Neutral Citation Number: [2010] EWHC 1527 (Fam)

Case No: COP 11759646

IN THE COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 24/06/2010

Before :

MRS. JUSTICE ELEANOR KING

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Between :

HBCC	**Applicant**
- and -	
LG (by her litigation friend the Official Solicitor)	**1st Respondent**
- and -	
JG	**2nd Respondent**
- and -	
SG	**3rd Respondent**

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Mr. O'B (instructed by **HBC**) for the **Local Authority**
Miss S (instructed by) for the **1st Respondent**
JG appeared in person
SG appeared in person

Hearing dates: 29th, 30th & 31st March 2010

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Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

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MRS. JUSTICE ELEANOR KING

This judgment is being handed down in private on 24/6/2010 It consists of 30 pages and has been signed and dated by the judge. The judge hereby gives leave for it to be reported.

The judgment is being distributed on the strict understanding that in any report no person other than the advocates or the solicitors instructing them (and other persons identified by name in the judgment itself) may be identified by name or location and that in particular the anonymity of the children and the adult members of their family must be strictly preserved.

Mr. Justice Eleanor King :

1. These proceedings concern LG, a lady of venerable age. She was born on 8 February 1914 and is now 96. JG, the (Second Respondent), is the daughter of LG and SG, (the Third Respondent), is her son. This court, in its capacity as the Court of Protection, is charged with determining whether LG remains capable of making decisions in relation to all aspects of her life and care and, if not, to consider how in her best interests, her future care can best be provided.

2. Expressed simply, the issue before the court is whether LG should remain living at the (QM), where she has lived since 1 September 2009 or whether she should return to the care of JG at ; her home prior to an admission to hospital on 18 August 2009.

3. Procedurally, the route by which the matter has come before the court has been via permission granted on 22 September 2009, pursuant to section 50(2) of the Mental Capacity Act 2005, to the Applicant Local Authority Borough Council (HBC) permitting them to make an application for various declarations as to LG's capacity to make decisions as to her residence, contact and care and, if she lacked such capacity, thereafter to make best interest declarations.

Background

4. For many years JG has had a difficult relationship with her mother, LG, although they have lived together for much of JG's adult life.

5. LG was first referred to HBC in 1999. At this time LG lived with JG who provided her mother with most of her day to day care. JG was herself recorded as having spondylosis of the spine (but see later in this judgment in relation to JG's health) and was at this time having difficulty providing her mother with the support she required. A carer's assessment was accordingly completed on JG and following the provision of appropriate equipment, the case was closed.

6. It seems that at times rather than JG caring for LG the perception was that LG was caring for JG. A referral was made in 2000 from a Community Psychiatric Nurse of whom LG was a patient; she reported that LG was becoming increasingly frail, she had poor mobility and because of her increasing frailty, was having problems struggling with the demands of being the sole carer of JG (presumably due to her Spondylosis). Furthermore, JG it is recorded was suffering from mental health problems and was, it was said, prone to hysterical and histrionic behaviour.

7. A further referral was made in 2002, following a domestic incident in which JG had allegedly pushed her mother over. In September of 2002, JG contacted the Applicant stating that the relationship between herself and LG was deteriorating and that there were tensions with other family members.

8. The limited information available in relation to this period does indeed reveal that throughout the period 2002 – 2003 there were disputes within the family as to what was in the best interests of LG. LG spent periods of time living with each of her

niece, her son and her daughter. There were regular allegations made by the family that JG was violent towards her mother.

9. In 2005, following a hip operation LG, who at that time was living alone, decided that she was unable to manage living on her own any longer and elected to move in with JG and her then partner at . Arrangements were made by social services to support JG in her care of her mother including a direct payment from social services to provide 21 hours of additional support to help with LG's personal care. On 28 June 2006 a review of the care package was carried out which identified no specific issues requiring action on the part of the local authority.

10. In August 2007 LG had a spell in hospital; when she was discharged she returned to live with JG, now at . A substantial package of care was put in place which included assistance each morning and evening, as well as 21 hours a week social support and a sum of money to cover sitting services (to allow JG time off) and 4 weeks respite care a year.

11. On 26 January 2008 LG was taken to the local Accident and Emergency department. The history given by JG was that LG had banged her lower right leg the previous week, that the wound had thereafter "burst". JG said that the District Nurse had been concerned about the wound and had suggested a referral to A & E.

12. The medical records show that on examination at the hospital *"the right lower leg was grossly bruised and swollen, foul smelling, infected and discharging with a large area of skin loss to the medial lower leg"*. The two sketches in the medical records show an open wound covering a significant portion of the lower leg. This wound was sufficiently serious to require skin grafts to be carried out on LG's leg under general anaesthetic.

13. All this was unpleasant enough for LG, but it subsequently became apparent that JG (who had been a nurse some 17 /20 years previously), had carried out some amateur surgery on the wound immediately prior to taking her to hospital. In evidence JG said the GP had seen the initial injury and the District nurse had subsequently seen to dressing the wound. The dressing had, JG said, thereafter 'slipped' she said:

> *"I knew there would be clots there needing evacuation and the skin around the haematoma becomes dry"*

14. JG went on to describe how the wound was bleeding and so she had decided to *'clean it up herself'* before taking her mother to the hospital. She therefore cut away the *'dead tissue'* with some *sterile scissors* and *'once she had made sure the wound was not open to further infection or the air'* she took her to hospital. When asked why she hadn't taken LG straight to the hospital or called the paramedics out to the house, JG said that she supposed she could have but had she left it, *it could have caused further infection on the way to the hospital.* When the inappropriateness of what she had done was put to JG by Mr O'B, Counsel for the Applicant, JG said that she had taken *'quick action'*, did not reproach herself for what she had done and that *'it is an utter disgrace'* if anyone suggested that what she had done was wrong.

15. LG was deemed to have capacity at that time and said she wished to return to JG after the surgery.

16. Unsurprisingly the District Nurse was most concerned about JG's behaviour and so when on 15 February 2008 in her presence, JG ripped the dressing off the skin graft she reported the incident to the duty social work team on the basis that it was alleged physical abuse on LG.

17. Soon after this JG asked for additional support in caring for LG To this end from May 2008 onwards the House Home Care Services visited the house four times each day instead of two. There continued however to be allegations of violence and LG complained to a care worker, CB, that JG had hit her. CB herself saw bruises on JG.

18. On 18th June 2008 the police were called to JG's property. They found LG locked in the house, banging on a window and shouting for help. The police rang JG twice on her mobile telephone. On each occasion she hung up before speaking to them. The police had no alternative therefore but to break into the house. When asked about this in evidence, JG said she had herself called the police about something else (unspecified) and she had not hung up it was that she simply could not hear what the police were saying because of background noise. A safeguard referral was made by the police and after consideration the local authority decided to keep LG in the care of her daughter. The situation was to be closely monitored by the in home care team. JG however refused to allow the Elderly Mental Health Team any access to LG to assess her mental health and capacity.

19. Matters finally came to a head in August 2009. On 6 August 2009 there was a further referral from a district nurse. When the district nurse had gone to the house in the morning she found LG with a gash on her head and bruising to her face. The district nurse did not feel that the account of the fall given by JG fitted with the injuries on LG's head and face. The following morning when the care worker went in and saw the injury she was told by JG that she (JG) had rung A & E about the injury.

