

Neutral Citation Number: [2020] EWCOP 59

IN THE COURT OF PROTECTION
12309225
IN THE MATTER OF THE MENTAL CAPACITY ACT 2005
IN THE MATTER OF AM

CASE NO:

BETWEEN:

AG

Applicant

-and-

(1) AM
(by his litigation friend, the Official Solicitor)
(2) LBE
(3) MH
(4) ECCG

JUDGMENT

District Judge Eldergill
Court of Protection, First Avenue House, 42-49 High Holborn, London WC1A 9JA
Heard on 1-3 April 2019 and on 22 November 2019

Judgment handed down on Monday 13 January 2020 at 10.15am

This judgment was delivered in private. The judge has given leave for this version of the judgment to be published on condition that (irrespective of what is contained in the judgment) in any published version of the judgment the anonymity of the children and members of their family must be strictly preserved. All persons, including representatives of the media, must ensure that this condition is strictly complied with. Failure to do so will be a contempt of court.

§1 — INTRODUCTION

This application concerns the liberty, residence and care of AM, who is deprived of his liberty at X Nursing Home under a 12-month standard authorisation issued on 14 August 2019.

The applicant is AM’s wife AG, and the proceedings are brought under section 21A of the Mental Capacity Act 2005.

The Official Solicitor acts on AM's behalf as his Litigation Friend. The other respondents are MH (a son of AM by a previous marriage) and the relevant local authority and CCG.

In broad terms, AG wishes her husband to be discharged to the family home and this is also his wish and that of a number of other relatives. Her application is opposed on the ground that such a move would be contrary to his best interests by the Official Solicitor on his behalf, by the local authority and by one of his sons, the Third Respondent MH. The CCG would also not approve a return home if the decision was for them to take, believing that it involves considerable medical risks and is not in his clinical interests. It invites the court to balance the clinical and other best interests considerations.

The reasons for opposing a return home include a belief that AM's needs are too complex for him to be safely cared for at home, insufficient local GP capacity to provide the required level of care and support at home, and that the family underestimate the level of care which AM requires. Those against a move say that it is very likely that home care would rapidly break down, resulting in avoidable hospital admissions and then discharge to another nursing home with less expertise than X Nursing Home, possibly many miles from the family home.

ECCG suggested that the parties might wish to explore the possibility of a nursing home closer to the family home. This was something which AG had been interested in exploring in previous court proceedings. However, on this occasion, neither she nor any of the other parties wished to pursue the idea.

AM is now aged 74. He and AG married in 1992. They are Muslims and originally came to this country from Somalia. They have had two children together, both of whom are now young adults. AM has six other children from previous marriages, one of whom, MH, is the Third Respondent.

After 16 years of marriage, AM suffered a brain haemorrhage in June 2008, at the age of 62. He maintains active movement in all four limbs but it is uncoordinated and not functional. His vision is impaired by cortical blindness. He has insulin type-2 diabetes and he suffered two epileptic seizures in the summer of 2014, one of which was unresponsive to first-line medication and resulted in admission to a critical care unit. He receives nutrition and hydration via PEG. He is doubly incontinent and requires all of his personal care and activities of daily living completed for him, with two carers and a hoist for transfers. He is eligible for NHS Continuing Healthcare, with the result that his treatment and care are funded by ECCG.

Since 4 March 2009, AM has been a long-term resident at a specialist nursing home for people with profound and complex disabilities who require long term 24-hour nursing care. This nursing home, which I refer to as 'X Nursing Home', is situated in an outer city location approximately eight miles from the family home where his wife lives. Depending on the time of day and the traffic, it takes his wife between 30-60 minutes to drive there by car.

Three other matters may be highlighted by way of introduction: Firstly, AM's private financial means are limited. Therefore, he relies on state-funded care and treatment and his options are limited to what the state can provide. Secondly, there is a limit to what the NHS can or is willing to spend on care at home as an alternative to care in a nursing home. Thirdly, provided they do not act so irrationally as to be unlawful, etc, it is NHS bodies, local and other public authorities — not judges — who decide how to allocate their limited resources between the local citizens for whom they must provide. Furthermore, the funds

available to public authorities, and levels of taxation and public expenditure, are political decisions, that is matters for all of us, *i.e.* for voters not judges.

§2 — STRUCTURE OF THE JUDGMENT

This decision is structured under the following headings:

§1 —	Introduction	Page 1
§2 —	Structure of the Judgment	Page 3
§3 —	Parties and Interested Persons	Page 3
§4 —	Procedure and Hearings	Page 4
§5 —	AM’s Mental Capacity	Page 5
§6 —	The Legal Framework: Best Interests and DOL	Page 6
§7 —	AM’s Situation and Best Interests	Page 13

§3 — PARTIES AND INTERESTED PERSONS

As can be seen from the above, the parties to these proceedings are:

<i>Party</i>	<i>Status</i>	<i>Relationship/representation</i>
AG	Applicant	<i>Mrs AG is AM’s wife. Represented by Ms Monica Kreel of TV Edwards LLP and by Ms Bethan Harris of counsel.</i>
AM	First Respondent	<i>The person concerned (‘P’ in the legislation), by his litigation friend, the Official Solicitor. Represented, on behalf of the OS, by Mr Will Whitaker of Bindmans LLP and by Ms Debra Powell QC of counsel.</i>
LBE	Second Respondent	<i>The relevant local authority and supervisory body for the purpose of AM’s standard authorisation. Represented in- house and excused from attendance at the final</i>

hearing.

MH	Third Respondent	<i>A son of AM by a previous marriage. Represented by Irwin Mitchell LLP and by Mr Conrad Hallin of counsel.</i>
ECCG	Fourth Respondent	<i>The relevant Clinical Commissioning Group. Represented by Mr Stuart Marchant of Bevan Brittan LLP. AM is eligible for NHS Continuing Healthcare.</i>

Interested persons

A number of relatives and interested persons attended hearings in support of the applicant without formally having the status of parties. They included Ms AM (sister of AM), MH2 (son of AM), HH (daughter of AG and AM) and HAM (son of AM).

§4 — PROCEDURE AND HEARINGS

The proceedings have a long history and were before another judge for several years. In 2013, AG made an application to the Court of Protection, seeking a declaration that it was in her husband's best interests to be cared for at their family home. AM then suffered two epileptic seizures, one in June 2014 and the other in August 2014. AG decided not to pursue her application for AM to return home, and she invited the CCG to consider transferring her husband to a nursing home closer to the family home. For various reasons, this possibility did not materialise and a final order was made on 27 April 2015, dismissing the proceedings without any final determination of AM's best interests.

The Second Respondent local authority, LBE, was not a party to the original proceedings. On 4 July 2016, X Nursing Home made a request to LBE for a standard authorisation in respect of AM's deprivation of liberty, which was granted. Because the first proceedings had concluded without any substantive order or determination, and there were objections to AM being deprived of his liberty at the nursing home, the local authority quite properly applied to the Court of Protection. It asked the court to determine whether AM satisfied the requirements for a standard authorisation, and in particular the best interests requirement.

By order of 23 June 2017, it was ordered that AG be named as the applicant and LBE was excused from attending further hearings unless their attendance was specifically requested by one of the parties, or ordered by the court.

From time to time, I have checked whether AM wished to meet with me or whether it was in his best interests to see me despite his own wishes.

The case was before the court for final hearing between 1 and 3 April 2019. That hearing was adjourned after three days, in order to obtain an OT assessment of AG's physical fitness

to be a carer and to try to identify a GP practice with whom AM could be registered should he return home. The final hearing was then resumed, and concluded, on 22 November 2019.

I should add that two hearings had to be postponed because I was called into hospital for unplanned surgery at short notice. It was extremely unfortunate that the same case should be affected on both occasions, and I have apologised to the parties for the delay.

Documentary Evidence (Court Bundle)

The Court had the benefit of two sets of bundles: several lever-arch files of documents from the original proceedings that concluded on 27 April 2015, and in addition four lever-arch files of documents filed in connection with the current proceedings. As would be expected, the written evidence included witness statements, independent expert reports, reports and statements from local experts, copies of the standard authorisations, daily care records, previous position statements and orders, care plans, emails, correspondence, and so forth. Excellent position statements were filed by the advocates, for which I am very grateful.

Oral Evidence

Oral evidence was given by AG (the applicant), Ms AM (sister of AM), MH2 (son of AM), HH (daughter of AG and AM), HAM (son of AM), MH (3rd Respondent), Mr IR (Head of Continuing Healthcare and Complex Placements) and Ms TR (Independent expert, Registered General Nurse, Best Interests Assessor). The court then had the benefit of written and oral submissions on the evidence.

Acknowledgments and thanks

I would like to thank all those involved in the proceedings for the many ways in which they have assisted the court. The oral evidence and commitment of the family witnesses was highly impressive and I have given their evidence considerable weight. I was also very impressed by the skill and fairness of Mr IR and the CCG, who made every effort to help the family construct the best home package of care and treatment that could be devised within available NHS resources. Sometimes I have found a marked reluctance on the part of NHS agencies to fully commit themselves to exploring home packages of care. That was certainly not the case here.

§5 — AM's MENTAL CAPACITY

For the purposes of the Act, a person lacks capacity in relation to a matter 'if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.'¹

For these purposes a person is unable to make his own decision if he is unable:

- to understand the information relevant to the decision,
- to retain that information,
- to use or weigh that information as part of the process of making the decision, *or*
- to communicate his decision (whether by talking, using sign language or any other means).²

¹ Mental Capacity Act 2005, s.2(1).

