Neutral Citation Number: [2023] EWCOP 67
Case No: 13290314-02

IN THE COURT OF PROTECTION

2 Park Street
Cardiff CF10 1ET

Friday, 1 December 2023

BEFORE:

HIS HONOUR JUDGE PORTER-BRYANT

IN THE MATTER OF:

Swansea Bay University Health Board
-v-
1) P
(by his litigation friend AB)
2) C
3) V
4) Swansea City Council

REPRESENTATION

Rosie Scott for the Applicant
Nia Gowman for the First Respondent
John McKendrik KC and **Anna Biccaregui** for the Second Respondent
Kriti Upadhyay for the Third Respondent
The Fourth Respondent did not attend

APPROVED JUDGMENT

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(Official Shorthand Writers to the Court)

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1. JUDGE PORTER-BRYANT: This is my judgment following a day of submissions from the parties yesterday. Although I have had overnight and some time today to consider my judgment, given the breadth of matters this judgment will cover, it is inevitable that I cannot deal with every submission that has been made, only those that have been instrumental or material to my decision. Accordingly, if there are any matters requiring clarification or amplification, parties are invited to draw those to my attention at the conclusion of my judgment.

2. This is a matter that concerns P. He was born on [date given]. He has a number of diagnoses including significant learning disability, atypical autism, attention deficit hyperactivity disorder, hypermobility, low muscle tone, bowel problems, neuralgia and hydrocephalus. The court is asked to make decisions regarding his residence, care and contact with others. There is no issue that he lacks capacity in those domains, and declarations have been made previously. P currently resides at M and his residence, care and support arrangements there constitute a deprivation of liberty and are authorised by way of a standard authorisation.

3. The parties are as follows. The applicant is Swansea Bay University Health Board, who are responsible for funding P's care and support. KP is the community nurse with responsibility for day-to-day management of his care. The Health Board is represented by Ms Scott. P is joined as first respondent and acts through his litigation friend Ms AB and represented by Ms Gowman. The second respondent is P's mother, C. C also acts as P’s Deputy. She is represented by Mr McKendrick KC and Ms Bicarregui. The third respondent is P's father, V, represented by Ms Upadhyay. The fourth respondent is Swansea City Council. Swansea have played little role in these proceedings to date and did not appear before me in this hearing.

4. This is a matter that has been before the court for far too long. It is a matter that has been protracted, costly and has been underscored by significant disputes between the parties, principally the Health Board and C. To understand why, it is helpful to set out a potted history of the positions taken from time to time by the parties. When I do so, I make absolutely clear that I make no findings of fact unless expressly stated. This matter was originally listed as a finding of fact hearing, but for reasons that I go on to consider, the position has changed. However, a history (potted though it may be) will

help to not only provide understanding as to why we find ourselves in the position we do today, but also to give some insight and understanding as to the significant work undertaken by the parties over the last week or ten days.

5. A large feature of the proceedings to date have concerned allegations as to C’s relationship with professionals involved in P’s care and how this has impacted upon P. I make clear at the outset that I understand fully both V’s and C's love for P. That is evident and apparent. I have spent considerable time with both and C has addressed me directly on a number of occasions. The hurt and upset that both have felt over these last few years resulting from P's situation is palpable and no doubt felt acutely by C given the nature of the allegations that have been made against her. I have never lost sight of her love or strength of feeling and determination to do all that she can to secure what she feels is the best outcome for P. I outline the allegations not to cause upset to them or to cast doubt upon their love for P, but to provide the context I have indicated.

6. In July 2021 the Health Board applied to the Court of Protection. P had up until that time been living with C at CG in [ ] supported by a CHC funded package of care provided by GRS under a care plan. That care plan required, among other things, constant two-to-one care. A statement of facts and grounds submitted with the application reads as follows:

> "There is a protracted history of disagreement between C and professionals regarding P's care that has led to difficulties in meeting P's needs. Some providers will only provide a service if two staff are providing two-to-one care, whereas C insists on being one of the two carers, which dramatically reduces availability of agency staff. The Health Board has consistently struggled to find providers willing and able to provide a package of care to P. In part, this has been due to the size of the package and lack of staffing resources generally in the area, but also due to the disagreement set out above."