20. At 4.15 in the afternoon Mrs. A, a care worker, who has been involved in the care of LG for eight years, went to the house. When she arrived LG was standing at the front window banging on the glass and shouting "help me". In her contemporaneous note of the events which followed, Mrs. A describes LG pleading with her not to leave her and of her saying that JG *had "beaten her up during the night"* At 6.45 that same evening Mrs. A once again returned to the house, once again she found LG on her own, banging on the window and shouting for help. When Mrs A went in she again found LG crying Mrs A recorded that LG:

> *"complained of a headache and kept touching the bruise on her forehead. I escorted L to the bathroom ... she as constantly asking me to "take her out of there before J gets back" I assisted L to bed.....she was saying over and over again "please don't leave me" at this point J arrived home and she said "hello Margaret, I suppose you know that she fell out of bed, stupid old woman". I informed J that her Mam is very upset and she replied "oh what for this time" I replied that her Mam doesn't like being alone J said "She we will have to get used to it" she told her Mam to "get to sleep".*

Subsequently JG called the local authority saying that under no circumstances were carers to let district nurses in to see her mother. The nurses she said were invading her privacy and her mother did not need them.

21. At some stage that day, 6th August 2009, JG took LG to A & E to have the wound to her head dressed. The notes show that JG appeared at that stage to be suggesting that the injury had been caused by the district nurse whilst LG was at home. In the light of this most serious allegation, a referral was made to the Safeguarding Vulnerable Adults Team. When JG was asked again about the injury, she said on this occasion that the bruises were caused by the nurses in A & E when holding LG's head to look at the bump. JG in evidence did not completely deny making these allegations but suggested that she had, *"floated them"* as possibilities. The bump on the head she said was caused by LG sitting up in bed and hitting her head on the work surface.

22. What ever may have been the nature of the impact which caused this injury I find that on 6th August JG was very upset and in some discomfort. I find that rather than staying with her mother and offering her comfort and reassurance, JG went about her own business leaving LG alone. She did this not once but twice that day with the consequence that LG was twice found banging on the window and calling for help.

23. On 12 August a psychiatrist, Dr M assessed LG as no longer having capacity and consequently two strategy meetings were held. A decision was made closely to monitor the situation but to leave LG at home with JG.

24. The strain was by this time telling on JG and she contacted social services saying she was too ill to care for LG and so on the 14,15,16 & 17 August overnight support was provided for JG.

25. On 17 August 2009 telecare the emergency support service were called; LG had had a fall. When the workers arrived LG was found slumped on the floor between a chair and her Zimmer frame, there was a red mark on her back.

26. The next day, on 18 August, following a further telecare call at 6.45pm, LG was again found on the floor and had been vomiting. When LG was helped up she began vomiting again. JG was advised to call the doctor but I am satisfied she declined to do so. The carers therefore showered LG to take the vomit out of her hair and assisted her to her chair. Once again LG was distressed and asking the home carer to take her away from the house.

27. On 19 August social services were made aware of the previous day's events and in particular that JG had declined to seek medical attention for LG. A decision was made to remove LG from the house and to take her to hospital to be assessed. The police, district nurse and a Best Interests Assessor attended at the property. When they arrived LG was once again found on her own in the house. She willingly got in to an ambulance and was taken to hospital to be examined. LG was examined by a Dr A a Consultant Accident and Emergency specialist at Hospital. She was found to have numerous bruises on her legs, body and her arms as well as a laceration to the head.

28. Dr A gave evidence before me. In cross examination LG who represented herself with the assistance of a McKenzie friend, asked Dr A *'Have you ever assaulted me?'* in her closing submissions JG suggested that Dr A had some grudge against her linked, she implied, with them having worked in the same hospital many years ago. Dr A appeared to recognise LG as a 'scrub nurse' who had worked in the same local

hospital as him many years ago, but he clearly had no recollection of any allegation that he had assaulted LG. This strange and unsubstantiated vignette is in my judgment one of a number of examples of "paranoia" exhibited by JG during the course of the trial.

29. Dr A saw LG without JG being present. LG said clearly and unequiically to him that she had been hit on the back of her head by JG. It was put by JG to Dr A, that he had coerced LG into making the allegation. He denied this. Dr A was challenged as to why he had not seen LG with JG present and he explained that he would not have had JG in the room until such time as LG had had an opportunity to give a history of her injuries in the absence of her daughter. Dr A told the court that where a patient says they have been hit on the head and he then found a wound to match the account he would believe, and had believed the account given by the patient.

30. As a consequence of Dr A's examination of LG the hospital sought a deprivation of liberty authorisation under schedule A1 of the Mental Capacity Act 2005. Safeguards were implemented and authorised by the Primary Care Trust with the authorisation being limited to 3 September 2009.

31. On the 1st September 2009 LG was discharged from hospital to the Q M Residential Home, where she has remained.

32. It is against this background that HBC applied for declarations in relation to LG's capacity to make decisions as to where she should live, the contact she should have with others and the care package that she should receive.

The Law

33. Mr. O'B set out the relevant law in his position statement with great clarity from which the summary below is largely drawn.

The Mental Capacity Act 2005 (the Act)

34. Section 1 of the Act sets out the principles which apply for the purposes of the Act.

- A person must be assumed to have capacity unless it is established that he lacks capacity.(s1(2))
- 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.(s1(3))
- A person is not to be treated as unable to make a decision merely because he makes an unwise decision.(s1(4))
- 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. (s1(5))

- Before the act is done, or the decision 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. (s1(6))

People who lack capacity:

35. For the purposes of the Act a person lacks capacity in relation to the 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 disturbance in the functioning of, the mind or brain. [Section 2(1)]. This has been referred to as the <u>diagnostic</u> test. Any question on whether a person lacks capacity must be decided on the balance of probability. [Section 2 (4)].

Inability to make a decision:

36. By s3(1) for the purposes of section 2 of the Act a person is unable to make a decision for himself if he is unable:

    (a) to understand the information relevant to the decision.
    (b) to retain that information
    (c) to use or weigh that information as part of the process of making the decision.
    (d) To communicate his decision (whether by talking, using sign language or any other means.

    This is referred to as the <u>functional</u> test.

37. Section 4 of the Act sets out a checklist of factors that must always be considered when determining whether a decision made on behalf of a person lacking capacity to make that decision for his or herself is in that person's best interests these include:

    a) The determination must not be made 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 her best interests (Section 4(1)).

    b) The person (including the Court) making the decision must consider all the relevant circumstances and take certain steps. (Section 4(2)).

    c) The Court 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 that appears likely, when that is likely to be (section 4(3)).

    d) So far as reasonably practicable, the person must be permitted and encouraged to participate as fully as possible in any decision affecting her (section 4(4)).

e) The views of anyone engaged in caring for the person or interested in her welfare as to what would be in her best interests must be considered (section 4(7)(b)).

38. In summary:

i) The welfare of the incapacitated adult is paramount. The focus must be on that adult's 'best interests, and this involves a welfare appraisal in the widest possible sense taking account, where appropriate of a wide range of ethical, social, moral, emotional and welfare considerations. Where the various factors engaged pull in opposite directions, the task of ascertaining where the individuals best interests truly lie will be assisted by the preparation of a balance sheet as suggested by Thorpe LJ in *Re A (Male Sterilisation)* [2000] 1 FLR 549, 560.

ii) The Court must consider, so far as is ascertainable:
   a) the past and present wishes and feelings of P,
   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 (section 4(5)).

39. The fact that the incapacitated adult lacks the relevant capacity does not mean that his wishes and feelings simply fall out of account. The wishes and feelings of the incapacitated person is therefore an important element in determining what is, or is not, in his best interests. Where he is actively opposed to a course of action, the benefits which it holds for him will have to be carefully weighed up against the disadvantages of going against his wishes, especially if force is required to do this. *See R (Wilkinson) v Broadmoor Special Hospital Authority and others [2007] EWCA Civ 1545, [2002] 1 WLR 419, para 64 and considered in (Local Autrhority X v MM and KM [2007] EWHC 2003 Munby J. (pargraph 123))*

40. It follows that as the inherent jurisdiction is exercised by reference to the vulnerable adult's best interests, then in determining where such an adult's best interests truly lie it is necessary to have regard to his wishes and feelings insofar as he is able to express them.