A person is not to be regarded as unable to understand the information relevant to a decision if he is able to understand an explanation of it given to him in a way that is appropriate to his circumstances (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 able to make the decision.⁴

The information relevant to a decision includes information about the reasonably foreseeable consequences of deciding one way or another, or failing to make the decision.⁵

Presumption of capacity

Section 1 provides that a person must be assumed to have capacity unless and until it is established (on the balance of probabilities) that he lacks capacity. Furthermore, a person is not to be treated as unable to make the decision in question:

- (a) unless all practicable steps to help him to do so have been taken without success;
- (b) merely because he makes an unwise decision.

However, whilst a person cannot be found to lack capacity *merely* because their proposed decision is unwise, fairly obviously an unwise (or irrational) decision may raise significant doubts and so trigger an assessment of their capacity.

Unjustified assumptions

A lack of capacity cannot be established *merely* by reference to a person's age or appearance, or to a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about his capacity.⁶

Evidence in this case of an impairment or disturbance of the mind or brain

AM is diagnosed with cognitive impairment secondary to haemorrhagic stroke (right cerebellar haemorrhage on 20 June 2008). This stroke resulted in cognitive impairment, severe expressive dysphasia and moderate receptive dysphasia. There is also evidence of significant visual impairment which means that pictorial support does not aid communication. According to the Second Respondent (LBE), AM is able to give reliable 'yes/no' answers to basic autobiographical questions in English and Somali, but is unable to answer more complex and/or open questions in either language.

It is not disputed that AM has an impairment of, or disturbance in the functioning of, the mind or brain.

Effect of this condition on AM's capacity to make the relevant decisions

² Mental Capacity Act 2005, s.3(1).

³ Mental Capacity Act 2005, s.3(2).

⁴ Mental Capacity Act 2005, s.3(3).

⁵ Mental Capacity Act 2005, s.3(4).

⁶ Mental Capacity Act 2005, s.2(3).

AG does not dispute that her husband lacks capacity to make the relevant decisions. However, she does believe that his cognition and ability to communicate are more preserved than some professionals imply. This is relevant to his ability to express his wishes, beliefs, values and feelings and to the weight which I should give to what he can communicate.

Although his support plan (G/363-G/372) refers to AM's speech as being unintelligible because of dysarthria, and to his limb movements as being purposeless, AG points out that a fuller picture of his cognition, and of his ability to communicate verbally and to make meaningful physical gestures, is gained from referring to other documents and records. Daily record sheets record that:

- *In September 2017, he 'initiated a wave to OT, held fingers up trying to indicate the number of children he has – he indicated 5 (actual 8), when OT inquired what job he used to do he said in Somali "not working", when asked his previous job prior to the injury he replied "lots of jobs" (accurate according to family).*
- *'He can say yes when asked if he is OK'.*
- *'Is more responsive to wife's commands than I/S, responds better to Somalian instructions (reported by Somalian HCA) ... HCAs reported AM sometimes actively participates ... has in the past replied "who are you?" in Somalian'.*
- *'Asked if AM spoke Spanish, he indicated "No" but gave a big smile. When MC said "Ola" he gestured a wave'.*
- *'Whilst AM was responsive to therapists (nodding head, using gestures) it was clear that he recognised his sister, was able to understand simple questions and instructions given in his own language and was also observed to laugh and say "news".'*
- *'AM allowed A to brush his teeth, then was able to continue this task himself with support'.*

I accept AG's observations, and I also note that some improvement in AM's cognition and level of responses were identified at an MDT review in October 2017 (I/40).

§6 — THE LEGAL FRAMEWORK: BEST INTERESTS AND DOL

The framework to be applied involves considering the European Convention on Human Rights, the Mental Capacity Act 2005, the Codes of Practice to that Act and public law issues.

I shall not give a lengthy recital of the law because it was not in dispute and this is a classic best interests case involving balancing many different relevant considerations.

European Convention on Human Rights

Article 5(1) imposes a positive obligation on the state to protect the liberty of its citizens.

The state is obliged to take measures providing effective protection of vulnerable persons, including reasonable steps to prevent a deprivation of liberty of which the authorities have or ought to have knowledge.

Article 5 is engaged where an incapacitated person is deprived of their liberty. A proper authorisation or court order is required, which in this case is the standard authorisation.

The person concerned should have access to a court and the opportunity to be heard in person or, where necessary, through some form of representation.

Special procedural safeguards may prove to be called for in order to protect the interests of persons who, on account of their mental disabilities, are not fully capable of acting for themselves.⁷

Article 8 provides a qualified right that everyone has the right to respect for their private and family life, home and correspondence. Any interference with AM's family or private life must be authorised by law, proportionate ('necessary in a democratic society') and for a permitted purpose, e.g. for the protection of his health.

Once the court has completed its analysis of AM's best interests under the MCA, it must satisfy itself that any infringement of his Article 5 and/or Article 8 rights which arises from its (provisional) conclusion is necessary and proportionate: see *K v LBX* [2012] EWCA Civ 79 at [35].

Mental Capacity Act 2005 — Statutory principles

The statutory principles set out in the Mental Capacity Act 2005 are well-known to the parties.

Very briefly, section 1 provides that a person must be assumed to have capacity unless it is established that he lacks capacity; a person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success; a person is not to be treated as unable to make a decision merely because he makes an unwise decision; an act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests; and before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

Codes of Practice

The relevant codes of practice are the *Mental Capacity Act 2005: Code of Practice* (Department for Constitutional Affairs, London: TSO, 2007) and the *Deprivation of liberty safeguards: Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice* (Ministry of Justice, London: TSO, 2008). The codes do not have statutory force but professionals and some carers must have regard to their provisions, and the courts must take them into account where relevant: see section 42.

Public law considerations

I accept that this court cannot direct a local authority or NHS body to provide services which they have assessed that AM does not require or which they have decided at their reasonable discretion not to provide.

Determining Best interests

The correct approach to determining questions about what is in AM's best interests is set out in Section 4 of the Mental Capacity Act 2005:

Section 4 Best interests

⁷ See *Winterwerp v Netherlands* 6301/73 (1979) ECHR 4.

- (1) *In determining for the purposes of this Act what is in a person's best interests, the person making the determination must not make it merely on the basis of—*
 - (a) *the person's age or appearance, or*
 - (b) *a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about what might be in his best interests.*
- (2) *The person making the determination must consider all the relevant circumstances and, in particular, take the following steps.*
- (3) *He must consider—*
 - (a) *whether it is likely that the person will at some time have capacity in relation to the matter in question, and*
 - (b) *if it appears likely that he will, when that is likely to be.*
- (4) *He must, so far as reasonably practicable, permit and encourage the person to participate, or to improve his ability to participate, as fully as possible in any act done for him and any decision affecting him.*
- (5) *Where the determination relates to life-sustaining treatment he must not, in considering whether the treatment is in the best interests of the person concerned, be motivated by a desire to bring about his death.*
- (6) *He must consider, so far as is reasonably ascertainable—*
 - (a) *the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity),*
 - (b) *the beliefs and values that would be likely to influence his decision if he had capacity, and*
 - (c) *the other factors that he would be likely to consider if he were able to do so.*
- (7) *He must take into account, if it is practicable and appropriate to consult them, the views of—*
 - (a) *anyone named by the person as someone to be consulted on the matter in question or on matters of that kind,*
 - (b) *anyone engaged in caring for the person or interested in his welfare,*
 - (c) *any donee of a lasting power of attorney granted by the person, and*
 - (d) *any deputy appointed for the person by the court,*

as to what would be in the person's best interests and, in particular, as to the matters mentioned in subsection (6).
- (10) *“Life-sustaining treatment” means treatment which in the view of a person providing health care for the person concerned is necessary to sustain life.*
- (11) *“Relevant circumstances” are those—*
 - (a) *of which the person making the determination is aware, and*
 - (b) *which it would be reasonable to regard as relevant.’*

In the case of *ITW v Z* [2009] EWHC 2525 (Fam), Munby J (as he then was) gave the following guidance with regard to the different considerations listed in section 4 which the decision-maker must have in mind:⁸

- i. *The first is that the statute lays down no hierarchy as between the various factors ... beyond the overarching principle that what is determinative is the judicial evaluation of what is in P's "best interests".*
- ii. *The second is that the weight to be attached to the various factors will, inevitably, differ depending upon the individual circumstances of the particular case. A feature or factor which in one case may carry great, possibly even preponderant, weight may in another, superficially similar, case carry much less, or even very little, weight.*
- iii. *The third, following on from the others, is that there may, in the particular case, be one or more features or factors which, as Thorpe LJ has frequently put it, are of "magnetic importance" in influencing or even determining the outcome.*

The fact that the individual's past and present wishes, feelings, beliefs and values must be considered tells us that this is not a sterile objective test of best interests. It is not a case of trying to determine what some hypothetical objective or rational person would decide in this situation when presented with these choices. Nor are we seeking to do nothing more sophisticated than impose on the individual an objective and rational analysis based on professional expertise of what they ought sensibly to do in that situation.

The law requires objective analysis of a subject not an object. The incapacitated person is the subject. Therefore, it is *their* welfare in the context of *their* wishes, feelings, beliefs and values that is important. This is the principle of beneficence which asserts an obligation to help others further their important and legitimate interests, not one's own.⁹ In this important sense, the judge no less than the public authorities is AM's servant, not his master.