The urgent application was to authorise removal of P from CG to M as a result of GRS withdrawing their services and there being no other domiciliary care provider available. C had opposed the move both in pre-proceeding discussions and before me at the first hearing of the application. The statement of facts and grounds continues:

> "C has applied for and seemingly been appointed as P's deputy for health and welfare matters by the Court of Protection. A copy of the order is attached."

7. The Health Board submitted that the decision of the deputy, C, to decline the only offer of a suitable care package, namely M, and accept the risks of caring for P without appropriate support is not in his best interests. The Health Board asserted it recognised its responsibility to make the application to uphold P's article 3, 5 and 8 rights and to have a determination as to whether the decisions being made by his deputy were valid as being in his best interests.

8. I approved residence at M at the initial hearing and made the declarations sought. A further hearing was listed on an urgent basis. That hearing, at the end of July, was largely ineffective. There was little evidence submitted that the parties could point to to enable the court to determine any argument for P to return home. The matter was therefore relisted for a hearing in August.

9. The litigation friend's position statement in advance of the hearing in August reads as follows:

> "No provider has indicated that it is able to meet P's needs at CG. As such, it clearly remains in P's best interest to remain at the emergency placement at M. Moreover, even if a potential provider were identified, it is considered by the first respondent that it would not be in P's best interests to return immediately to reside at the home. There have been multiple past breakdowns of care packages in the community and there is a limited pool of potential providers. Any rush to put in place a package of care in the

> community runs the risk that it would be insufficiently planned, increasing the risk of breakdown. In particular, there are no up-to-date needs assessments or PBS plans, both of which are necessary to ensure that a potential provider can meet needs. An environmental assessment is also required because the ongoing work at CG is understood to impact on the availability of the necessary ground floor accommodation for P and because a manual handling assessment has noted that CG has areas where there may be insufficient space for the necessary support for mobilising to be provided. Consequently, even if a potential provider is identified, it is considered by the first respondent to be in P's interests to remain at M."

It continues:

> "Moreover, P's care at CG has historically involved a high level of CCTV surveillance and recording, and concerns have been expressed that C is not following a safe restraint procedure. The first respondent considers that the court cannot endorse a package of care at CG being in P's best interests, even in the short term, without considering these issues, and so evidence addressing this will be required."

10. At that hearing in August, Swansea and V were joined as parties. The matter was listed again for an urgent hearing but again no domiciliary carer could be identified. It was the Health Board's position at that time that domiciliary care agencies were reluctant to engage with C as a result of her previous conduct. At that stage no real detail was specified. The parties agreed to enter into dispute resolution. In the meantime, P remained at M. Although this is a Swansea matter and at that time I was sitting in Newport, there was a request that I retain the case, to which I agreed, for judicial continuity.

11. Little further progress was made through 2021 with continued searches for domiciliary carers who might be able to provide care at CG. There was a hearing regarding Christmas contact. By the end of 2021, two final hearings had been listed but then vacated due to the fruitless search to identify domiciliary carers or alternative accommodation in the event that return to CG was not possible.

12. In April 2022, KW, the then litigation friend, reported discussions with M. She asserted that there had been a number of allegations made to her by staff and management at M of frequent complaints originating from C and demands upon them and their time which they felt were unreasonable. In paragraph 10 of the litigation friend's position statement, it is said that A, the manager of M, stated that they had to bring in a counsellor for staff members who are working on supporting P. I was told that this was largely due, they said, to the behaviours and accusations that C was making and directing towards M. It was said at that time in April 2022 that M had a stress risk assessment carried out by a counsellor and the counsellor's conclusion was that there was a high stress risk. I was also informed that staff at M had contacted safeguarding regarding concerns they had with C and her behaviour. C was subsequently told by management at M that she could not enter the premises.

13. In July the Health Board arrived at a commissioning decision set out in two letters dated 17 June and 21 June 2022. The Health Board confirmed that it would support the identification of a supported living placement for P, but it would not fund a domiciliary package of care at CG. The Health Board cited several reasons for its decision, including financial proportionality, having regard to the resources of the Health Board and its general duty to the Health Board area, and sustainability in light of what they perceived to be C's demands and behaviours.