Article 8

41. Article 8 and its interrelation with and impact upon declarations made under the Act were considered in *Re F (Adult: Court's Jurisdiction)* [2000] 2 FLR 512. In that matter the issues were whether the court should make a declaration that it was in the

incapacitated adult's (T) best interests to remain in local authority accommodation and thereafter to restrict and supervise her contact with her mother.

42. In relation to the Article 8 rights of T. Sedley LJ stated at 531H:

> *"But it should clearly be said now that it is T's welfare which will remain throughout the single issue. The family life for which Art. 8 requires respect is not a proprietary right vested in either parent or child; it is as much an interest of society as of individual family members, and its principle purpose, at least where there are children, must be the safety and welfare of the child. It needs to be remembered that the tabulated right is not to family life as such but to respect for it. The purpose, in my view, is to assure within proper limits the entitlement of individuals to the benefit of what is benign and positive in family life. It is not to allow other individuals, however closely related and well-intentioned, to create or perpetuate situations which jeopardise their welfare. As the European Court of Human Rights said in Marckx v Belgium (1979) 2EHRR 330, Art. 8(1) 'does not merely compel the state to abstain from...interference; in addition to this primary negative undertaking, there may be positive obligations inherent in an effective "respect" for family life'.*

43. In *Re S (Adult Patient) (Inherent Jurisdiction: Family Life)* [2003] 1 FLR 292 Munby J (as he then was) gave full consideration to the corresponding rights under Article 8 of the father and the adult incapacitated son. At page 303 para 42 Munby J said:

> *"If the rights of the father...and his son conflict then domestic law, as we have seen, requires the conflict to be resolved by reference to the son's best interests. In domestic law the governing consideration is the son's welfare. So it is under the Convention. Strasbourg jurisprudence has long recognised that, in the final analysis, parental rights have to give way to the child's - that the case may be one of sufficiently pressing necessity as to justify, in the interests of the child's welfare, the supercession and assumption by the State of parental rights and responsibilities. The answer can be no different where the child, although now an adult, remains unemancipated because mentally incapacitated."*

44. I accept Mr. O'B's analysis of the applicable law and it is against the backdrop of the Statute and case law that I consider whether LG lacks capacity and if so what future arrangements for her care are in her best interests.

CAPACITY

45. Dr S, Chartered Clinical Psychologist was instructed as an independent expert to assess LG's capacity. She prepared two reports dated the 10 November 2009 and 6th March 2010. Dr S is a specialist psychologist dealing with old people who suffer from either dementia type illness or functional problems. She told the court that she has carried out 'hundreds if not thousands' of dementia assessments.

46. Dr S has not met JG. This in itself is a cause of considerable complaint on the part of JG but she feels even more strongly that Dr S should have seen her and LG together. Dr S gave evidence to the effect that on 20 October 2009 she had offered, through JG's then solicitor, to meet JG at her home together with Miss S the Independent Social Worker also instructed in these proceedings. Given the history of alleged aggression revealed in the case papers, Dr. S did not feel it appropriate to meet with JG alone. JG's solicitor responded to Dr S's proposal saying that JG was not willing to meet a psychologist under any circumstances. JG now denies that she gave any such instructions. Having seen and heard JG and Dr S give evidence I prefer the evidence of Dr S in this regard.

47. In fact the Official Solicitor brought to the attention of the court at an early directions hearing Dr. S's sense of having been disadvantaged by not having had an opportunity to see the proposed home of the incapacitated adult, (namely LG), or to see and speak to the proposed primary carer (JG). On 6 November 2009 HH Judge Moir made an order which recorded JG's agreement given to the court to speak to the psychologist on the telephone. Two telephone calls did take place even though there was no face to face meeting.

48. JG was highly critical of these two telephone calls and even appeared to suggest that it was not even Dr S but some unknown third party to whom she spoke. Having seen and heard Dr S I am entirely satisfied that she got as much information and understanding from those telephone calls as was possible in the circumstances.

49. Dr S did not feel that her ability to comment on contact had been compromised by not having seen mother and daughter together given the wealth of statements and contemporaneous contact sheets relating to contact which she had read.

50. Dr S said in evidence that she had attempted to carry out what is called a Mini Mental State Examination on LG. This is a commonly used screening method for cognitive impairment. Dr. S did not proceed beyond the first couple of questions with LG. LG did not know what day it was or where she was. Dr S stopped the assessment as she did not think it to be in her best interests to subject LG to the tests. During the course of the assessment LG did however tell Dr S that JG had hit her.

51. Dr S regards LG as being severely disordered; she put this in context by explaining that there is a scale used by psychologists for assessment with the figure of 30 representing full cognitive functioning. A score of 20 means a dementia type problem. LG, she says, is operating with a score of less than 6.

52. Unsurprisingly in these circumstances Dr S felt unable to get any sort of reliable expression of wishes from LG. She was severely disordered as to time and space. She

thought she was 15 and that her father was coming to see her. This belief on the part of LG is a feature of the evidence although it is disputed by JG. Time and again LG has asked for her father and expressed her desire to go to her child hood home. Dr S explained in her evidence that this is commonly seen in those with dementia; their most recent memory is eroded first, leaving much older memories intact long after the present has evaporated.

53. In summary Dr. S says:

(a) LG suffers from cognitive impairment and dementia. LG has an impairment of, or disturbance of the functioning of the mind or brain. The impairment is dementia which is a progressive deteriorating illness. The diagnostic test in section 2(1) is accordingly met.

(b) LG lacks the capacity to litigate. She has a moderate to severe level of cognitive impairment that interferes with her ability to sufficiently understand, retain and weigh up information about the Court of Protection proceedings. She could not understand the information about the decision to be made or retain that information

(c) LG lacks the capacity to make decisions regarding her residence. She has no insight into her condition. She has expressed a wish to return to her childhood home and believed her father would be visiting. Her cognitive impairment significantly compromises her ability to understand, retain and weigh up the advantages and disadvantages of where she should live.

(d) LG lacks capacity to make decisions as to the contact she should have with others. She was vague about who was in her family and at times unsure whether JG was her daughter or her niece.

(e) LG lacks capacity to make decisions regarding her care. She lacks insight in to her general health and dementia. She requires significant help with personal care and activities of daily living and lacks capacity in this area.

54. In the light of the evidence of Dr. S, HBC submit that the presumption of capacity is rebutted. I agree that on the balance of probability LG lacks the capacity to make decisions as to her residence, the contact she should have with others and the care she should receive. In those circumstances HBC seek declarations that LG lacks capacity in these areas. JG's case as to her mother's capacity lacks clarity. At the end of the day it would seem that whilst she accepts her mother lacks capacity to litigate (hence her acceptance that her mother should be represented by the Official Solicitor) she says she retains her capacity to decide where she wishes to live.

55. In my judgment the evidence is overwhelming as to LG's lack of capacity and I unhesitatingly make the declarations sought in this respect recognising in doing so that LG no longer has the capacity to make decisions in relation to any aspect of her life and not merely in relation to her capacity to litigate

BEST INTERESTS

56. I turn then to a consideration as to what form of care package will be in the best interests of LG. In this regard the Court has had the benefit of the reports of Dr S and also the reports of the independent social worker, DS, I also heard evidence from:

i) CB – Care Support worker who has been helping with the care of LG in her home for approximately three years

ii) MA – Care Worker who has been involved in the care of LG for eight years

iii) JR – Interact Direct Care Support Worker employed by HBC who has been involved in the care of LG for three years

57. I also had evidence on behalf of HBC from PS who is the strategic lead for safeguarding vulnerable adults, and JH, Principal Practitioner who has been involved in the case since 2007.

58. JG called her McKenzie friend CP and her neighbour TS. JG gave extensive oral evidence.

59. The Official Solicitor acts as the Litigation Friend of LG and has been represented by Counsel throughout.

60. Any consideration of the best interests of a vulnerable adult will necessarily involve an assessment of any party who is either closely involved with or offering a home to that vulnerable adult. In LG's case the two significant adults are her two children.

