context of capacity though the other two remain troubling and complicating factors. Dr Browne described DID in the following terms:

> "… The defining feature of DID is the presence of two or more distinct personality states. The disruption in identity involves marked discontinuity in sense of self and sense of agency, accompanied by related alterations in affect, behaviour, consciousness, memory, perception, cognition, and/or sensorimotor functioning. These signs and symptoms may be observed by others or reported by the individual. Other features include recurrent gaps in the recall of everyday events, important personal information, and/or traumatic events that are inconsistent with ordinary forgetting. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning."

He continued by referring to texts which suggest that borderline personality pathology is common in cases of DID and that there is reason to believe that factitious behaviour is part and parcel of DID. This led Dr Browne to conclude that in P's case the three conditions of DID, borderline personality disorder and factitious disorder formed "a cluster of conditions with significant overlap".

[7] DID is associated with a history of overwhelming experiences, traumatic events and/or abuse occurring in childhood. In terms of its functional consequences, Dr Browne stated that impairment varies widely, from apparently minimal to profound. The classification of the disorder which he referred to also states:

> "Regardless of level of disability, individuals with DID commonly minimise the impact of their dissociative and post-traumatic symptoms …"

[8] Dr Browne was asked to provide an opinion on how the presence of multiple personalities affects P's daily functioning. At Section 14.5 of his report he set out a long list of those effects and concluded:

> "It seems clear from [P's] description that she experiences substantial difficulties in her daily life as a result of mental conditions, particularly the [DID]".

[9] He went to report that it seems that P has shown increased stability in recent years, an improvement which he thought was related to a number of factors including having given birth to M, her relationship with R, the support she has received from Ms C, the psychotherapist and the absence of contact with her family of origin. He added however that various stresses may trigger switches in her personalities, that these switches reduce her ability to provide consistent parenting and that "it seems likely that these difficulties will have substantial effects on her capacity to parent a child under her care."

[10] When asked about the current interventions including Ms C's therapeutic work and the timescales of interventions, Dr Browne reported that:

> "I consider that psychotherapy is likely to be difficult in [P's] case because of a number of factors including the lack of awareness that each identity has for the others and the inconsistencies in [P's] accounts. [P's] intelligence and her continuing engagement with therapy are positive factors. I expect that prolonged therapy is likely to be required."

[11] A report was provided by Dr Andrea Shortland, a forensic and clinical psychologist. While the report is relevant to the application for a care order, in this ruling on capacity I note that Dr Shortland encountered three of P's personae and that at paragraph 160 she stated:

> "Of central concern are P's frequent shifts in personality, limited shared information between personalities, and frequent loss of time. These issues create an unpredictable interpersonal and care giving environment for M. For example P and R have reported a recent absence of the personality, P, who historically has been the most central and dominant care giver for M. P and R reported that P has returned a few times recently and is expected to return in the longer term yet when she is present she has extremely limited knowledge of just under half of M's life to date."

[12] Subsequent to the provision of his report Dr Browne was asked to confirm whether in his opinion P is legally competent. He described that as a "complex issue" but stated:

> "I consider it is important to recognise that DID is a condition wherein P is confused about her identity but she is not suffering from the sorts of psychiatric conditions that are generally recognised as potentially making a person incapable of managing his/her property and affairs such as learning disability or brain damage; nor is there evidence of psychosis such as schizophrenia or Bipolar Affective Disorder.
>
> I suggest that the pragmatic method of dealing with this situation is to tolerate the uncertainty that she creates and rather than asking her to produce an identity that she calls P we assume that this person, this physical body **is** P and that this person may call herself different names and present in different ways at different times. This **is** the person to whom the birth certificate refers and, in my view, her mental disorder does not make her incapable of managing her property and affairs."

In this context it is relevant to note that Dr Browne met P in the persona not of P but of L.

[13] Dr Browne gave evidence on this issue on 11 December 2014. In the course of that evidence he stated that while some of P's personae were those of a child and some were those of an adult she had the mental apparatus in each personality to understand the issues. I found this somewhat difficult to follow because as Dr Browne acknowledged very little is actually known about some of her personae but he emphasised his point that she has no brain dysfunction in the sense of learning disability, brain damage etc. At the same hearing P herself gave oral evidence, in the persona of L. In the course of that evidence she said that all of her personalities have the same goal, that most of them have the same traits and that she instinctively knows what to do. She also said that she could not remember what happens when other personalities or personae come to the fore and that while there were gaps in her memory there was no deviation in her aim to care as best she possibly could for M.