14. At this point contact between P and C was still supported by V. There were, however, developments such that in 2022 V withdrew initially from supporting that contact. There were then said to be relationship dynamics identified by the Health Board and the litigation friend that both said demonstrated that contact supported by V was not appropriate. Both cited evidence from experts instructed in the case. DNS, an external care agency, then supported contact between C and P from around August 2022. That proved to be largely uneventful until recordings on a Dictaphone possessed by C were

found. I have not heard those recordings but it is said by the Health Board and by the litigation friend that those recordings were suggestive that a member of staff at DNS, identified, was not entirely supportive of the regime. DNS removed that member of staff from the care package but ultimately they themselves withdrew entirely.

15. C was also seeing P at a day centre. Mr ST, who worked at the day centre, provided a statement. He alleged that C was behaving in a manner that was inappropriate. He, in June 2023, stopped C from attending.

16. There have been allegations that C has behaved inappropriately in medical appointments. Professor Powell, who works in neurology, wrote a letter in July 2021 in which he complained that C had been verbally aggressive. He was not prepared to continue seeing P within his clinic. The complaints, he said, led to an independent review of the work performed by the neurology department by a separate neurology department in Cambridge. Dr Pickrell saw P and C on 1 August 2023. He raised concerns also; similarly Dr Gandy, who has now developed her own protocol for consultations involving C.

17. The search for a residential placement has not gone well during these proceedings. TH, managed by Cs, had been identified as a potential placement but the suitability of the same has been called into question. Further, CS have, according to the Health Board, reported behaviours on the part of C that they felt were not conducive to the role they were being asked to play. Indeed, CS have now stopped communicating. CA was identified as a potential placement. The Health Board had, earlier in 2023, sought to persuade the court to make a final order in respect of that particular placement. It is right to note that C had significant concerns about the same which were entirely merited, justified and borne out. MI were to provide care in CA. It is said they too expressed concerns about whether they were able to fulfil that role following their own meeting with C.

18. I stress again that these are all allegations only and they are allegations that are strongly disputed by C or said by C to be lacking context. They are not allegations I have found to be proven. I have not set out the specifics since it is not necessary to the matters this judgment addresses. Reference to such allegations is not intended to cause C distress

but to simply outline the situation that we have found ourselves in, in that we found ourselves in a situation where M would not allow C on their premises so she could not see P there. C was not permitted to attend a day centre to see P. External agencies who were supporting contact had withdrawn. One treating medical practitioner had declined to continuing seeing P as a result, they said, of C. In respect of others treating P, there were restrictions and controls upon the role C could play. There was escalating tension between the Health Board and C.

19. In light of the strong, principled and continued dispute raised by C in respect of the accuracy and validity of a number of the complaints that had been levelled at her, I directed that this matter should be listed for a finding of fact. It was hoped that a finding of fact hearing would provide a basis upon which care planning could then move forward. It would give C the opportunity to present her case. Undoubtedly, through these proceedings she would have felt attacked. She felt that needed to have her say and to test the allegations.

20. Without a finding of fact, it was felt that matters would continue to simply return to the court with no resolution. To say that we were going nowhere fast would be a mistake; we were going nowhere slowly. In respect of residence, at the time when the finding of fact was directed, it was anticipated that there would be a residential placement onstream and available for P within a reasonable period following the hearing and so any findings made would assist in planning for P. As it was, that did not turn out to be the case. Accordingly, it became apparent that there was a real risk that the determination of allegations would be made within a vacuum - there was no plan in place for P's residence and no obvious plan to resolve the issue of contact with no external agency available. There were also concerns regarding the appropriateness of the schedule that had been submitted by the Health Board for the purposes of the finding of fact. It was lengthy and it was voluminous. It contained a number of allegations that could not be supported by direct evidence. The earlier iterations were wholly inappropriate.

21. At a further hearing to consider the direction of this finding of fact hearing, I ordered that the focus of the hearing should be changed. With no obvious resolution to the question of residence, I directed that the finding of fact hearing should be utilised as an

opportunity for the court and the parties to address the issue of contact. This was the immediate significant, pressing and overwhelming issue and the issue upon which a finding of fact might assist and enable progress to be made.