That this is so is emphasised by Lady Hale in the *Aintree* case:¹⁰

45. Finally, insofar as Sir Alan Ward and Arden LJ were suggesting that the test of the patient's wishes and feelings was an objective one, what the reasonable patient would think, again I respectfully disagree. The purpose of the best interests test is to consider matters from the patient's point of view. That is not to say that his wishes must prevail, any more than those of a fully capable patient must prevail. We cannot always have what we want. Nor will it always be possible to ascertain what an incapable patient's wishes are. Even if it is possible to determine what his views were in the past, they might well have changed in the light of the stresses and strains of his current predicament. In this case, the highest it could be put was, as counsel had agreed, that "It was likely that Mr James would want treatment up to the point where it became hopeless". But insofar as it is possible to ascertain the patient's wishes and feelings, his beliefs and values or the things which were important to him, it is those which should

⁸ *ITW v Z* [2009] EWHC 2525 (Fam), per Munby J, at para. 32.

⁹ *Westminster City Council v Sykes* [2014] EWHC B9 (COP) (24 February 2014), at §10.
Aintree University Hospitals NHS Foundation Trust (Respondent) v James (Appellant) [2013] UKSC 67 at para. 45.

be taken into account because they are a component in making the choice which is right for him as an individual human being.

It also emerges from various decisions of the previous President of the Court of Protection. Naturally, precisely how much weight to give to a person's present wishes and feelings will depend on the particular context and their circumstances. These include the degree of their incapacity; the strength and consistency of their views; the possible impact on them of knowing that their wishes and feelings are not being given effect to; the extent to which their wishes and feelings are, or are not, rational, sensible, responsible and pragmatically capable of sensible implementation; and the extent to which their wishes and feelings, if given effect to, can properly be accommodated within the overall assessment of what is in their best interests. However, while the weight to be attached to the person's wishes and feelings will always be case-specific and fact-specific, their wishes and feelings will always be a significant factor to which the court must pay close regard.¹¹

Managing risk

Risk cannot be avoided. All decisions that involve a deprivation of liberty or compulsion involve balancing competing risks, of which the risk that the individual or others may suffer physical harm is but one. For example, detention and compulsory care or treatment may risk loss of employment, family contact, self-esteem and dignity; unnecessary or unjustified deprivation of liberty; institutionalisation; and the unwanted side-effects of treatment.

The court 'must adopt a pragmatic, common sense and robust approach to the identification, evaluation and management of perceived risk'. There must, as Peter Jackson J observed in *Hillingdon LBC v Neary*¹² [2011] EWHC 413 (COP) at para 15(3), be a proper, factual basis for such concerns.

Pessimism not necessarily determinative

In *Re: GC*,¹³ Hedley J considered whether to allow an elderly man to be discharged from hospital to the home where he had lived for many years with his nephew KS, notwithstanding that there were serious though entirely unintentional shortcomings in the care provided by KS. Hedley J commented:

'GC is a man in the 83rd year of his life and my concern is to ask myself: how will he most comfortably and happily spend the last years that are available to him? Secondly I have approached this case on the basis that his primary need is for emotional warmth, emotional security and the commitment of human relationship. That has been a huge feature of his life to date and one that is not readily to be set aside. Next it seems to me that for the elderly there is often an importance in place which is not generally recognised by others; not only physical place but also the relational structure that is associated with a place ...'

In connection with the issue of a trial placement, the Judge commented at paragraph 24:

'It seems to me that it would be wrong not to try, even with a degree of pessimism, a placement with a package of support that has been advanced, and this is another factor that has weighed with me in this case ...'

¹¹ *ITW v Z* [2009] EWHC 2525 (Fam), per Munby J, at para. 35.

¹² *Hillingdon LBC v Neary* [2011] EWHC 413 (COP) at para 15(3).

¹³ *Re: GC* [2008] EWHC 3402 (Fam), per Hedley J.

A balance-sheet

The following passage about the need for a balance-sheet approach to best interests comes from the then President's judgment in the case of *Re S (Adult's lack of capacity: carer and residence)* [2003] FLR 1235:¹⁴

'... The question ... is: which outcome will best serve his interests? ... [It] is clear that the court goes about deciding that question by drawing up the balance sheet identified by Thorpe LJ in Re A (Male Sterilisation) [2000] 1 FLR 549 at 560F–560H:

Pending the enactment of a checklist or other statutory direction it seems to me that the first instance judge with the responsibility to make an evaluation of the best interests of a claimant lacking capacity should draw up a balance sheet. The first entry should be of any factor or factors of actual benefit ... Then on the other sheet the judge should write any counter-balancing disbenefits to the applicant ... Then the judge should enter on each sheet the potential gains and losses in each instance making some estimate of the extent of the possibility that the gain or loss might accrue. At the end of that exercise the judge should be better placed to strike a balance between the sum of the certain and possible gains against the sum of the certain and possible losses. Obviously only if the account is in relatively significant credit will the judge conclude that the application is likely to advance the best interests of the claimant.'

The drawing up of a 'balance sheet' in personal welfare cases, listing the actual and potential advantages and disadvantages of each alternative,¹⁵ should not be a dry accountant's exercise which omits what is personal but one that includes the 'personal' element of 'personal welfare'.

Deprivation of Liberty Provisions

The relevant Mental Capacity Act provisions are found in sections 4A, 21A, Schedule A1 and Schedule 1A.

The underlying rationale of the legislative framework is that it is a protective scheme. Anyone who is deprived of their liberty — that is, who is under another person's complete and effective control and is not free to leave — is vulnerable to abuse.

That risk is multiplied if they are unable to decide whether to remain or leave. Children and adults with mental health problems are particularly at risk and the law has usually afforded them special protection. This protection involves imposing legal duties on those with power, conferring legal rights on those in their power, and independent scrutiny of how these powers and duties are exercised. The effectiveness of such schemes depends on whether, and to what extent, they are observed.

In this arena, the deprivation of liberty scheme ensures that there is at least an annual assessment by two suitably qualified and independent professionals, who can ensure that the arrangement really is necessary to protect them from harm, is in their best interests, proportionate and so forth.

¹⁴ *Re S (Adult's lack of capacity: carer and residence)* [2003] FLR 1235, per Wall J, at (14).

¹⁵ *Re S (Adult's lack of capacity: carer and residence)* [2003] FLR 1235

Six requirements

Schedule A1 to the 2005 Act provides that a person may only be deprived of their liberty in a care home under a standard authorisation if they satisfy six statutory requirements: age, mental health, mental capacity, best interests, no refusals, eligibility.

The purpose of these requirements is the same as in the case of the 'sectioning criteria' in the Mental Health Act 1983, i.e. to prevent people who do not meet certain conditions or requirements from being deprived of their liberty. In AM's case, it is common ground that only the best interests requirement is in issue.

The best interests requirement

The 'best interests requirement' is in reality four requirements masquerading as one. It is satisfied only if all of the following four conditions are satisfied:

1. *AM is being detained in the care home for the purpose of being given care or treatment in circumstances which amount to a deprivation of his liberty;*¹⁶
2. *This is in his best interests;*
3. *This is necessary in order to prevent harm to him; and*
4. *His detention in the care home for the purpose of being given care or treatment in circumstances which amount to a deprivation of his liberty is a proportionate response to the likelihood of him suffering harm, and the seriousness of that harm (if he were not so detained).*

If one or more of these conditions is not satisfied, the relevant person does not meet the best interests requirement; and, because a standard authorisation may only be given if all six requirements are satisfied, AM may not be deprived of his liberty under the MCA scheme.

§7 — AM'S SITUATION AND BEST INTERESTS

There is no solution. AM's situation will be less than optimal in both suggested care settings in the sense that he will have to forego some of the benefits that he would have in the other setting. Neither option will provide him with security, safety, liberty, happiness, an absence of suffering and an unrestricted home life.

Participation of AM in the decision-making

So far as reasonably practicable, AM has been permitted and encouraged to participate as fully as possible in the decision-making process. He has been ably represented by an experienced specialist solicitor, Mr Whitaker, has had the assistance of the Official Solicitor, and has also benefitted from the application, encouragement and assistance of his wife and

¹⁶ More precisely, he is a 'detained resident'. By paragraph 6 of Schedule A1 to the 2005 Act, a 'detained resident' is 'a person detained in a hospital or care home — for the purpose of being given care or treatment — in circumstances which amount to deprivation of the person's liberty.' If this is not the case, no authorisation is required because there is no deprivation that needs authorising.

children. He has had many opportunities to express his current wishes and preferences and, as far as his circumstances permit, has done so.

Whether a recovery of capacity is likely

Following a review in October 2017, some improvement in AM's cognition was identified in 2017. However, the evidence clearly indicates that it is unlikely that his capacity will improve sufficiently in the foreseeable future to enable him to make these decisions for himself. Therefore, a decision must be made for him now, by me, in his best interests.

AM's wishes, feelings, beliefs and values

AM's wishes and feelings are extremely important factors to be taken into account when reaching my decision. However, account must also be taken of his limited understanding of the evidence about the risks involved in being treated and cared for at home. For example, it has not been suggested to me that he understands that the likely price of returning home is that he will be more vulnerable to a deterioration of his health, to more severe forms of illness and to an increased risk of premature death, or that he will be at increased risk of hospital admissions. Nor, on the evidence, can he understand, even in the most general terms, that the NHS treatment and care that will be available to him will be sub-optimal compared with that currently provided by the team of GPs, nurses, therapists and care staff at X Nursing Home.

There is a lack of reliable evidence about AM's views prior to his stroke concerning the relative importance of these considerations and what weight they should be given. Family members expressed different opinions about whether he would be likely to prefer the medical advice to remain at X Nursing Home or prefer to take the risks involved in a return home.