61. SG has attended court unrepresented. He has given short oral evidence and has, on occasion asked various witnesses questions. SG has largely observed the proceedings and has through out presented as composed and appropriately concerned about the welfare of his mother.

JG: 2nd Respondent: daughter of LG

62. JG was born on 7 May 1953 and is approaching 59 years of age. JG has represented herself during the trial assisted by her McKenzie friend, a CP OBE about whom I shall say a little more in due course.

63. JG has attended court each day on a mobile scooter. She has throughout the hearing, worn substantial and elaborate dark glasses covering the upper portion of her face. These are necessary she says, in order to ensure that no light whatsoever gets to her eyes.

64. Whilst LG is the subject of these proceedings, the reality has been that the primary focus has through out the hearing, centred upon JG. JG alone does not accept that her mother suffers from a serious dementia type illness. Her case is that her mother wishes to return to her care and is capable of expressing that wish. In the event that she no longer has the capacity to make a choice as to where she should live, JG's case is that her mother should in any event forthwith return to her full time care. Evidentially therefore the focus has been on JG, the care she has hitherto provided for her mother and her ability to provide appropriate care for her in the future.

65. The case papers disclose JG as having had significant contact with the mental health services over a number of years. Initially JG declined to provide this court with any information about her own psychiatric history. She also declined to allow her former

GP, Dr M, who gave evidence before me, to answer questions designed to shed light on either JGs mental or psychological health.

66. During the course of her evidence, JG did at my request agree to the disclosure of a report which had been prepared on 28 October 2009 following an assessment of JG pursuant to the Mental Health Act 1983. That report gives some useful insight into the alleged immobility and photosensitivity which together form the basis of the description JG gives of herself as disabled.

67. Absent direct medical evidence, the court has had to rely upon other sources for its assessment of JG, these include: references in the papers, observations of JG made from time to time by health care professionals, Dr M's evidence together with my own observation of JG (who has been in court for a period of three days acting as litigant in person and has given lengthy oral evidence).

68. JG's refusal to allow Dr M to give other than the sketchiest evidence about her health is unfortunate. The court having concluded that LG lacks capacity to make decisions, now has the task of scrutinising the Local Authority Care Plan. Such scrutiny will necessarily involve comparing that plan with the proposals put forward by JG for her mother's future care. The local authority's plan is that LG should remain where she is in residential care and JG's plan is that she should return home to her care.

69. It follows that where JG's proposal is that this 96 year old lady should return to her 24 hour a day care with only some unspecified additional support, then the physical and mental health of JG must be matters of considerable moment.

70. JG told the court that she has limited mobility and that the bungalow in which she lives has been adapted for the scooter. During the trial she has told me that her disability is such that she cannot lift a lever arch file or even manipulate the papers sufficiently to lean over to pass a document to Counsel for the Official Solicitor. JG said that if she had "grabbed" or "struck" her mother as has been alleged, the effect would probably have been that she herself would have been rendered disabled and she would *"have to be taken away by ambulance"*.

71. Dr M was JG's GP until the middle of last year. JG was willing to agree to his answering some questions about her physical health. Dr M explained that in his capacity as JG's doctor he had over the years often questioned whether there is a psychological aspect to JGs physical difficulties. Her symptoms as she describes them, do not, he says fit with any recognised condition which would serve to explain her allegedly limited mobility.

72. Dr M referred JG to a specialist unit in Oxford in July 2009 for a 'functional restoration programme'. JG 'collapsed' as soon as she arrived and returned home immediately. Dr M said that he had suggested to JG that she should see a psychiatrist but that she declined. Dr. M told the court that he had refused a subsequent request made by JG to arrange a further assessment at a different specialist unit after the Oxford assessment had failed to get off the ground. After that, Dr M said, his practice felt that they could not do anything more for JG and by mutual agreement JG moved to a new practice. Despite repeated requests made by both Counsel and the court during the course of the trial, JG has vehemently declined to discuss the trip to Oxford or what went wrong.

73. In cross examination as to her physical condition, JG declined to say more than that she had a spine injury as a result of an accident caused by negligence. She accepted that the mobile scooter had not been recommended by a doctor or provided by the National Health but rather had been acquired and paid for by her on her own initiative, for her own use. She also said, in a tone conveying considerable resentment, that Dr M had declined to support her in an application for a disabled blue badge as, in his opinion, she could walk.

74. During her evidence, JG became agitated when Mr O'B sought to press her on issues relating to her physical health. She suggested he was being discriminatory and accused him of suggesting that disabled people have no right to live. She indicated her intention to 'report' him. Mr O'B at no time made any such suggestion and none of his questions were even remotely discriminatory. In any event JG has accepted to me on a number of occasions during the trial that she understands and accepts that her physical condition is relevant to the issues to be considered by the court.

75. Given JG's rather wild accusation against Mr. O'B I should perhaps set out why JG's physical and mental health is relevant to the case. The health, (in the widest sense of the word), of any proposed carer of LG given the considerable needs and challenges she presents inevitably require consideration. Such consideration is an intrinsic part of any best interest's assessment. Its consideration is not for one moment because JG would be automatically excluded as a carer if she is in fact immobile and therefore disabled; but because her health is an essential part of the picture when considering JG's case that it is in the best interests of LG that she should live with and be cared for by her daughter.

76. If JG, as the proposed carer has her own significant physical limitations and/ or mental health issues and/or an unusually difficult personality, it is all the more important that the court can be satisfied that should LG live with JG then any package of support put in place by HBC for the care of LG is in her best interests and will provide a safe, secure and comfortable environment in which LG can end her days. To be in her best interests that the care package must be realistic and achievable. Further because of the heavy reliance that would inevitably be placed on outside carers, the court must be satisfied that JG would in both the short and the long term work collaboratively with those carers and health professionals who would necessarily be coming into the house several times each day.

77. Unhappily a feature of JG's personality is that she 'reports' and makes incessant complaints about those with whom she comes into contact. JG's name has been placed on a register, called somewhat bafflingly the Problematic Orientated Policing Register. This was as a consequence of making 49 calls to the Police in 2008 and 50 in the first 10 months of 2009; in these calls JG was complaining of harassment and intimidation by services such as the social services, the NHS and the Police. Dr M in evidence spoke, with what can only be described as an air of exhausted resignation, of the effect of the endless complaints made by JG upon those who dealt with her at the surgery.

78. In giving his oral evidence Dr M quite obviously felt himself significantly constrained in what he said about JG by the fact that JG had formerly been his patient. Whilst I was left with a real sense that he could have said more, he felt sufficiently goaded

when he was challenged by JG in cross examination to allow himself to be forthright to a degree.

79. JG has throughout the hearing been pre occupied with LG's medication and, somewhat unusually, with the question of whether LG's medication contained additives which would have a deleterious effect on her.

80. Dr M said that JG was constantly on the phone, unhappy about LG's medication and being very forceful about her requests. Dr M explained and indeed JG does not dispute, that JG was interfering with the LG's medication by altering her dosages without consultation. He was confident that in the event that JG went back to live with JG this would continue to be a problem. That that he says makes it very difficult to care for LG.

81. Dr M explained that the incident in August 2009 which led to LG being moved to a nursing home was only one incident in a long line of incidents. JG, he said, complained constantly and was paranoid. When replying to questioning by JG, Dr M said *"you cause chaos wherever you go. You are on the phone all the time, and the nursing staffs are always being complained about"*. He went on to say that JG was forceful and demanding and significantly he said that there have been no problems with LG and no bruises since she has been in residential care and JG has no longer been involved in the care of her mother.

82. As already noted the papers disclose that in 2000 JG was the patient of a Community Psychiatric Nurse. The limited mental health history available record JG receiving inpatient mental health treatment in May 2000 and of her having taken overdoses in both 2000 and 2001.