22. At a pre trial review in November (by which point Ms Scott was instructed by the Health Board), we had reached a stage where, in effect the Health Board and C were pulling as tightly as they could on either end of a rope. At the centre of this tug of war was P. It became clear that, even with a finding of fact hearing, the risk would be run that the positions of the parties would simply become more entrenched, and that findings of fact might not assist in making best interest determinations for P. To make any progress and retain a hope that the parties could have a meaningful constructive relationship in the future, one party needed to take a step forward to provide slack in the rope. Realistically, that could not be C. She was faced with a situation where the Health Board's position, if substantiated, may have led to a submission that there should be no contact between her and P unless the external provider, who had not been identified and could not be identified, could step up to support the same. It was the Health Board, through Ms Scott, who ultimately took that step forward and suggested to me at the last pre-trial review that there may be an alternative way in which this matter could be progressed.

23. There then followed some ten days of negotiation between the parties. That has resulted in four protocols being put forward: a medical clinical appointments protocol; a protocol governing contact in the community; a Christmas contact protocol; and a care planning and best interests meeting protocol. Those four documents I will not set out in any detail. They are detailed, they are regimented and they provide a clear basis upon which the parties can move forward. Those protocols provide for contact to take place between C and P in the community, supported by people known to C - DD or LA, who, through the Health Board, have undertaken the necessary training to assist in caring for P – or V.

24. The protocol in respect of contact covers pretty much every conceivable situation, from P's illness to his wheelchair not being available, to illness on the part of one or other of those supporting contact. It provides a basis and a framework to enable C to enjoy her time with P in the community. It goes so far as to set out the venue for contact and the

activities that P might enjoy with C and the other carer supporting. There is a medical clinical appointments protocol as indicated. It sets out a means and a methodology by which C can engage in those medical appointments and convey information to the treating practitioners. There is a care planning and best interests meeting protocol which sets out the means and methods by which C can engage in future care planning.

25. Those protocols provide a basis for moving this matter forward while the search for a residential placement continues. Those protocols, if they work, will help to unlock the issues that have been before this court for a significant period of time. Those protocols, subject to some continued tinkering as regards certain mechanics, are agreed between the parties, and are adopted by all four parties before me today.

26. I consider, having looked at those protocols and having heard submissions and having considered the skeleton argument and position statements advanced by the parties, that those protocols are overwhelmingly in P's best interests. But those protocols have to work. Everybody must do all that they can to avoid going back to the position we were in. Those protocols set out the duties, the rights and the responsibilities that all four parties have. They will assist in moving matters forward and ensuring that the focus and energy of the parties can be focused solely and firmly, squarely and exclusively on finding residence for P. They will ensure that P has good quality contact with C.

27. Having approved those protocols, the remaining matter before the court is the issue of the deputyship for personal welfare held by C in respect of P.

28. By an order of 2 April 2019, DJ Crowley (as he then was) made an order appointing C as the deputy to make personal welfare decisions on behalf of P. A copy of the order appointing does not feature in the bundle. That which is within the bundle appears to be a draft. It is unsealed and it misses important detail, but through investigations performed by C's legal team, the actual order has been obtained and circulated.

29. The appointment provides, among other things, that C has authority to make decisions on behalf of P in respect of where P should live, with whom he should live, decisions on day-to-day care, including diet and dress, consenting to medical or dental examination and treatment on his behalf, making arrangements for the provision of

care services, whether he should take part in particular leisure or social activities, complaints about his care or treatment and decisions about his future care and education. The appointment is said to last until further order. Initially V objected to the appointment but by the time the matter came before DJ Crowley, those objections had been withdrawn and were no longer maintained. There was no objection to the making of the deputyship from either the Health Board or the local authority, although it is right to note that only subsequent to the making of that deputyship did the Health Board receive a referral to consider P's primary health needs, and thereafter became responsible for funding.