There are some things of which I can be confident:

- Firstly, that he loves his wife, children and sister, and that — now and always — he has placed a very high value on family life.
- Secondly, that he wishes to live with his wife and family at home, rather than just to have extensive contact with them at X Nursing Home. This is clear from, for example, his interview with his solicitor at G/292 ('go home, with my wife') and from psychiatrist Dr K's DOLs assessment in November 2017 at L/5 ('He informed us repeatedly and consistently during the interview that he wished to be at "home". In my opinion, he is likely to experience distress by being deprived of his liberty').
- Thirdly, his wish to be cared for by family members within his own home has an important cultural aspect. The significance of this can easily be imagined by reversing the roles, and asking a white English person, brought up say in a traditional shire town, to imagine being displaced and then, after having a severe stroke, living as a refugee, separate from their spouse and children, dependant on others, in a Somali care home. Someone in that vulnerable situation is likely to have a great need to cling on to their trusted life-partner and children and the reassuring familiarity and sense of safety of being with them in a familiar environment. The people, customs, traditions, language, values, dress, religion, cooking, cuisine, smells and scents are familiar and imbued with feelings of familiarity, reassurance and well-being, and a sense of belonging.

- Fourthly, his culture also places a high value on family life and ties, and on mutual family duties and responsibilities.
- Fifthly, he would wish to be looked after by his wife if at all possible. They entered into marriage vows and have enjoyed a long and close marriage. She has continued to attend the nursing home almost every day for the last ten years, staying for the best part of each day. He has expressed and reciprocated her devotion during that time by the way in which he readily accepts her touch and care. As with almost all people who have had that benefit, it is therefore natural that they should wish to live together under the same roof, as husband and wife.
- I must therefore see if I can facilitate this for him by finding a way of giving practical expression to his wishes in a way that is not self-defeating. By that I mean that there is no benefit to him and his wife in authorising a return home if it is likely that he will suffer unduly and be back in hospital, and then a nursing home, within a short period – and in a worse position from the point of view of their family life, because it is not X Nursing Home but somewhere less good and less accessible.

AM's current treatment and care arrangements

AM's current situation is that, since 4 March 2009, he has been a resident of a specialist nursing home for people with profound and complex disabilities who require long term 24 hour nursing care.

AM's current and recent medical and care needs are described in various reports, including the independent nursing expert report of Ms TR (I/15 – I/19); the 'Support plan identified at assessment/review' compiled by ECCG on 13 December 2018 (G363-372); a Multi-Disciplinary Team report signed on 20 December 2018 (I/37-I/41); a medical update report signed by Dr AJ of X Nursing Home on 6 December 2018 (I/42–I/43); and a Multi-Disciplinary Team report signed on 10 October 2019 (I/65-I/68):

- AM is currently medically stable (I/42). As at 10 October 2019, he had not had any 'recent' episodes of chest infection (I/66). Less 'recently', he was diagnosed with pneumonia in January 2018, and required admission to hospital for a chest infection in August 2018 (I/38). His medical records record quite frequent chest infections.
- He requires specialist input from a number of disciplines to prevent physical deterioration (I/42).
- He is not consistently orientated to person, place or time. However, he knows his family and he is happy whenever they visit. He appears to recognise regular carers who are familiar to him (G/366).
- At an MDT review in October 2017, some improvement in his cognition and level of responses were identified compared with when he was last reviewed (I/40).

'The most advanced behaviours observed were using a gesture, a wave when his family requested he said hello, and attracting [the] attention of another person by making a sound. AM demonstrated eye contact and turn-taking in conversation. He was inconsistently able to follow some basic 1 stage instructions (e.g. touch your head) and inconsistently 2 stage instructions (touch your head then look at the floor). His yes/no (head nod/shake) was not reliable (e.g. nodded yes to both 'are you

sitting? Are you standing?'). His speech was largely unintelligible. He would look and track an object, picture or written word though we are unable to assess his vision accurately due to his communication impairment.' (I/40).

- He cannot reliably express his needs in any way, therefore all of his care needs must be anticipated for him (I/40). He is not able to communicate his needs (G/366).
- He has active movement in all four limbs. His left side is stronger and more coordinated. Generally, his active movements are not functional except to adjust his lower limb position in bed himself 'or to attempt to hit out at staff, in particular during personal care' (I/39).
- He is unable to sit unsupported but has head control (G/363).
- He is fully dependent on two carers for all his personal activities of daily living; and 'fully dependent on others to assist him to initiate, plan and carry out all aspects of his health and care needs' (G/364).
- He remains unable to effectively swallow his saliva/secretions, and therefore there is a risk of silent aspiration and of developing pneumonia (G/162), and a choking risk (I/49), if mouth care is not undertaken. He uses a hyoscine transdermal patch, which is changed every 72 hours. He has also been prescribed a PRN saline nebuliser to help liquefy accretions.
- He remains doubly incontinent.
- He remains nil by mouth, and in December 2018 had a newly placed gastrostomy feed in a new stoma site.
- He requires all medications to be administered via the PEG system or via injection (G/371).
- A hoist is used for all transfers. His bed mobility is facilitated with use of slide sheets.
- He is at high risk of skin integrity breakdown on the Waterlow scale (G/369). He requires routine turning in bed every four hours, to prevent skin pressure areas from being compromised. His daily care also includes daily limb stretches to prevent contractions.
- He requires daily monitoring of his blood pressure, glucose levels and adjustment of his feeds to ensure adequate nutrition and optimal diabetic control.
- There is clear evidence of AM being calm and responsive when with family members, demonstrating his contentment when cared for by them. His family continue to be involved daily in his care and he enjoys extended visits from them every day of the week, for around 6-9 hours per day. His wife has been attending the hospital almost daily for the last ten years, staying for the best part of the day. Currently, she is there every day except Saturday, when her daughter HH attends. AM's sisters are there two mornings during the week. On those days AG arrives in the afternoon.
- His wife does his shaving and oral care daily. She told me that on her return from five days holiday in August 2018, her husband's mouth was full of mucus and he was unwell, requiring admission to hospital with a chest infection. She also prepares his clothes daily.

- He is given routine podiatry treatment every six weeks.
- He sleeps well during the night for at least 6 to 8 hours without the need for sedation (I/40).
- He seems to like to stay in his room and to watch television or listen to the radio.
- He has exhibited oppositional behaviour to many tasks, such as mouth care, the administration of insulin, administration of suppositories and access to his feeding tube. One person holds his hands whilst another executes these tasks.
- Previously it was recorded that he was prone to sustaining bruises due to 'occasional unpredictable behaviour' especially during personal care, including manual handling. The behaviours included hitting out and pulling and bending thumbs/fingers. However, in the recent MDT report of October 2019, it is recorded that 'Psychology completed a thorough assessment ... There were inconsistent reports, with most staff stating that they had no concerns. No ABC charts were completed. Some behaviours were observed during oral cares, but staff reported that since these have been handed over to family there had been no further incidents. He accepts oral care from his wife and, to a lesser extent, other family members. AM was discharged from psychology on 4 June 2019 as no further input was required (I/67).
- Consistent with this, in December 2018, the ECCG Support plan stated that he had become more compliant with care; 'however when he is cared for by a carer he does not know or remember he can become unsettled' (G/365). Occasionally, when he is unsettled, he may need the assistance of three carers (G/365).
- AM requires a fully wheelchair-accessible environment. He also requires a hospital profiling bed, bed rails, a pressure relieving mattress, a hoist and sling and shower trolley. He requires a customised seating system with adaptations to accommodate his needs. The environment needs to be large enough both to accommodate this equipment and to enable staff to perform personal care tasks (I/40).
- Visits into the community are not currently undertaken but would be supported by ECCG. According to Dr AJ, they should be supported by a family member and a nursing home carer.¹⁷ AM could spend around five hours outside, until his medications are required, e.g. from 1pm to 6pm. His sitting tolerance is usually limited to about five hours (I/43), but (I was told in November) has shown further recent improvement. His sitting tolerance is probably now good enough for him to be taken to his preferred Mosque near the family home. There is a more convenient if unfamiliar Mosque nearer to X Nursing Home which may not be of the right school.
- AM's last home visit was in 2011. The CCG gave evidence that structural adaptations to the family home will be necessary before further visits home are practical. However, the CCG would be prepared to fund the necessary transport and a carer to

¹⁷ According to IR, 'A staff member who is familiar with his needs from X Nursing Home would need to accompany him to manage his positioning needs in the wheelchair and to manage the water pump set which runs during the time he sits out during the day. He would require specialist transport to be pre-booked to accommodate his wheelchair safely' (G/352).

accompany AM should the necessary adaptations be carried out. Similarly, the nursing home would be willing to provide a carer to facilitate this (I/43).

- Dr AJ (the GP at X Nursing Home) states that the collective decision of the multidisciplinary team is that AM requires this present level of care in a structured multidisciplinary environment. It is unlikely that this level of care can be safely delivered in the community. In the past, care in the community did not work and placed him at risk.¹⁸ 'Subsequent opinions from a range of hospital specialists have maintained that AM's needs can only be met in a good long-term care unit that is able to cater to his complex medical and care needs.' (I/42).
- At X Nursing Home, AM has access to 24 hour nursing care and active medical management. Any significant clinical concern is assessed by a specialist nurse, and during office hours (9am – 5pm Monday to Friday) a referral can be made to the on-site GP service, which enables a response straight away. Overnight, and at weekends, the on-call GP service is called by the nurse and a GP is expected to be on site within one hour if required to attend. (The oral evidence of AG and HH was that this is not always the case.)

It can be seen that AM has very significant disabilities, requires substantial support, and benefits from a very good package of care, treatment and family contact.¹⁹

This is highly relevant. AM's case is not of the kind that I see all too frequently, that of an older person having to endure minimum standards of care, and little in the way of social stimulation, in a care home far away from family and home. If I give up AM's place at X Nursing Home, I am giving up something of real benefit to him — Something that only by chance will be available to him again should home care break down.