83. The assessment report records JG's then GP, Dr McG, saying that JG:

> "had been diagnosed in 2000 with Personality Disorder with hysterical features. ...She complains of photosensitivity which Dr McG describes there being no neurological evidence for'

84. I found much of JG's oral evidence to be frankly bizarre and it served graphically to reinforce the written and oral evidence concerning both her personality and mental health.

85. One further example of JG's paranoid view of the world (which in this case relates directly to her care of LG), was in relation to the issue of LG being left locked in for long periods of time on her own. JG accepts that this was the case and said that she could see that *'it would look as if she had left her'* JG went on to say that she had had a new back door put on the bungalow and she had only been given one, (as opposed to two), keys by the workmen. So she said, she was wondering if in fact someone had the second key and would have been going in and out anyway. The clear implication of this being that her mother was not therefore really on her own. This was a disturbing piece of evidence which exhibited not only the paranoid traits already referred to, but also a complete lack of insight into the lonely and frightening (not to mention dangerous) position she was leaving LG in when, day after day, she was left alone for protracted periods of time.

86. The records from 2009 reveal that JG's perception was that her own health was deteriorating and there are 5 noted telephone calls between May and July 2009 between Social Services and JG about her own increasing health difficulties. Additionally it will be remembered that in July, JG went on the abortive assessment to Oxford and in August was obliged to seek overnight carers to stay in the house to help her look after LG.

87. On 22 October 2009 and 23 October 2009, at a time after LG at moved to live at QM, the LG's carers reported that JG appeared to be acting bizarrely. The Team Manager reported that JG suspected that a particular district nurse was 'an alien'. The following day JG told the safeguarding officer that she was going to London, as the Queen was of a similar age to her mother and 'would understand'. JG also said that she thought her solicitor was in fact a community psychiatric nurse in disguise.

88. JG now denies saying these things, but I am satisfied that she did. I reach this conclusion as not only having seen and heard her in court do they ring true, but why else was it decided, as a direct consequence of these allegations, that it was necessary to carry out a Compulsory Mental Health Assessment on JG . That assessment took place on 28 October 2009. When JG was asked by the assessor why she wore dark glasses, JG attributed it to medication prescribed by the Mental Health Services 10 years previously. She also referred to a 'shock' but would not elaborate. JG was asked (presumably as a consequence of a reference in the medical notes which are not available to this court), if she spoke in a foreign language when she removed her glasses. JG did not deny this was the case but simply said 'no comment'.

89. The Approved Mental Health Professional, JP described JG as having 'paranoia and a persecutory complex' but did not take the view that it was necessary to detain her under the Mental Health Act; in particular she said that :

> "Her refusal to comment on the suggestion that she spoke in a foreign language when she removed her glasses did not raise sufficient concerns to warrant further assessment at this stage"

Dr R the attending psychiatrist was of the view that her presentation was due to personality traits rather than mental disorder.

90. JG said to Mr. O'B in evidence that her 'eye' trouble was as a consequence of tablets she had been given in 1999 and that the tablets caused her light sensitivity. The legal case arising out of this is being dealt with, she said, 'in Europe'. JG at this stage of her evidence also spoke of various health care professionals that she had reported 'to Europe' and that 'Europe' was monitoring the case.

91. During the course of his cross examination, Mr O'B asked JG what happens when she removes her glasses. Initially she said that she would rather not remove them. She then said *'I don't know if I speak a foreign language when I remove my glasses',* then she said *'people say I do'* and finally she said *'Yes I do'.*

92. JG then offered to remove the glasses and did. Initially she said nothing and then, in reply to a question from Mr O'B, she started to speak with a heavy French type accent

using some words which were decipherable and some which were not but did not, so far as I could tell, sound French. After speaking like this for a little time, she put on her glasses again and continued to talk with the 'French' accent for a couple of sentences before once again talking normally.

93. This behaviour by JG in court was quite extraordinary. The medical records say there is no neurological reason why JG is photo sensitive and in any event it is simply unfathomable why light on the eye should make JG speak in such a way. It seems probable that the explanation lies in complex psychological reasons which are beyond the remit of this court.

94. JG's unusual behaviour and seeming paranoia has a direct impact on the interests of her mother. One example relates to a carer MA. JG alleges that MA, who has been a devoted carer of LG for many years, has been 'stalking' her around Homestyle in Newcastle. Her account is that MA followed her around and unnerved her to the extent that she approached the manager of the store and a police officer, each of whom challenged MA about her behaviour. JG says she has proof and has produced a piece of paper to the court. The piece of paper is not on headed paper and purports to come from a manager. It says:

> Customer left store to talk to Police Lady was pointing inside store so I went out and ask lady if she was OK she said yes.

95. Both JG and, more worryingly CP, offer up this wholly ambiguous scrap of paper as conclusive proof that MA was 'stalking' JG, even though both were at a loss to offer any semblance of a reason as to why MA should have done such a pointless thing. JG has made no attempt to call the Police officer that she alleges told her that she had been watching MA go around the store.

96. MA said in evidence that she and her sister were in the store looking buying a vacuum cleaner and offered to show me her receipt. She heard someone say 'excuse me' and saw that it was JG on her motor scooter, she moved aside to allow her past and that was the end of the incident.

97. I accept the evidence of MA unreservedly. I am not a psychiatrist so I am unable to hazard a guess as to whether JG simply invented the whole thing to undermine MA, who is one of the carers who has reported JG as having hit her mother, or whether she genuinely, but wrongly, believes it to have happened. Which ever it is it is a disconcerting piece of evidence and has had an unhappy knock on effect for LG as, unsurprisingly, MA who has known LG for all this time and has also been supervising contact now feels she should now withdraw from that role and will no longer be involved with LG.

98. During the course of her evidence JG made a new and extraordinary allegation. She said that during a hearing in front of DJ Goudie, Mr O'B had produced from his pocket what she initially said was a video but then said a mobile phone with a film or something similar. She alleged that in the presence of the judge Mr. O'B had passed it over to show the screen to an unidentified third party. They had, she said, looked at it together and laughed at it before Mr O'B rudely leant across her (still in the presence of the Judge) in order to show the film to her then Solicitor Mr G.

99. Mr O'B could not of course give evidence about this, but I was told that Mrs H from Social Services and Mr O'B's instructing solicitors were both in court and could give evidence if need be. I have declined to add yet more witnesses to this matter, the astonished looks on their faces spoke volumes and I would be astounded if a senior district judge such as DJ Goudie would tolerate such discourtesy in his court.

100. Once again as with Mrs B and the stalking allegation, it is quite impossible to work out why Mr O'B would behave in such a way.

101. All in all the evidence given by JG was both disquieting and sad. JG's initial presentation is that of a well groomed, articulate, woman coping efficiently with a serious physical disability. I have not had the benefit of medical evidence and so my terminology is necessarily that of a layman, but JG's behaviour and presentation in court has confirmed in my mind the justification of the use by a number of health professionals of the word 'paranoid' in relation to JG. Paranoid is defined in the Oxford English Dictionary as:

> 1.a mental condition characterised by delusions of persecution, unwarranted jealousy, or exaggerated self-importance. **2** unjustified suspicion and mistrust of others.

The definition provides a precise description of JG as she has presented both on paper and in court.

102. The 'speaking in tongues' is obviously a matter which those carrying out the emergency assessment in October 2009 thought to be significant. In my judgment it is highly significant but requires the assessment of a psychiatrist or a psychologist.

103. The court is left with a lady presenting as profoundly disabled and behaving bizarrely. There is more than a suggestion that the genesis of the physical problems is psychological. JG unfortunately declines to co-operate with relevant assessments whether they be recommended as her GP as part and parcel of her own health needs or as part of these proceedings. The court in the light of all the evidence can only conclude that JG has significant, deep seated psychological and psychiatric problems.