[14] In light of the complexity of the case and the highly unusual diagnosis I directed that a second report be obtained. Dr Maria O'Kane, consultant psychiatrist was engaged by the Official Solicitor to provide an urgent assessment of P's capacity to litigate. Among the points made in her very helpful report, I note the following in particular:

(i) P agrees that she suffers from DID but denies Borderline Personality Disorder or Factitious Disorder.

(ii) Her predominant personality for some months has been L.

(iii) When she becomes very upset her dissociative states are triggered and when she comes out of them she is calmer.

(iv) Her partner R has described to her that each persona has a different sense of humour, a different means of responding, different levels of tolerance, distress and react differently in interpersonal relationships.

(v) She attempted to hang herself in October 2014 in the identity of P, not L. This came about, she says, because of the stress involved in the legal proceedings about M.

(vi) She loses time regularly, almost daily, but comes round to find that the interim persona has added to written notes which she makes as L.

(vii) She has dissociated, lost time and moved into the other identities when she has been in the High Court, when she has noticed that she has lost time when P was doing this. She also stated that she has lost time in consultations with her legal team but catches up because she is in the habit of getting them to repeat things over and over again. She told Dr O'Kane that she did not remember what P said in the course of all of this but only knows this from others.

[15] Dr O'Kane concluded:

> "P understands the purpose of the court case, believes that as L she can follow the narrative of the court and as L can instruct counsel. However I am of the opinion that this capacity can [**not**] be sustained continuously between identities."

In her oral evidence on 8 January 2015 Dr O'Kane confirmed that the word "not" had been inadvertently left out of the sentence quoted above – the sentence makes little grammatical sense otherwise.

[16] Dr O'Kane continued by concluding that P suffers from a mental disorder within the meaning of the Mental Health (Northern Ireland) Order 1986, that she suffers from DID but that she does not suffer from either Factitious Disorder or Borderline Personality Disorder. Having said that, she was of the opinion that P "has traits of a variety of personality disorders and that on occasions she has presented with physical illnesses that have not had an organic basis". As a result of her DID, Dr O'Kane advised, there are issues of capacity and her conclusion was that "continuously or consistently she does not have the capacity to instruct her lawyers to deal with the court proceedings".

[17] At page 18 of her report Dr O'Kane advised that having read the reports from Dr Browne and Dr Shortland, she could not reassure herself or the court that she had sound working knowledge of P's different mental states or identities. She could find no coherent description or narrative of the mental state of all the different identities and as Dr Browne had stated following a conversation with Ms C the identities and characteristics of these personalities are not well known. Like Dr Browne, Dr O'Kane met P only in the persona of L. She said that:

> "The only one of these identities that the three of us as assessors has had experience of for any length of time was L. It is not completely clear whether this is P's core identity or not – I would hypothesis that her core identity lies between L and P only because to the best of her knowledge, and thus ours, these are the two that seem to appear most frequently and most well-formed throughout. As such I could state that L – **if L is a stable entity** – is capacitous enough for the proceedings of the court but having never examined the mental states of the other identities I cannot know if they are or not."

[18] Dr Browne volunteered a short supplementary report dated 7 January, taking issue with Dr O'Kane's conclusions. He referred to the presumption of capacity unless the contrary is established and he said, at paragraph 2.5, that:

> "I note that the number of P's identities appears to have changed over the years. If it is accepted that P's identities are unaware of each other it is difficult to know how P can accurately ascertain and report the number and nature of the identities she may have."

However by reference to research he advised that memory can transfer between identities, leaving him to conclude that there is "considerable reassurance that if P should switch identity during the legal proceedings she will still retain memories from her previous identity even if, subjectively, she feels she has lost memory".

On this basis he confirmed his earlier opinion that P has capacity.

[19] Dr O'Kane and Dr Browne gave evidence on 8 January. Before doing so they had discussed their positions with each other – a particularly helpful step in this difficult case. The result was that in her evidence Dr O'Kane stated that she now agreed with Dr Browne that P has capacity. She did so on the basis that since competence is presumed unless the contrary is proven and since the currently dominant personality of L appears to be competent and since it cannot be said that the relatively unknown other personae are not competent, P's competence is established. Dr O'Kane did not seem entirely comfortable with this analysis because

she also referred to the fact that the ability of other personae to make decisions is simply not known. Highlighting the exceptionally unusual nature of DID, Dr O'Kane stated that she has run an adult personality disorder clinic for more than 10 years during which time she has come across only about five patients with DID, none of whom was as severely affected as P.