With regard to this risk, I should make two observations. Firstly, the CCG can or will only keep his place at X Nursing Home open for 14 days if he goes home.²⁰ Secondly, for this reason, and because ECCG is unwilling to incur the costs of adapting the family home and training family carers for a trial at home, to establish if home treatment and care is viable, a trial at home is not an option available to me.

If a three-month trial at home were an option then it is likely to have been my preferred option. Without that option, if I discharge AM and matters go awry after 14 days, he stands

¹⁸ I was referred to events and reports from many years ago, for example, a failed attempt to discharge AM home in December 2008. This resulted in a hospital admission and then discharge to a care centre, rather than back home. The situation is very different now. The family and CCG have devised a thoughtful and considered home care package, the level of conflict is greatly reduced, and some of the proposed family carers were children at that time. I have assessed their case on how matters presently stand, and do not find that the circumstances in 2008 and 2019 are sufficiently similar to significantly assist me.

¹⁹ The ward on which AM is a resident was subject to a safeguarding report and inquiry shortly prior to the hearing in November 2019. However, having regard to the evidence that I received and X Nursing Home's CQC report, I am satisfied that care and treatment AM receives there is very good, and that the general service provided is good.

²⁰ I asked IR whether ECCG might reconsider for how long it could keep open AM's bed at X Nursing Home, and for its position to be confirmed at a higher level. The CCG later confirmed its position: Although 14 days is necessarily a somewhat arbitrary figure, it believes that it should not offer longer, having regard to its budget and reasons of equity (the need to be fair to other local patients with a claim on its budget).

to lose a lot:²¹ a place at a nursing home with a national reputation, within a short drive from home, which provides him with good quality care and treatment, staff who know his needs, family visits daily for 8-9 hours, and the possibility of visits to his Mosque and the family home.

His wife's answer to this observation was, in part, that she cannot go on as she has been. If her application is refused, she is too worn out by many years of driving and caring for AM to be able to continue to visit him at X Nursing Home, or at any rate to do so regularly (see e.g., G/295-G/304). It is not the case therefore that her husband will have the benefit of her presence and care for much of the day regardless of the outcome. Her absence will not only cause him distress. It will adversely affect the quality of his care at X Nursing Home. Staff rely on her to perform oral care and other tasks, and her presence means that his behaviour is less oppositional. Nor, if he remains at X Nursing Home, is it possible (or, at any rate, likely) that he can also have the benefit of enjoying time at the family home and his local Mosque. His sitting tolerance and the journey time make visits to his local Mosque impractical, and a Disabled Facilities Grant will not be available to fund adaptations to the family home if he is not residing there.

I have given considerable weight to AG's evidence, and I greatly admire all that she has done to support her husband. Her contribution to his care and well-being is particularly significant. Her presence makes him calmer.²² She does sometime pick up on things that other people, including his children and care assistants, do not notice. She has a good record of appreciating when he is unwell or is not behaving normally; she will ask him questions, and he will respond either verbally or with gestures, pointing to an area of his body. She has demonstrated an understanding of knowing when to call the GP, for example in August 2018, which led to AM being prescribed antibiotics and then being admitted to hospital (see I/47-48; K/190).²³ She also assists staff with communication. For example, the daily record sheet on 21 September 2017 records that AM's 'wife reported that AM also requests for feet to be elevated' (K/15).

Fulfilling a caring role in the conscientious way that AG has been doing over many years is exhausting, and a 30-45 minute drive to the nursing home in urban traffic adds to the strain. I hesitate to turn her own virtue against her. However, it is because of her unwavering devotion and commitment over so many years that I find it implausible that she will cease to visit AM if the court refuses her application, or visit only occasionally. I accept that she is suffering from long-term fatigue and that her own health may well have suffered. I am her husband's decision-maker and, if he realised the strain she is under, he would no doubt want me to give weight to her comfort. I have therefore factored into my decision the fact that caring for him at home will spare her the daily drives, be better for health and add to her happiness.

²¹ Ms TR considered that any deterioration in AM's health would be likely to result in admission to an acute hospital, whilst a breakdown in the care package would necessitate admission to a different nursing home, unless it were to occur within the first two weeks.

²² DL, the Head of Service at X Nursing Home, stated that, 'The RN agrees that AM is calmer when his wife talks to him in his first language, Somali' (G/305).

²³ As concerns the care provided to AM in August 2018, when he was admitted to hospital with a chest infection, Ms TR could find no evidence of a lack of care, commenting that medical, nursing, therapy and care input had been appropriately delivered and recorded. She was, though, critical of the fact that a hyoscine patch had not been appropriately administered during this period, which would have contributed to AM's oral secretions.

On balance of the evidence, I find that AM's sitting tolerance has improved and that visits to his local Mosque are now likely to be possible. As to the possibility of visits home, it was not established that the £11,000 cost of adaptations to the family home cannot be funded. If an application for a Disabled Facilities Grant is refused, this still leaves open the possibility of obtaining funding under other legislative schemes, such as the Chronically Sick and Disabled Persons Act 1970. In my view, home visits ought to be a key part of any care and treatment package at X Nursing Home.

Available Home Care Package

The CCG is willing to fund a care package at home. However, given its finite resources, the following was the most that could or would be funded:

- Four care visits per day, carried out by two carers each visit;
 - One overnight waking carer, 'to observe that AM's position in bed remained optimised to mitigate the risk of aspiration of his overnight feed via PEG tube' (see G/344);
 - Once daily district nurse visits, in order to give insulin and to monitor blood sugars.
- As to who would actually provide the paid care:
 - Local community nurses, combined with a Clinical Nurse Specialist provided through the community dietician service, would be able to manage AM's basic needs relating to the PEG feeding tube system and his insulin management:

'NHS Community Nursing would be able to provide daily administration of subcutaneous insulin injections, reading of blood glucose levels and providing response to concerns raised by family members and care provider staff regarding skin integrity' (G/348).

'[The] NHS Community Dietician service ... provide telephone contact within 5 working days of receipt of a fully completed written referral to check there are no immediate concerns following discharge and will provide a Dietician home visit within 2 weeks. Once AM is set up and has a stable regime, Dietician follow up AM face to face every 6 months with telephone calls in between. AM's weight and Body Mass Index would be monitored every 6 months most likely by taking a mid-arm circumferential measurement as his safety would not be able to be maintained in a standard weigh chair. // The service provides a Clinical Nurse Specialist who is able to train family members and care provider staff on how to look after the gastrostomy tube, stoma site and administer feeds. The Nurse is able to change the balloon gastrostomy tube when it is due for changing and the Dietician will ensure that spare consumables are available at home' (G/348).

'Any deterioration in his condition would require referral to the GP for assessment and to initiate treatment or therapy management options' (G/344).

- A care agency called CM had visited AM to assess him. It reported that they would be able to care for him with a team of six carers who had the required competencies. Furthermore, their insurance would not prevent them from being able to work with trained and competent family members.
- The remainder of the personal care at home would need to be provided by family carers. They had agreed a family care rota to provide the additional care which AM needs that the NHS cannot fund. The original rota is at G/473. At the time it was written, it was likely that AG would require knee surgery and be out of action for several weeks. The rota is carefully thought out and comprises three weekly alternatives: a rota for when AG is fit to provide day and night care; a rota for when AG is fit to provide day care but not night care; a rota for when AG is unfit to provide any care. In the event, AG underwent a right total knee replacement on 19 August 2019. In my view, by the time the hearing resumed in November 2019, the general concerns which the Third Respondent raised at the hearing in April 2019 — that AG's own health might prevent her from being a carer or from performing some of the care tasks required of her — were not supported by the evidence (see the OT assessment and the letter from her Consultant Orthopaedic Surgeon, at G/496).
 - The competencies which paid and unpaid carers will require were assessed and set out by IR on behalf of ECCG at para. 5 of his statement of 31 January 2019 (G/344-G/345). They include matters such as manual handling, positioning requirements, correct use of equipment to ensure AM's safety, personal care, PEG and water system operation, respiratory management, communication strategies, social activities and stimulation, and the identification of when to alert clinical services as required. All of the proposed family carers were willing to undergo necessary training and accepted the need to meet the required competencies. The CCG told me that it would support them in accessing the appropriate training. Evidence of completion would be required prior to discharge. Many of the required competencies are considered valid for one year only and therefore refresher training will be necessary (G/345).
 - I have no concerns about the suitability of the proposed family carers. AG has been providing care to her husband at X Nursing Home over many years. AM's sister works as a paid carer for a care agency, and she already spends 2-3 days at X Nursing Home caring for her only brother. AG's and AM's daughter HH was previously co-President of her university student union, and impressed me by her willingness to make considerable personal sacrifices to look after her father. MH2 runs a tutoring company and, as a diabetic himself for 20 years, has a particularly good understanding of that area. HAM is a qualified optician. All of the children can assist AG with translation and interpretation. As to the required competencies, they are able to understand and implement some quite technical requirements.
 - Given their commitment and skills, and the careful way in which they have devised a home care package, I do not share TR's reservations about the sustainability of a home care package. Nor do I believe that they have under-estimated the level of care and expertise required to continually care for someone with AM's needs (I/49-I/50). They have been providing a great deal of care for many years already, are highly intelligent and have a very good understanding of what is required. They consider that it is their duty, and an honour, to care for AM within the family home. Their devotion and commitment to him, and their willingness to give up their time and comfort, and in one case their job, to care for him is admirable.