The allegations in relation to JG's care of LG

104. The case does not turn exclusively on the personality and behaviour of JG. There are a number of serious allegations made by the Local Authority in relation to the care that JG gave to her mother including that :

    i) JG frequently left LG alone, locked in the house

    ii) that on number of occasions JG hit LG and in particular that JG hit LG on the head causing the cut to LG's head seen by Dr A on 19 August 2009

    iii) that JG was routinely verbally abusive, domineering and subjected LG to rough handling

iv) that JG is incapable of accepting advice or working with health professionals, this includes an assumption by her of a medical expertise she does not have and which leads her unilaterally to alter LG's medication and 'treat' LG.

105. I have all the daily care records from 3 April 2008 onwards. I have also heard oral evidence from various care workers who were going into the house every day and routinely saw how JG treated LG (it should be born in mind that carers were going into the house four times a day.) These records revealed numerous examples of LG being found alone and distressed. Time and again the carers arrived to find LG not just alone but locked in and upset. There are regular recordings of verbal aggression and rough handling on the part of JG as well as such unpredictable and bizarre behaviour such as the excision of skin from LG's leg.

106. TS gave evidence that his wife, who had been a friend to JG, died in the middle of 2009. He explained how supportive JG had been and how much time she had spent with his wife towards the end of her life. He spoke also of how much comfort JG had offered to him after his wife's death, spending as she did, many evenings with him. It was put to him by Mr O'B that this necessarily meant that LG was being left alone much of the time, particularly in the evenings. TS said that his understanding was that JG did not come round to his house until her mother was in bed at 7.00pm.

107. Whilst it must be to JG's credit that she has been such a caring friend to Mr S; Mr. S's comfort was LG's neglect. LG was being locked in the house most evenings with no one to reassure her and no way of getting out of the building.

108. Dr S explained that when she is on her own LG has no idea how long she has been left, be it for 5 minutes or 5 days. However long it is, it is always frightening and distressing for her. In QM, although she is inevitably disorientated much of the time, there is always someone there to reassure her, to show her where to go if she gets lost and as Dr. S put it, to tell her whether it is night time or breakfast time.

109. I have no doubt that during 2009 LG was routinely left alone, locked into the house where she was distressed and frightened. I have seen no evidence that JG has any insight or understanding of how frightening and distressing that must have been for her mother. Although she said in evidence that "it must not happen again", I had no sense of her having any empathy for her mother or understanding of the bewildering and frightening world in which she lives.

110. A perfect (but not the only) example of the recurrent themes of JG's alleged brusqueness, rough handling, constant criticism of medical professionals and interference with medication is found in a recording dated 17 June 2008 by CB who also gave evidence before me:

> … supported (L) to the dining table where breakfast was ready. While rinsing the bath L tried to leave dining table. Explained she needed to eat her breakfast before it went cold. L very confused and unsteady on her feet, L left the table a further 3 times. Also said she wasn't hungry. Took away cooked breakfast and placed banana and bread in front of L. J (daughter) came out of lounge as I was coming downstairs from making the bed and emptying the commode and L was attempting to leave the dinig area. J grabbed L and raised her voice and roughly

> turned L back to go round and sit back at the dinig table. She then reheated the eggs, tomato a little, told L to shut up and eat. She then told me she would be fine once her medication had kicked in as she had given her a higher dose than yesterday… went into lounge to write care plan, overheard J raising her voice to L and L looked quite distressed on me leaving. J also mentioned that the Drs were to blame and she was going to report them.

111. The records reveal not just one or two, but numerous occasions when LG accused JG of having hit or slapped her even at a time when the view was taken that she still had capacity. Bruises were seen on LG's body by carers at the same time as such allegations were being made.

112. JG did not directly challenge much of the evidence given in statements or orally by the care workers to the effect that JG was stern, rough and left LG alone on a regular basis. I do however bear in mind that JG was a litigant in person and although articulate and capable of putting her case, does not have the cross examination skills of the professional advocate.

113. JG did complain about many of the care workers who had gone to the house and who had, as she put it been 'banned' for what seemed to me to be the most trivial of reasons. JG was in the main complementary about those carers who gave evidence before me, save for MA on to whom I have previously referred.

114. I found the evidence of the carers universally convincing. I was struck by the down to earth and practical approach they exhibited. They were clearly all fond of LG and I got the distinct impression that in the main they felt that they simply had to cope with JG in order to provide LG with the care she needed.

Conclusions as to allegations in relation to JG and her care of LG

115. I find and indeed JG concedes that LG was regularly left on her own locked in the house. I am entirely satisfied that this was distressing and frightening for LG. It was also very dangerous Not only does JG have no insight into the seriousness of what she was doing, but in evidence she suggested that LG was not really alone as some unknown person may have a key to the back door and have been going into the property.

116. I accept the overwhelming body of evidence that JG had over many years treated LG harshly both physically and emotionally. I find that JG denied to LG the gentleness, reassurance and affection that, as her mother she was due, and as an old lady with dementia, she was entitled to and needed if the world is not to be a wholly frightening place.

117. I accept the evidence of Dr M that LG habitually changed the dosage of LG's medication. In my judgment she sees herself as some sort of medical expert as opposed to a person with some antique nursing experience. The incident when she

cut away the skin around her mother's leg must have been very painful for LG and the consequences were that she was exposed to considerable risk by having had to have a general anaesthetic at her advanced age as a direct consequence of JG's actions. JG's outrage that she should be criticised for this simply confirms the court's view that her total lack of insight leaves LG vulnerable to other such incidents. I accept unhesitatingly the evidence of Dr M.that JG will continue to tamper with LG's medication.

118. I make no finding as to the cause of the cut to LG's head. Given the advanced nature of LG's dementia I do not think it would be safe to make findings based on her allegation that LG hit her even though that allegation has been clear, consistent and made to more than one person. I do find, as I was invited to do by Mr O'B, that LG believes she was assaulted by JG and I do find that JG routinely subjected her mother to rough handling.

The Care Plan

119. The court had the benefit of the independent evidence of Miss S who carried out a best interest assessment of LG. Miss S has 30 years experience as a SW and has spent the last 12 years working with people with cognitive difficulties and dementia. Miss S visited LG twice. The first time LG was very confused and distressed and the second calm and relaxed. On both occasions Miss S found it very difficult to distract LG from the theme of wanting to be at home with her parents.

120. LG came across as settled and content and frequently told Miss S how good the people were to her how 'lovely' and 'nice' they were to her. In her discussions with Miss S, JG said that although she had no 'proof' that her mother was being 'physically and mentally abused' in QM but that she was of the view that it was mentally and physically abusive for her M to sit in a circle rather than being out and about at the shops. Miss S in response explained that the care of very old people is a matter of balance; LG at 94 does not have great energy levels. She had however a room which had been deliberately chosen to be on the ground floor in order for LG to be near to the hub of things so she could get about and see and hear the comings and goings.

121. Miss S assessed LGs various care needs; these include the need to wear continence pads (and LG's dislike of having them changed), and of the need for two people to bath her. JG asserts that LG can go to the toilet on her own and that she should be allowed to retain her dignity by doing so.

122. In my judgment this suggestion by JG that LG is still able to go to the toilet on her own is but one of many examples which reveal, JG's lack of insight. Whilst no one should under estimate the need to be sensible of the importance of the preservation of the dignity of any elderly person, it is equally undignified if such an elderly person is left feeling humiliated and physically uncomfortable as a consequence of having been pushed to maintain personal autonomy at a time when it is no longer realistically possible.

123. It goes without saying that any lady of LG's age is entitled to be treated with respect and to retain her dignity. I am entirely satisfied that all who have been involved with

her at QM have done so. I have had oral evidence from a number of people whose job has been to help to care for LG and have been struck in each case by the obvious affection and respect in which LG is held.

124. JG's case in its essentials is that:

   i) LG is consistent in expressing a wish to return home to her.

   ii) An elderly lady such as LG is better living in her own home than 'sitting in a circle'

   iii) LG is being forcibly and illegally kept at QM

   iv) She (JG) is willing and able to care for LG and will make such arrangements for additional care as she deems to be necessary and appropriate.