30. The Health Board apply to discharge that appointment. With both the assessment I have made in respect of protocols and the application to discharge the deputyship, the overarching principles of section 1 of the Mental Capacity Act are engaged, with section 4 providing the guidance and the principles to be applied and the matters relevant to any assessment of best interest pursuant to section 1. As *G v E* [2010] EWHC 2512 (COP) makes clear, subsection (1) has primacy.

31. The specific provisions relating to deputies is to be found at section 16 of the MCA. Section 16(2) provides:

> "The court may -
>
> (a) by making an order, make the decision or decisions on P's behalf in relation to the matter or matters pertaining to property and affairs or personal welfare, or
>
> (b) appoint a person (a 'deputy') to make decisions on P's behalf in relation to the matter or matters."

32. The powers of the court under section 16 are subject to the provisions of the Act and in particular section 1 and section 4. 16(4) provides:

> "When deciding whether it is in P's best interests to appoint a deputy, the court must have regard (in addition to the matters mentioned in section 4) to the principles that -
>
> (a) a decision by the court is to be preferred to the appointment of a deputy to make a decision, and
>
> (b) the powers conferred on a deputy should be as limited in scope and duration as is reasonably practicable in the circumstances."

33. Subsection (5) provides:

> "The court may make such further orders or give such directions, and confer on a deputy such powers or impose on him such duties, as it thinks necessary or expedient for giving effect to, or otherwise in connection with, an order or appointment made by it under subsection (2)."

34. Subsection (6) reads:

> "Without prejudice to section 4, the court may make the order, give the directions or make the appointment on such terms as it considers are in P's best interests, even though no application is before the court for an order, directions or an appointment on those terms."

35. 16(7) reads, "An order of the court may be varied or discharged by a subsequent order."

36. Finally, subsection (8):

> "The court may, in particular, revoke the appointment of a deputy or vary the powers conferred on him if it is satisfied that the deputy -

(a) has behaved, or is behaving, in a way that contravenes the authority conferred on him by the court or is not in P's best interests, or

(b) proposes to behave in a way that would contravene that authority or would not be in P's best interests."

37. I turn first to consider the legal framework that applies to an application to discharge a deputyship. The focus of argument in that regard has been on sections 16(7) and (8), the Health Board asserting that the court has power under 16(7) to discharge an appointment. The position taken by C was that 16(8) is the only gateway.

38. The application is dated 8 October 2022 and is supported by a statement of facts and grounds that commences at B199.1 of the bundle. 199.3 makes clear that the application at that point was brought pursuant to s16.8 (the conduct provision). It was said that there had been inappropriate conduct in a number of regards identified as (a) through (n) within the statement of facts and grounds. It is right to say that a number of those matters were specifically identified in the various schedules produced for the finding of fact hearing I have referred to.

39. The statement of facts and grounds also cites the conclusions of Dr Hellin, a psychologist who was instructed within these proceedings, where it is said that C and P have an enmeshed relationship and that C assumes that P feels that what he likes is what she likes, that what he wants is what she wants, and it is difficult for her to countenance the possibility that he might have his own wishes and desires that are at odds with hers. The Health Board asserted that those conclusions, together with the issues of conduct they identify, were such that the test for discharge under 16(8) was met.

40. The Health Board's position statement or skeleton argument produced in support of this hearing now makes clear that the application is not advanced upon allegations of conduct but rather is now presented as a pure best interest decision. It is founded on the following factual basis, in outline: that such deputyships are appropriate only very rarely and in particular circumstances; that P's situation does not warrant the

continuation of such a deputyship, noting that P does not reside with C; his care is provided externally; C is unable to visit the placement at M and that there are restrictions placed upon the nature of her engagement with medical consultations. The Health Board observe that, whatever the reasons, C's relationship with professionals involved with P have been very difficult. It is also said by the Health Board that the appointment is extremely wide and the scope of the same is not in accordance with s16(4) and that the specific decisions envisaged by the appointment are now matters falling to decision makers that are not C.

41. The application is presented on s16(7) grounds, albeit it should be noted that the secondary position of the Health Board in submissions was that 16(8) would be engaged if, on determining that a deputyship was not in P's best interests, there was a decision taken by the deputy to continue to act.