- The local authority's Adaptations Team considered that it was reasonably straightforward to adapt the family home to suit AM's needs (see the statement and plans at I/9-I/12). The necessary work could be completed within around six weeks of approval by the relevant housing department, and the preliminary view was that the proposed adaptations would probably be approved. TR, the independent nursing expert, also considered that the proposed adaptations would be appropriate and provide adequate accommodation. However, the accommodation would be 'cramped' and carers could be hampered in their delivery of care. She raised a concern that AM's dignity could be compromised during transfers to the bathroom, but I think it likely that overall being cared for in his own home, with his wife or a family member present, will be a more dignified experience for him.

Looking at this package, it can be seen that the family have worked thoughtfully and assiduously to construct a viable alternative to X Nursing Home. Equally, ECCG and the relevant local authority have put in a lot of hard work to assist the family with their endeavour. That is particularly commendable given their limited resources and the fact that they believe that remaining at X Nursing Home is in AM's best interests.

There is much that can be said in favour of AG's application. AM wishes to live at home with his wife and family, and therefore my starting point is to try to enable him to live the life he wishes if it is feasible: the underlying purpose of the Act is that it is an enabling Act. He is fortunate in having a devoted wife and family. The family home can be adapted to suit his needs. The CCG have constructed a care package which, taken with the family care rota, meets his day-to-day care requirements. Furthermore, although the package is not equivalent to what is provided at, or readily-available, on-site at X Nursing Home, it is nevertheless a significant package of care.²⁴

I agree with much of TR's balance sheet (I/33-I/35) but not with all of her assessment of the burdens of home care. The family carers are competent, devoted and willing to undergo training; it is inevitable that assuming a care role comes at a cost; on the evidence I believe that the pool of carers is sufficient; I do not agree without more evidence that the fact that AM has not been home since 2009 is likely to be a significant problem; the family home can be adapted and 'made fit for purpose' quite easily; the family carers are sufficiently experienced and committed that I find it is more likely than not that they can sustain their care roles; a suitable domiciliary care provider appears to have been identified; and I believe that regular visits to AM by MH can be managed by the court if necessary. The burden that I agree with is that, 'AM will not have immediate access to the Primary Care Services i.e. GP, Community nurses and therapists.' This, it seems to me, is the fundamental difficulty.

Despite the fact that AG's application and care package has many positives, there are difficulties. There is a past history of conflict; the service provided will be reactive rather than active in many areas; and the issue of GP and medical input has still to be considered.

A past history of conflict

²⁴ ECCG has recently 'reprocured' its adult community, nursing, dietician and therapy services, which resulted in a new NHS provider taking over the delivery of the contract (G/349). Given AM's vulnerability and need for support, I have borne in mind that there is always a risk that some services may not remain available to AM, and also that the current configuration of local services may change, for better or worse.

I am mindful that the Third Respondent, MH, says that his family life with his father will be negatively affected by a return to the family home. He says that AM's residence at X Nursing Home ensures both that his health and care needs are well managed and that he is able to spend time with all of his family, who are all kept aware of his wellbeing.

The Court of Protection bundle for the original proceedings contains significant evidence of conflict between AG and proposed family carers, on the one hand, and professional carers and the Third Respondent on the other. In my opinion, the Third Respondent was unfairly and unjustly treated. Most of the criticism of professionals was also unfair and damaging to AM's interests. The picture is a familiar one for a Court of Protection judge, of tension and conflict between distressed step-relations with different perspectives, and of conflict between a distressed family and professional services that spiralled completely out of control.

The picture is different now. The oral evidence of AG and the proposed family carers was measured and fair. All of them reiterated that they understand the need to work co-operatively with medical staff and professionals. They also emphasised that the Third Respondent would be welcome to visit his father at the family home. I believe that their offer is sincere, and a genuine attempt to move forward in a more collaborative way. The history of past conflict does make it inevitable that, at least initially, there would be a certain tension or awkwardness in the air during such visits, which the Third Respondent does not have to endure when he sees his father at X Nursing Home. However, I do not think that this in itself would justify denying his father the opportunity to live in his own home if his needs can be met there and the risks can be adequately managed. The family carers would have a considerable incentive to avoid MH's visits breaking down and the matter coming back to court. Furthermore, if it ever became necessary, the court could facilitate visits by way of a visiting schedule and/or undertakings or orders concerning the behaviour of family members who are not carers, such as AG's son GH. I would be fairly confident that the court could deal with any difficulties.

Medical and GP input

This is, I believe, the critical issue. The Official Solicitor submitted, and I agree, that the evidence establishes that the proposed care package at home comes with risks but is potentially viable save for the issue of the medical input that AM requires.

It was the Official Solicitor's submission that the concerns about the quality of the clinical and medical care which can be provided in the community, and the consequential health risks, are so significant in the balancing exercise that they amount to the 'magnetic factor' in the overall determination.

Having reviewed AM's records, Ms TR told me that there is very little day-to-day GP input at X Nursing Home when he is well. However, when he is unwell and needs medical input, he tends to need it quickly. He will then be visited daily at X Nursing Home, which (she says) is more often than is likely to be available from a GP practice at the family home.

In the original proceedings, no general practitioner was willing to provide GP services to AM should he be discharged home.

A letter from local GP Dr VT dated 25 September 2013 (G/431) states:

'I have reviewed the details provided and based on my opinion and experience on managing brain injury patients ... I believe this gentleman will require enhanced medical and nursing support to be able to remain at his home address. He will most likely require daily nursing intervention and I suspect anything up to three times a week medical review and intervention ... I believe it would be very unlikely that a Primary Care Surgery would be able to provide this service without enhanced provisions and capacity.'

There is then a letter from local GP Dr ML (G/53-G/54), undated but written in 2014. Dr ML visited AM on 24 April 2014, and his letter has that extra weight. He reported:

'It is my opinion after my visit that our practice will definitely not be able to give an adequate level of support to this patient in a home environment. Indeed, I feel that he needs to be in an environment with 24 hour nursing care and a home discharge would be dangerous and potentially disastrous

I also understand that AM is prone to getting frequent chest infection and silent aspirations which do not present with the normal symptoms, and he tends to deteriorate very quickly. It requires skilled medical staff, who know him well, to identify early signs and initiate early treatment to prevent him getting very ill. I am afraid that primary care and GPs are simply not able to give that level of care and supervision at home, and again I think it is imperative that he remains in some kind of facility with 24 hour nursing input.'

By the time the previous proceedings concluded, it had not been possible to secure GP services for AM at home, despite the involvement of NHS England.

The carefully constructed home care package which the family and CCG have put together in the current proceedings was not a feature of the earlier proceedings. There are also other reasons to be more positive now, for example much reduced conflict. However, as will be seen, it remains the case that no local GP considers that they are able to provide AM with sufficient medical input at home.

If AM does return home, the service provided to him by whichever GP practice he is registered with would be provided in accordance with the GP's contractual requirements.

It is important to note that the CCG 'do not expect GPs to provide active management home visits for patients in the community' (G/347). They provide reactive care. IR deals with this distinction at paragraphs 8 and 11 of his statement of 31 January 2019 (G/346-G/347):

'8. At [X Nursing Home], AM has access to 24 hour nursing care and active medical management ... any deterioration results in ... prompt access to medical treatment and therapy. The optimisation of AM's health and care needs has resulted in stabilisation of his well-being and fewer hospitalisations. At [X Nursing Home] any significant clinical concern is assessed by a specialist nurse who is part of a 24 hours per day service. A referral will be made to the unit's dedicated on-site GP service which is available Monday to Friday from 0900hrs to 1700hrs enabling response straight away. Out of hours and on weekends the on-call GP service is called by the nurse and expected to be onsite within one hour if they are required to attend ... the ward has 24 hours a day, seven days a week nursing presence ... A SALT [Speech and Language Therapist] and two physiotherapists are allocated to the unit Monday to Friday 0900 to 1700hrs who are able to see AM straight away for urgent swallow and chest

physiotherapy. A Dietician reviews AM monthly, or as required to monitor and adjust his nutritional intake

11. The CCG's position is that reactive GP care would be adequate but sub-optimal compared to level of service he currently has access to at X Nursing Home. The CCG has concerns that the services available in the community are unable to respond in the rapid manner he is currently able to access. At X Nursing Home his ability to access early assessment and treatment has helped mitigate escalation of medical deteriorations when they occur, enabling him to remain where he is familiar by limiting the need for hospital admissions. His poorly controlled blood pressure and blood glucose levels have now been optimised with this level of medical input. In the community, if unable to access GP or other community services for assessment and treatment, AM would need to attend hospital to meet his needs. The current GP service at X Nursing Home is experienced at working with patients such as AM due to their relationship with the unit.'

Most of AM's contact with carers is with paid care assistants and family carers and this will not change if he goes home. However, it is obviously a benefit for AM that at present there is an on-site GP service between 9am and 5pm, that out-of-hours a GP is expected to be on-site within one hour, and that X Nursing Home has a nursing presence 24 hours a day. This, I am told, has facilitated early assessment and treatment and avoided an escalation of medical deteriorations, which in turn has reduced the number of hospital attendances and/or admissions.

It is significant that it is not just local GP services that are reactive rather than active:

- The time of NHS Community Nursing home visit can only be approximated reflecting the daily fluctuations in demands on the NHS Community Nursing service.
- The NHS Community Dietician service is a Monday to Friday service. The Clinical Nurse Specialist is able to respond to urgent issues within 2 working days. If for any reason the nurse cannot make it to the visit or it is outside working hours, the patient would need to go to hospital.
- The NHS Community Speech and Language Therapy (SALT) service requires referral from a GP or Clinician. They respond to urgent referrals within three days or alternatively within six weeks as standard. The service is not able to provide on-going monitoring and maintenance therapy once the reason for referral has been resolved or stabilised.
- The NHS Community Physiotherapy service will respond to urgent referrals within three days or alternatively within six weeks as standard. The service is not able to provide on-going monitoring and maintenance therapy once the reason for referral has been resolved or stabilised.