125. JG put to Dr S, as indeed she did to a number of witnesses that someone with dementia can and should be looked after at home. Dr S replied that most dementia patients are cared for at home but they should not be where as in this case:

   i) the vulnerable adult is severely cognitively compromised

   ii) there are concerns spanning a number of years about the quality of her care

   iii) there are concerns about the quality of the relationships between her and her carer.

126. A theme of JG's case has been that LG constantly asks to go home, as indeed she did on the one occasion when Mr S was taken to see her. I have read the contact sheets and seen the frequent references by LG to her father, nearly all of which are made in the context of going 'home'. Dr S's opinion is that LG's recent memory has been eroded so she now thinks she is about 15 years old. Dr S is satisfied that when LG refers to home she is referring to her childhood home and particularly to her father.

127. I am satisfied on the balance of probabilities that when LG says that she wants to go home she is referring not to   but to her childhood home.

128. Even if it were the case that LG was referring to her daughter's home then, whilst I would as required by the Act take into account her expressed wishes and feelings when considering her best interests, I would have also to consider that expressed wish against the background of LG's severe disorientation, the fact that she can neither retain information nor weigh it up and the quality of care she had received and was likely to receive in the care of JG.

129. It is JG's case that whilst LG does not have capacity to litigate she does have capacity to decide where she wishes to live and in that she relies on LG's requests to 'go home'. I can understand that if JG really does believe that LG is asking to return to her care then that it is distressing for her and she must feel frustrated as to why 'no one is listening'. I am however entirely satisfied that LG is not referring to JG's home and that even if she were, it would be inimitable to her best interests to return to live with and be cared for by JG.

130. In relation to LG's residence Mr O'B puts it this way:

(a) LG has significant levels of care which are best met in a 24 hour care environment. There are risks to LG were she to returns to live with JG. She would be vulnerable to abuse.
(b) JG appears to lack understanding and insight into LG's condition and does not agree that LG has dementia. JG does not appear to appreciate that LG no longer has the ability to make complex decisions. This lack of insight places LG at risk should she returns to live with JG as she may not be aware of or responsive to her mother's needs.
(c) JG, as the gatekeeper of LG, would have the power to control professional access to LG.
(d) Accordingly, it is not in LG's best interests to reside with JG at .

131. In my judgment it is in LG's best interests to remain at QM Care Home.

CP

132. I have been asked by The Local Authority to make some findings in relation to CP's role in the case. CP worked in hospital administration for some 32 years, most recently before his retirement, at D psychiatric hospital near . In 1988 he was awarded an OBE for public and political services. In his evidence he said that his views about the case had largely been framed by an examination of the documents. He takes the view that the Code of Practice which supports the Mental Capacity Act has not been complied with and that there had been no serious examination of the alternatives before LG was 'put into a home': CP accepts that LG has dementia but did not accept that JG lacks insight into her mother's dementia.

133. CP was deeply critical of the two experts. He said that he drew on his experience as a hospital administrator in support of his criticism. He said that he had a great deal of experience of experts' report although in cross examination he accepted that he had no experience of court appointed experts. He said that the experts had each *'compromised their independence'* by *'allying themselves'* to the local authority. Although CP said that the experts should have met with JG, he made no reference to JG's refusal to meet either expert.

134. CP accused HBC in terms of putting misleading evidence before the court. He said that in his opinion the piece of paper referred to at paragraph 79 herein proved beyond per adventure that MA had been 'stalking' JG.

135. HNC submit that whilst they entirely accepted his right to assist JG, it is incumbent upon CP, as an elected member of the Council which controls the area of this Local Authority, to be moderate and cautious in his approach to the litigation. The Local Authority say CP has wrongly inflamed the situation and has made allegations of the

most serious kind against Local Authority as well as attacking the integrity of the two independent experts.

136. CP has written a number of what can only be called strident letters about this case. In particular he wrote a most intemperate letter dated the 3rd March 2010 to the Chief solicitor of HBC. That letter was written a matter of days before this trial began. At that time CP had had an opportunity both to consider and weigh up the evidence in the case and to provide JG with his measured view and opinion. He did not do so and it is only necessary to give one extract from this letter in order to illustrate CP's extreme approach:

> In the 19th and early 20th centuries it was not uncommon for mentally ill people to be needlessly put away for life but in the NHS such barbaric practice has been abandoned for most of the last 50 years. It is quite shocking to find it happening again in the 20th century.
>
> Though I earnestly hope this case is unique, HBC's own writing and recording reveal a pattern of over-reaction and extreme choices strikingly similar to the series that culminated with the Butler-Sloss Inquiry in Cleveland County after inadequate and misleading evidence was used to separate children from parents to protect them from alleged abuse which had been grossly exaggerated and existed chiefly in the minds of the professionals determined to stamp it out.

137. In a further letter filed as his statement in the proceedings and dated 12 January 2010 CP said:

> I have been able to examine most of the flood of documentation sent to JG. I can readily understand why most of those caught up with this troublesome and time-consuming case would welcome a conclusion which takes it off their agenda.
>
> I find HBC's relentless pursuit of draconian legal restrictions enforced ruthlessly and even vindictively alarming and quite incompatible with the philosophy underlying the guidance published by the Mental Capacity implementation programme which I have read. It is hard to believe that a less compulsive and confrontational approach could have produced a worse outcome.

138. Given that JG said she had difficulties reading because of her dark glasses, Mr O'B has throughout the trial read aloud all the passages in the written material to which witnesses were from time to time referred. This meant that as witness after witness came into the witness box, Mr O'B read out the contemporaneous recording for example referring to such things as LG being locked in the house for long periods of time, her fear and distress at being left alone and of her having banged on the windows for 'help'. Mr O'B also read out accounts of rough handling and LG's own allegations that she was being hit by JG.

139. It was most unfortunate that CP announced only during his own oral evidence, at the conclusion of the local authorities' evidence, that he had a hearing problem and had heard little of the extensive oral evidence. Nevertheless I am satisfied that CP had

read the papers in the case and was fully aware of the strength and nature of the evidence. It is hard in those circumstances to see how he could have come to the conclusion expressed in the letter/statement of 12 January 2010 even before hearing JG give evidence.

140. CP felt that other options should have been tried before LG was removed from her home. He was reminded that Mr O'B's Position Statement/Case Summary recorded a number of occasions where, rather than seeking to remove LG, additional support was put into that family. His response was that that he doubted the veracity of the case summary which, he said, *twisted things and contained half truths*. CP did however agree that the situation where LG was being locked in the house alone was *not satisfactory and it cannot recur.* Mr O'B asked CP how he would compare LG's present deprivation of liberty, (resident in the care home where she is by all accounts content and spoke of the kindness of those caring for her), with the deprivation of liberty she had suffered consequent upon being regularly locked in a house and having to bang on the windows to get out. CP simply repeated that the actions of the LA in removing LG from JG's home were disproportionate.

141. This court is always keen to welcome McKenzie friends; they give time and support of inestimable value to the litigant they have agreed to assist. McKenzie friend come from all walks of life: often they are personal friends or connections of the litigant; sometimes they are 'professional' McKenzie friends. Sometimes, as here they are respected members of the community who have been approached by a litigant for support and advice. Each has their place.

142. On 14 October 2008 the then President issued Guidance on the subject of McKenzie friends found at [2008] 2 FLR 110. Much of the note deals with circumstances in which a McKenzie friend will be permitted to attend court and support a litigant in person. The Guidance in addition sets out the parameters for the role of a McKenzie friend as follows:

What a McKenzie Friend May Do

- Provide moral support for the litigant
- Take notes
- Help with case papers
- Quietly give advice on:
  - points of law or procedure;
  - issues that the litigant may wish to raise in court;
  - questions the litigant may wish to ask witnesses.

What a McKenzie Friend May Not Do

- A MF has no right to act on behalf of a litigant in person. It is the right of the litigant who wishes to do so to have the assistance of a MF.