42. On behalf of C it is said that the only route for discharge of a deputyship is s16(8), and without findings as to conduct that would meet either limb of s16(8) the application must fail. It is said by them that s16(7) applies to orders - those made under 16(2)(a) and 16(5) - with an order to be distinguished from an appointment. An order can be varied or discharged under 16(7) but an appointment can only be discharged or revoked under 16(8). I indicated yesterday at the conclusion of submissions on this point that I preferred the analysis of the Health Board and that I would give my reasons at a later stage as part of an all-encompassing judgment which I do now.

43. There were a number of cases identified to me in which 16(8) is said to be the source of the power to discharge or revoke, but similarly a number were cited on behalf of the Health Board and the litigation friend, which support the Health Board's contention that s16(7) can be used as a means of discharging a deputy. In *EXB v FDZ* [2018] EWHC 3456 (QB), Foskett J, sitting in the Queen's Bench Division and the Court of Protection sat with Ms Butler-Cole (now KC) appearing as an amicus, determined at paragraph 40 that a deputyship could be varied under 16(7). The reasoning in paragraph 40 applies to discharge as well as variation. In *Re EB; EB v RC* [2011] EWHC 3805 (COP), Senior Judge Lush considered the authorities presented to her and cited a decision of the New South Wales Court of Appeal (*Holt*) with approval. While it should be noted that s16(8) is referred to by Senior Judge Lush, the order discharging one deputy and

replacing that former deputy with another was a decision that was arrived at purely on a best interests basis with no findings made by Senior Judge Lush in respect of conduct, and no attribution of blame pursuant to section 16(8). It is plain also from the decision in *Holt v Protection Commissioner* (1993) 31 NSWLR 227, the decision of the New South Wales Court of Appeal which has been recognised as a useful starting point by higher courts in this jurisdiction, that where there are no findings of unsuitability, the matter comes down to a pure best interests decision (I note paragraph 40(v) of *EB v RC* setting out that principle from *Holt*).

44. In *Essex County Council v CVF* [2020] EWCOP 65, when faced with allegations of poor conduct on the part of the deputy in that case, Lieven J at paragraph 26 then proceeded to determine the application on the following grounds:

> "CVF's wishes are very clear. She does not wish for her mother to continue as her deputy. She feels that her mother is using this as a way to control her via the money. In my view, this is a very clear-cut situation because JF's role is leading to conflict between CVF and JF and is undermining the prospects of them having a better relationship. I can see no disadvantage to the local authority becoming property and affairs deputy and so clearing the way so that JF and CVF can try in the near future to regain a relationship. Such a change is plainly in CVF's best interests and accords with her wishes and feelings. I have no hesitation in making the order sought by the local authority."

45. While in *CVF* s16(7) was not expressly stated as the gateway for discharging the deputyship, the decision was arrived at without making findings as to conduct and grounded in the language of 16(7).

46. I conclude that the case law is not such as to lead me to determine that 16(7) is not an appropriate mechanism or means by which a deputyship can be discharged. I am fortified in that view by the decision of *Long v Rodman* [2019] EWHC 753 (Ch), a decision of Newey J, who made it quite clear that the power to vary or discharge the

order appointing Mr Long in that case was conferred by section 16(7) of the Mental Capacity Act. Newey J went on to say:

> "Since decisions under the Act must be made in the best interests of the patient (see section 1(5)), the ultimate question must be as to what is in Mrs Rodman's best interests. In determining that, all the relevant circumstances must be considered (section 4(2)). I must, in particular, take into account the views of 'anyone engaged in caring for the person or interested in [Mrs Rodman's] welfare' (section 4(7)(b)). The persons 'interested in [Mrs Rodman's] welfare' can be expected to include her four daughters."

47. If I were to accept the submissions made on behalf of C and proceed on the basis that discharge could only occur in the circumstances set out within 16(8), it would lead to a curious position whereby the court would have to be satisfied as to the conduct set out therein before making the order discharging even if such continued appointment were no longer appropriate or necessary for reasons other than conduct of the deputy. The Court of Protection is by necessity an agile and responsive court. It makes orders that reflect changing circumstances to promote the needs and best interests of P. It would not be consistent with that or the overriding objective if the court could not discharge a deputyship when the best interests of P require it, notwithstanding that there is not the conduct under s16(8).