Most of the relevant therapies — such as physiotherapy, speech and language, and dietician input — will be reactive only once the home care package is established. There would be a delay of 2-5 working days in obtaining face-to-face assessment and input in most instances. In contrast, at X Nursing Home, a speech and language therapist and two physiotherapists are allocated to AM's unit between 9am and 5pm on weekdays.

The response of GP practices contacted in the current proceedings

The GP practice initially contacted on AM's behalf was that nominated by AG, namely C Rd GP Surgery. IR told me that it is open from 8am to 6.30pm from Monday to Friday. It provides a home visit service in between the morning and afternoon clinics when GP capacity allows; this would have to be requested first thing in the morning. If there is no GP capacity on the day, a GP would attend the following day. The practice nurses are not able to make home visits. Out of hours, the NHS 111 telephone service would have to be used. If a blood sample is required for diagnostic purposes this could be undertaken through the domiciliary phlebotomy service on a Thursday. There is a 2-3 week wait for domiciliary phlebotomy.

What this seems to mean is that if a GP cannot visit in the middle of the day (between the morning and afternoon surgeries) or AM needs immediate medical evaluation or attention outside this window, the gap will need to be filled by NHS 111, the local Rapid Response Service and, where necessary, an ambulance to A&E.

The local Rapid Response Service (RSS) is part of the local Home Ward service. It requires a telephone referral from the ambulance service, a GP or from members of a patient's primary care team after discussion with the GP, e.g. district nurses. It is an urgent service and would not be an integral part of AM's care package. It can be contacted between 8am and 10pm daily. This multi-disciplinary team is composed of consultants, doctors, advanced nurse practitioners, nurses, an occupational therapist, a physiotherapist and rehabilitation support workers. There is no defined limit on how often the service can be used. However, IR said that the frequency with which it is used could indicate that a home care package is insufficient to meet the patient's needs.

The service provided by the Rapid Response Service is described at G/501. Following referral a member of the team will triage the patient. In practice, it is most likely to be a nurse or an 'associate healthcare professional' who is sent out (oral evidence of IR).

Broadly speaking, the triaged patients are then dealt with in one of three ways:

- Some patients will be suitable for the 'Home Ward' service. The Rapid Response Service's admissions guidelines state that the 'Home Ward' service 'aims to avoid admissions into local hospital and facilitates the safe treatment of patients in their own home, for example in cases of, *inter alia*, 'simple' chest infection; exacerbation of COPD/shortness of breath with 'observations stable'; falls/reduced mobility; hyperglycaemia ('no ketones/not unwell').
- At the other end of the scale, the suggested outcome is usually that the patient should be taken to Accident & Emergency (A&E). The admissions guidelines give as examples the following types of medical condition: acute dysphagia/swallowing disturbance, acute eye disturbance, chest pain, choking, new altered level of consciousness, seizures, suspected new CVA. IV antibiotics can, however, be dealt with by the district nursing service.
- In the middle are an intermediate range of medical conditions which 'may warrant discussion with doctor to consider the safest and most appropriate alternative service'. These cases do not fit so easily into the Home Care or A&E paths, and the triage outcome turns on a careful weighing up of all the signs, symptoms and options. In some of these cases, 'if the suggested alternative service does not have capacity and the next option is to refer to A&E, we should consider whether we can safely manage the patient in the short term to avoid an acute admission'. Examples of medical conditions that may come within this intermediate band are blood tests

in the context of acute care, delirium, acute/chronic lower back pain, 'primary PEG issue', 'primary problem – wound care/blocked/bypassing catheter'. The outcome options include District Nurse service, A&E, palliative care service, domiciliary phlebotomy, Home Ward, GP service and hospital.

Unfortunately, C Road GP Surgery declined to register AM. The surgery stated that it is a 'smaller' practice and there are more suitable larger practices closer to the applicant's home. Furthermore, 'it would be a safeguarding issue for a patient with AM's needs to be managed in the community' (G/344). An email was received by IR from Dr F at C Road Surgery during the April hearing, which was admitted into evidence as 'Exhibit 2'. In that email, Dr F set out his reasoning for strongly recommending that AM should not be registered with his surgery. His reasons included that AM requires a doctor and team with specialised skills

'which is over and above what we could provide and is not covered by our GMS [General Medical Services] contract with NHS England;²⁵ the input needed from a GP practice contractual arrangements do not cover a practice for the amount of input that a patient with AM's needs should receive and these types of patients are normally cared for under separate enhanced contractual arrangements ... Registering a patient like this in an unplanned way and assuming a practice could cope, would potentially put staff and other patients at risk due to the disproportionate amount of time needed by such a complex patient.'

According to Dr F, caring for AM at home would put him 'at massive risk of hospital admissions, re-admissions and rapid deterioration in his health due to the nature and relatively slow response of primary care to urgent issues'. He went on (J/33):

'Registering him with a GP practice amounts to willingly harming his health and the first thing a GP team would do upon being faced with such a patient would be to admit him to hospital again and seek placement for him in a nursing home as a matter of urgency.'

The CCG told me that under contractual arrangements it would compel C Road GP Surgery or another surgery to register AM if the court ordered that AM should return to live at home with his wife.

In oral evidence, IR stated that no patient would or should be admitted to hospital unless there was a clinical need. He disagreed with Dr F's view that there would be a 'massive' risk of hospital admissions, and described that as 'an exaggeration'. A move home, and registration with a GP surgery, would be 'moving from a proactive to a reactive service'. The

²⁵ General medical services (GMS) contracts deliver core medical services and are agreed nationally. The funding for these types of contract is calculated based on the practice's registered list size with a fixed, nationally agreed, price per patient, and the actual amount paid is calculated practice-by-practice. Patients such as AM are likely to require significantly more care from their GP than the standard nationally agreed price per patient. Enhanced Services (ES) require enhanced service provision over and above what is included under core GMS contract funding. They are commissioned nationally through the GP contract. ECCG provides local enhanced GP services to all but three of 41 local nursing homes through the A GP Surgery, in order to prevent unnecessary hospital admissions. When I asked IR whether ECCG might allow AM to receive an enhanced service at home from A GP Surgery, he told me that it could be done 'in law but we don't do it. It would not be equitable to do it for one patient'. I asked for that position to be confirmed at a higher level, and the CCG's position was confirmed after lunch on the third hearing day.

CCG considered that reactive care would be 'adequate but sub-optimal' compared with the care which AM receives at X Nursing Home. The CCG was concerned that community services would be unable to respond in the same rapid way as at present, which has limited AM's need for hospital admissions.

I agree with IR with regard to Dr F's evidence. IR's assessment and language was measured in a way that Dr F's was not, and was based on a careful and thoughtful balancing of the relevant factors. I find that Dr F's stated view was exaggerated. To my mind, the use of phrases such as 'willingly harming his health', and the suggestion that a GP would simply have AM readmitted to hospital if he was discharged from X Nursing Home, cannot be supported. The weight I give his evidence is that he is another GP who strongly believes that AM should remain at X Nursing Home.

Because the problem of GP and medical support at home could not be resolved adequately at the hearing in April 2019, further evidence was filed about other local GP practices with whom AM might potentially be registered (G/461-G/464).

The CCG contacted B Road Surgery, the closest GP practice to AG's home. It responded that it was 'not willing to register' or 'would prefer not to register' AM as a patient. Having reviewed the report of Dr AJ, it was their opinion that it is not possible safely to provide, in the community, the level of medical input that AM requires. Their view was expressed in measured tones.

AG then asked that EP Health Centre be approached and the CCG contacted it. The response was similarly negative. The partners had reviewed AM's case. They felt that his needs would be 'extremely difficult to meet in primary care'. Furthermore, it would be better if he was registered at the same practice as the rest of the family. However, as the practice could not refuse to register a patient within their catchment area, if a request was made that AM be registered with them, they 'would have no option but to accept'.

Unfortunately, the position therefore is that no GP practice has at any stage in the two sets of proceedings been willing to provide community medical support for a home care package. I find that there is an economic factor, as well as a safety factor, in this. To my mind, Dr F's email and Dr VT's letter make this clear. No doubt a GP would be professional and do all that is professionally required of them under their general GMS contract. The problem is that they might not be willing to continue to do, or be in a position to do, more than is professionally required of them under the contract; and their common evidence is that that is insufficient. I understand their point that enhanced services are required.

A suggestion that the family might wish to investigate whether supplementary GP support could be available from a medical practitioner within the local Muslim community, perhaps as a religious obligation, was not practical. Although in theory it might fill some service gaps, such a GP would not have access, or sufficient access, to NHS GP notes, and there might be problems of insurance, working or liaising with NHS community nurses, and so forth.

Given this situation and the current configuration of local NHS services, what then would be the likely consequences ('risks') for AM of receiving home treatment and care if the medical input is provided by a local GP under a GMS contract?