- A MF is not entitled to address the court, nor examine any witnesses. A MF who does so becomes an advocate and requires the grant of a right of audience.

- A MF may not act as the agent of the litigant in relation to the proceedings nor manage the litigant's case outside court, for example, by signing court documents.

143. In this case the court, (with the agreement of HBC), has given CP (in his capacity as McKenzie friend) considerable latitude. CP has however felt it appropriate to go significantly beyond merely providing JG with assistance and support in court. He has become actively involved in the case having written letters to the Local Authority and the Official Solicitor and not only attended the hearing but given oral evidence to the effect that LG had been wrongly removed from the care of JG.

144. Given that Mr O'B has asked the court to criticise CP about his role in the case, I gave him the opportunity to respond orally to the Local Authority submissions. I felt this to be not only fair but important. CP gave 'bullish' evidence prior to JG having given her evidence and it may therefore have been that he wished to moderate his view and his criticism of HBC and the experts having, seen for example JG speak "in a foreign language" and heard her suggestion that some mysterious third party had a key to the house so that LG was not in fact alone when she had been locked in the house by JG.

145. CP was essentially unrepentant. He said he was happy to stick by what he had written in his letters, although he was sorry if his reference to Cleveland had been what he called, *'misconstrued'*. He had, he said, detected a similar *'over reaction'* and *'extreme'* reaction in this case to that held to have occurred in the Cleveland Child Abuse case. He remains of the view the criticisms contained in his letter are valid.

146. I am afraid that I regard CP's approach to the litigation as having been unhelpful and inflammatory; not it should be made clear during the trial itself, where his approach and behaviour as McKenzie friend were exemplary, but prior to the hearing (in particular in relation to the letters which I have already referred) and at his dogged maintenance of his stated position as to the behaviour of the local authority, after having heard the oral evidence.

147. CP undoubtedly went beyond what is proper in his role as McKenzie friend in his dealings with the local authority and the Official Solicitor outside the court proceedings prior to the hearing. I understand that democratically elected representatives be they Members of Parliament or local Councillors will often, appropriately, take up issues on behalf of their constituents. It follows that any elected

representative must be cautious that in doing so they do not find themselves in conflict with their role as a McKenzie friend.

148. The Court of Protection Rules r90 (1) provides that the general rule is that Court of Protection hearings are heard in private. In addition Practice Direction A (7) says

> 7. Section 12(1) of the Administration of Justice Act 1960 provides that, in any proceedings brought under the Mental Capacity Act 2005 before a court which is sitting in private, publication of information about the proceedings will generally be a contempt of court.

(Provision is made for the court to authorise publication of information)

149. The President's Guidance on McKenzie friends sets out the general duty of confidentiality by which a McKenzie friend is bound. This is the natural consequence of the fact that a McKenzie friend has access to all the court papers. In this case the papers contain not only information about HBC and how they have handled the case but also information about LG which is both deeply personal and very sensitive.

150. It follows therefore that CP in taking up arms on behalf of JG in the way that he did immediately placed himself in two obvious areas of potential (and in his case actual) conflict:

i) that he would be in breach not only of his duty of confidentiality que McKenzie friend but also in these Court of Protection proceedings, be in breach of s12(1) AJA 1960 and thereby in contempt of court

ii) that he would by his actions be regarded as being in breach of the prohibition within the President's Guidance of 'acting as the agent of the litigant'

151. I bear in mind that the President's Guidance says that the *fact that a proposed MF belongs to an organisation that promotes a particular cause'* should *not outweigh the presumption in favour of allowing a McKenzie friend.* In saying so the Guidance recognises that a McKenzie friend may hold strong views about the subject matter of a case and those views may well be in the public arena. Once such a person becomes a McKenzie friend however, they are thereafter subject to the duty of confidentiality and the 'Dos and Don'ts' contained in the Guidance and set out a paragraph 142 above.

152. In my judgment it where a person finds there to be a conflict between two roles: here as between his role as a representative of a constituent and his role as a McKenzie friend, then it is incumbent upon that person forthwith to withdraw from one role other.

153. Even regardless of the fact that CP's communications with the HBC and Official Solicitor went way beyond that which is permitted by a McKenzie friend, CP did not in any event seem to understand just how serious it is for an elected member of the Council to make allegations of the type he made against his own local authority: allegations which in my judgment were wholly unwarranted. People in CP's position

with authority in the community simply do not have the luxury of having a 'rant' or 'getting matters off their chest' in hyperbolic and exaggerated correspondence. They must understand that what they say can lead to very serious consequences, consequences which may include expensive and time consuming investigations into the allegations and of hard working carers and other professionals being placed under suspicion for improper conduct of the case.

154. CP as JG's McKenzie friend first read the papers and then heard the unanimous and overwhelming evidence relating to JG's treatment of LG. He was in court throughout her disturbing oral evidence. It came as a considerable surprise to me therefore that he in a positively belligerent manner, continued to assert that the local authority had acted prematurely and had over reacted in removing LG from the care of her daughter. One feels that had he been able to bring himself to be less partisan in his approach, he could have proved himself to have been a valuable counsellor to JG. He could have provided her with moral support and advice and thereby helped her to understand and accept what he must have known was likely to be both the inevitable and proper outcome of the case, namely that LG would remain living at QM.

Contact

155. Dr S and Miss S were both of the opinion that the attitude of JG during contact often causes LG distress. LG becomes very upset when certain topics are raised. For example when LG thinks her father is still alive and speaks of him, JG tells her abruptly that her Father is dead. JG cannot or will not see that that this unkind and wholly unproductive. JG says she 'believes in telling the truth' but at LG's stage of dementia there is no truth but only what beliefs her ravaged memory have left her. In her mind she is a young girl who lives at home with her mother and beloved father, each time she is told he is dead she is distressed.

156. I have been referred to numerous contact records. These regularly record inappropriate behaviour on JG's part. Dr Scott has read all the contact sheets she regarded them as 'very balanced'; she noted that it had been reported when contact had gone well and both had enjoyed it.

157. Since the hearing on 30 November 2009 LG has had contact with JG once a week supervised by two local authority homecare staff. Happily the quality in contact has shown some recent improvement with JG showing more tolerance of LG's disorientation. Unfortunately she persists in telling LG that she is being kept in QM against her will and that she has been put there by social services and SG.

158. Miss S recommends that contact continues on the same basis. Despite the improvement in quality she is of the view that JG needs clear and consistent boundaries regarding her visits. I agree. Having said that however, I hope very much that if the quality of contact continues to improve that the length and frequency of contact can be increased and the level of supervision be reviewed. In any event it is most important that contact is kept under review. In making that decision I have in mind the observations of Sedley LJ in *Re F (Adult's Courts Jurisdiction)* and those of Munby LJ as he then was in *Re S (Adult Patient)*..

Conclusion

159. Having reached the conclusions set out in the body of this judgment I will make the following orders and declarations:

i) LG lacks capacity to make decisions as to residence, contact, care and the management of her financial and property affairs

ii) It is in LG's best interests to live at QM

iii) It is in the best interests of LG to have contact with JG once each week such contact to be supervised. The contact should be kept under review and the Local Authority shall have discretion to reduce the level of contact. I have considered whether it is appropriate in the circumstances of this case to make an order giving the local authority discretion to terminate contact if they believe that to be in the best interests of LG. I have concluded that that is a step too far. Instead I will grant the local authority discretion to suspend contact but order that in the event that such a suspension is to last over 4 weeks, the matter must be returned to court for further consideration as to issues of contact.

iv) It is in the best interests of LG to have unsupervised contact with SG.

v) It follows that as I anticipate that LG will remain living at QM in the long term and in the light of the findings I have made in relation to JG, it is no longer appropriate for JG to be involved in the administering of LG's finances and accordingly I will make an order removing JG as appointee in relation to the finances / benefits of LG.

160.