[20] When Dr Browne gave evidence he was referred to Dr O'Kane's report at paragraph 18, cited at paragraph 17 above and asked how anyone could be reassured that the personality of L was stable. He said that such reassurance was not possible but that in terms of capacity the reassurance was that P is an individual with one brain and that research shows that information transfers within the brain between personalities in the absence of any underlying brain dysfunction. He referred me to a criminal case, R v Podola (1960) 1 QB 325 in which the Court of Appeal held that a defendant could not rely on alleged amnesia to bring himself within the scope of Section 2 of the Criminal Lunatics Act 1800 i.e. he was not insane. By extension Dr Browne appeared to suggest that an individual who can express herself and can respond to questions does not lack capacity as a result of her DID even if she regularly loses time and adopts other personae.

[21] As she had done on 11 December, P gave evidence, once again as L. She contended that I should accept Dr Browne's approach and asserted that she herself is very analytical, that she receives and accepts legal advice and that all of her persona are protective of M.

[22] Counsel for M, for the Trust and for the Guardian made no submissions.

Conclusion

[23] I am extremely grateful to Drs Browne and O'Kane for the time and attention which they have devoted to this most unusual and troubling case. They agree on the diagnosis of DID. Their disagreement on the other two diagnoses is limited and secondary. The fact that Dr O'Kane has moved to accept Dr Browne's position on capacity is significant and entirely appropriate - in cases such as this open-minded and engaged experts should be willing to consider other views with a view to helping the court. However I have encountered considerable difficulty in accepting their joint position and I am concerned whether they have laid too great an emphasis on the presumption of capacity which is far from being irrebuttable.

[24] Notwithstanding the agreed approach of the experts, having considered the reports and the oral evidence I am unable to accept their conclusion that P has capacity. My reasons for reaching a contrary view are as follows:

(i) I believe that they have given excessive weight to the presumption of capacity – it is no more than that, a presumption. It has to be analysed and it can be displaced in a case such as this where an individual's mental health problems have been identified, diagnosed and witnessed

by a range of professionals including two psychiatrists, a psychologist and a psychotherapist.

(ii) I do not believe on the reports before me that L is as dominant a persona as has been suggested – P loses time on virtually a daily basis, it is not just an occasional event. And a range of personae take L's place, not just one persona.

(iii) Dr Shortland's report does not support the application to P's case of the research relied on by Dr Browne to suggest that P's single memory shares the information held by the different personae. On the contrary, paragraph 160 of that report suggests that in the persona of P, she has extremely limited knowledge of just under half of M's life. This point is added to at paragraph 88 of the same report at which P stated that "there is amnesia between the personalities" and that knowledge is shared through Ms C, R, notes, e-mails and credit card statements.

(iv) While I accept the evidence that a person with DID does not inevitably or necessarily lack capacity, Dr O'Kane's evidence was that in a handful of cases she has experienced over ten years P's is the most severe.

(v) Little or nothing is known about most or many of P's very different personae.

(vi) The critical caveat in Dr O'Kane's report is that "**if** L is a stable entity" she has capacity – but I do not find her to be a stable entity and Dr Browne agreed that she could not be said to be stable. Indeed P told Dr O'Kane that she reverted from P to L only in October 2014 "after an attempted hanging in the identity of P".

(vii) This lack of stability is evidenced again in Dr Shortland's report at paragraph 162 at which Dr Shortland refers to a lack of continuity having been experienced by herself, P, R and another lady. She states "we have all experienced P's shifting personalities suddenly without warning or introduction, creating confusion and discomfort for the other person. In addition the dominant adult personalities vary according to their sense of humour and behaviour …"

(viii) While P's condition might well continue to improve with continued therapy, the fact is that after 2½ years she is still only in the early stages of change.

[25] Having reached this conclusion it is important that I make the following additional points:

(i) Dr Shortland in particular, but the experts generally, acknowledge the genuine progress which P has made and the relative stability she has achieved since M was born.

(ii) DID is not an unchanging condition – its extent and consequences vary over time and from one person to another. Accordingly my conclusion that P does not currently have capacity does not mean that she will always lack capacity. Nor does it follow from her lack of capacity that she is or will be unable to care for M either now or in the future. That separate issue will be explored in the course of these proceedings.

(iii) Unlike many parents involved in family cases, P cannot be blamed for her circumstances (though there are alleged to be occasions when her behaviour is controllable but unacceptable). She is not at fault for having DID – it is a reaction by way of a self-defensive mechanism to the trauma of abuse in childhood.

(iv) Notwithstanding my conclusion as to her competence, P remains a party and will still be heard in these proceedings but through the Official Solicitor who will be appointed to represent her interests and views to the court.