Dr ML referred to the fact that AM is prone to getting frequent chest infections and silent aspirations which do not present with the normal symptoms, and that he tends to deteriorate very quickly. It requires skilled medical staff, who know him well, to identify

early signs and initiate early treatment to prevent him getting very ill. Consistent with this, IR states that the additional medical risks include increased vulnerability to a deterioration in his health and increased risk of hospital admissions ('almost inevitable'), of more severe illness and of premature death (G/347-G/350):

'12 ... The likely consequences of community GP, nursing and therapy services being unable to meet his needs in a timely manner include:

- *AM will be more vulnerable to deterioration in his health and increase his risk of premature death.*
- *AM will be at increased risk of requiring hospital to access assessment and treatment.*
- *Delays identifying deteriorating health conditions may result in a more severe form of illness each time. Non-clinical care staff and family are providing 24 hour care, their scope of practice does not require them to have the assessment skills of a trained nurse who are currently accessible 24 hours per day. Community nurses would attend once per day and AM may need to wait 72 hours if over the weekend to see a GP.*
- *The medical management available in the community is sub-optimal compared to the current team of GPs, nurses, therapists and care staff with a special interest and skills training in his areas of need.*
- *Reduced consistency of staff availability and frequency of visits in community. There would be a reliance on the family to be able to communicate what is of concern for AM who is unable to communicate for himself.*
- *Increased stress on family members when/if he becomes unwell to coordinate all the service providers involved in his care.*

14.1 The CCG believe that with the medical supervision and access to the community services available, management of AM's health and wellbeing needs would be sub-optimal. His risk of frequent hospital admissions would be increased as would his potential for a premature death as compared to if he were to remain in a 24 hour nursing care environment. The level of care and safety that he is able to access in a 24 hour nursing care environment cannot be replicated in the community.

14.2 In the community, GP services available are reactive, all treatment and therapy as a result of GP assessment would require GP referral and may take 3 days for face to face service initiation.

14.3 The CCG believe, that the increased risk of delays in accessing services in the community would require more hospital admissions than he has required while at X Nursing Home.

14.4 AM would need to be admitted to hospital to access the nursing, medical management and therapy he is able to receive currently in house at X Nursing Home.

14.6 AM's situation at home would result in significant risks being sub-optimally managed leading almost inevitably to increased admissions to hospital.

14.9 If AM is discharged from X Nursing Home, he is most unlikely to be readmitted there, given the high demand for places and lengthy waiting list.

Some of these risks may not materialise. However, they are sufficiently serious that they can properly be categorised as risks connected with AM's safety, because they include increased 'vulnerability' to a deterioration in AM's health and increased risk of hospital admissions ('almost inevitable'), of more severe illness and of premature death.

Conclusions

A trial is not needed if one can be reasonably sure of the outcome. It is sensible to test an alternative that may or may not be viable before 'burning one's bridges'. That is not possible here and I must choose.

On balance, I do not believe that currently it is in AM's best interests to be discharged home under the proposed package of treatment and care.

There is much to be said in favour of AG's application. Home has very significant benefits in terms of the warmth and personal care his family provide, cultural familiarity and customs, and visits from friends and neighbours. The valuable contribution which his family now make to his care would be enhanced because a family member would be present to interpret and attend to his needs all the time. His home can be adapted, and the CCG has constructed a care package which, taken with the family care rota, meets his day-to-day care requirements. Although it is not equivalent to what is provided at, or readily-available, on-site at X Nursing Home, it is nevertheless a significant package of care.

I agree with the Official Solicitor that the proposed care package at home comes with risks but is potentially viable save for the issue of the medical input that AM requires.

At present most of AM's contact with carers is with paid care assistants and family carers, rather than with GPs and nurses, and this will not change if he goes home. However, it is a considerable benefit for him that at present there is an on-site GP service between 9am and 5pm, that out-of-hours a GP is expected to be on-site within one hour, and that X Nursing Home has qualified nurses on-site 24 hours a day. This has facilitated early assessment and treatment and avoided an escalation of medical deteriorations, which in turn has reduced the number of hospital attendances and/or admissions. His ward also has a speech and language therapist and two physiotherapists allocated to it on weekdays.

The services provided by AM's local NHS are mainly reactive rather than active.

The CCG has declined to provide AM with enhanced GP services and therefore his medical input will be provided by a GP under a General Medical Services contract.

Under a GMS contract, that GP will not be required to provide more than reactive care. For example, the expectation is that the GP will visit between morning and afternoon surgeries if capacity allows.

The likely consequences for AM of this reduced medical input indicate the appropriate weight which I should attach to this risk: some delays in being assessed and treated (i.e. from time to time, a prolongation of suffering when ill), an increase in the number of

hospital admissions and an increased risk of premature death (compared with how long he would be likely to live at X Nursing Home).

AG has not been able to find a GP who is willing to try to support her husband at home, nor has the court received evidence from a medical practitioner in support of home treatment. As a judge, I am bound to accept the evidential position.

While I accept that most often AG will quickly identify changes in her husband's presentation, and request professional help, it does not follow that the NHS will be able to respond quickly, or be able to offer an alternative to taking him to hospital.

No local GP practice has wished to register AM. The strong resistance of local GPs to assuming responsibility and a caring role for AM has weighed heavily with me, and been decisive.

Someone with AM's complicated needs requires maximum effort and commitment from all involved in providing home care for it to have a chance of success. I cannot rely on the GP who is forced to register AM being able or willing to do more than is required under their general contract.

It is a considerable negative that AM would be the responsibility of a practice that does not wish to receive him as a patient, one that believes that his needs are greater than it can fulfil under its contractual obligations.

AM's medical condition is complicated, he can deteriorate quickly and some signs and symptoms may be difficult to recognise. Given that he will not always have prompt access to medical treatment and therapy from his GP at home, necessarily there is an increased risk of his health further deteriorating before his condition is diagnosed and treated. The fact that a delayed medical response may mean that he is more ill than he would be at X Nursing Home before treatment is commenced brings with it an increase of suffering and an increased risk of hospital admissions.

The Rapid Response Service cannot sufficiently plug the gap in terms of the medical input that will be provided by a GP practice operating under a GMS contract. The RRS is an urgent service and it is not a 24-hour service. It would not be an integral part of his care package. Most importantly, given AM's history and the fact that my concern is with those occasions when he is at risk of becoming significantly unwell, the guideline response will most often be that he should be taken to A&E. Given the unanimous and often frank views of the GPs and other medical practitioners about the inadvisability of home care, it is likely that on reaching hospital there would then be a considerable drag back in the direction of hospital admission and then discharge to another nursing home. Local NHS services are not configured to care for a person with AM's needs at home.

As matters presently stand, on the balance of probabilities it would be self-defeating for me to give practical expression to AM's wishes by authorising his return home. Without committed GP input at home, it is very likely that home treatment would be unsuccessful. By committed support, I mean the type of support that in a different field a legal aid practitioner so often gives to their client, which is willingly given for meagre financial gain and over and above what is legally or contractually required.

It follows that, on the balance of the evidence, I believe that granting AG's application carries a significant risk of her husband losing his place and current quality of life at X Nursing Home without there being a corresponding 'risk of gain' which justifies this risk of

harm. The benefits which he has at X Nursing Home are considerable. He is medically stable, receives good quality care and treatment, is cared for by staff who know him, enjoys excellent contact with his wife and family, and most often appears content. There is also the possibility of visits outdoors, including to his local Mosque and, depending on funding, to the family home.

It is a very sad situation and I am sure that everyone involved in the case regrets the fact that it has not been possible to find a way of reuniting this couple.

Deprivation of liberty provisions

As regards the best interests requirement, AM is being detained at X Nursing Home for the purpose of being given care or treatment in circumstances which amount to a deprivation of his liberty. This is common ground.

For the reasons given, I have found that it is in his best interests to continue to reside at X Nursing Home, and to be cared for there in accordance with the current treatment and care plan, notwithstanding that the arrangements involve a deprivation of liberty.

This is necessary to prevent harm to him. If I permit him to go home in the current circumstances, he will be at significant increased risk of suffering a deterioration in his health, and an increased risk of hospital admissions ('almost inevitable'), of more severe illness and of premature death.

Furthermore, for the reasons given, the current arrangements for his treatment and care at X Nursing Home are a proportionate response to the likelihood of him suffering harm, and the seriousness of that harm (if he were not so detained).

Whether the relevant purpose can be achieved in a less restrictive way

In reaching my view, I have had regard to section 1 and the need for me to consider whether AM can receive treatment and care in a less restrictive way at home. For the reasons stated, I have decided that this is not the case.

Compliance with the European Convention on Human Rights

In my opinion, the interference with AM's home and private life is prescribed by law (the Mental Capacity Act 2005), proportionate (to the identified risks concerning his health and safety) and for a permitted purpose (his health and safety).

Other matters

It is, I believe, very important to AM's happiness that he should have the opportunity to visit his local Mosque and have other regular opportunities for outings. I would therefore ask the parties to agree suitable wording for a condition to this effect.

It is also very important that he has the benefit of visits home. It is worrying that he has not been home for so many years. The cost of adapting the family home to facilitate this is not

large in proportion to the fundamental importance of enabling him to enjoy family life at home from time to time.

If funding cannot be secured, I would ask his solicitor and his wife's solicitor to ascertain whether in the past he was able to visit his home in its present unadapted state, and whether that is feasible now.

I am sure that it will give AM pleasure to be reintroduced to his home, Mosque and local community, and it could open up further possibilities for him.

Future applications

As someone who is deprived of his liberty, AM is entitled to make further applications periodically. How much time the court will allocate to each application will depend partly on whether his circumstances have materially changed. Material changes might include significant changes to local GP and community medical services for people in his position (IR said that the CCG were looking to expand the Rapid Response Service); identifying a GP who is actually willing to try to support treatment and care at home; eligibility for enhanced GP services; the fact that his house has been adapted combined with a willingness to keep his place at X Nursing Home open for longer than two weeks; new medical evidence in support of treatment at home; new medical evidence setting out ways in which he could be successfully treated at home; improvements in his cognitive functioning and/or communication abilities, and/or the devising of new communication strategies by a Speech and Language Therapist, which enable him to say more about his wishes and the risks of home care; more reliable evidence about his past wishes and feelings, when he had capacity.

District Judge Anselm Eldergill

13 January 2020