48. I further note paragraph 8032 of *Heywood & Massey: Court of Protection Practice* where the learned authors say as follows:

> "MCA 2005 section 16(8) provides that the court may in particular revoke the appointment of a deputy or vary the powers conferred upon him if it is satisfied that the deputy has behaved or is behaving in a way that contravenes the authority conferred upon him by the court or is not in P's best interests or proposes to behave in a way that would contravene that authority or would not be in P's best interests."

It goes on to say:

> "However, it should be noted that the court's power to revoke or vary the appointment of a deputy is not confined to these circumstances and it may revoke or vary such appointments whenever it considers that it is in P's best interests to do so."

The learned authors draw a distinction between lasting powers of attorney and deputyships, and of course the language of sections 22 and 16 differs. Section 22 does not carry the equivalent of 16(7).

49. It is also, in my judgment, wrong to draw a distinction between appointment and order. It is, if there is a distinction, a distinction without a difference. It is in my judgment plain that any appointment is made pursuant to an order. Accordingly, 16(7) is engaged.

50. It is said that if the court proceeds upon the basis that 16(7) is a mechanism by which a deputyship can be discharged, 16(8) is rendered superfluous. I reject that submission. The words "in particular" featuring within 16(8) do not connote an exhaustive list of circumstances in which a deputyship may be revoked or discharged. While it may be odd to have a specification under 16(8) together with a generality under 16(7), that oddity is not such as to lead me to conclude that s16(7) is not a gateway to discharge if appropriate.

51. The question for the court then is whether it is in P's best interests for the deputyship to continue, whether in the form currently drafted or in an alternative form.

52. I return to section 16(4), which sets out the circumstances in which a deputy may be appointed. It says as follows:

> "When deciding whether it is in P's best interests to appoint a deputy, the court must have regard (in addition to the matters mentioned in section 4) to the principles that -

(a) a decision by the court is to be preferred to the appointment of a deputy to make a decision, and

(b) the powers conferred on a deputy should be as limited in scope and duration as is reasonably practicable in the circumstances."

53. The Code of Practice to the Mental Capacity Act says this under paragraph 5.8:

> "Under the Act, many different people may be required to make decisions or act on behalf of someone who lacks capacity to make decisions for themselves."

It then goes on to set out examples of decision-makers that may feature in any particular case.

54. At 8.31:

> "Sometimes it is not practical or appropriate for the court to make a single declaration or decision. In such cases, if the court thinks that somebody needs to make future or ongoing decisions for someone whose condition makes it likely they will lack capacity to make some further decisions in the future, it can appoint a deputy to act for and make decisions for that person. A deputy's authority should be as limited in scope and duration as possible."

55. At paragraph 8.38:

> "Deputies for personal welfare decisions will only be required in the most difficult cases where:
>
> [1] important and necessary actions cannot be carried out without the court's authority, or

[2] there is no other way of settling the matter in the best interests of the person who lacks capacity to make particular welfare decisions."

8.39 then provides examples of circumstances in which a deputyship may be required.

56. Court of Protection Practice records statistics demonstrating how rare a personal welfare deputyship is, no doubt reflecting the principles that I have set out above and are repeated within the case law. However, it is right to note that reference to "the most difficult cases" in paragraph 8.38 should not be construed as a gloss upon the words of the statute. Indeed, as Hayden J observed in *Re Lawson, Mottram and Hopton (Appointment of Personal Welfare Deputies)* [2019] EWCOP 22, that wording is reflective of the likely outcome and should not be regarded as the starting point.

57. As noted, in support of the application to discharge, the Health Board cite the fact that P is not living with C, the care provided to him is commissioned by the Health Board with no expectation of change, C is not allowed into M, her contact is supported by others, and her relationship with many of the professionals responsible for providing care is in some circumstances very poor and now governed by prescriptive and detailed protocols. They say the specific decisions she is able to make under that deputyship are not matters over which she has any control.

58. It is said by the Health Board that the deputyship is not consistent or conducive to positive working relationships. The answer in this and in any other similar case is for those involved in the care of P to work collaboratively. The deputyship is not conducive to that. The deputyship has the effect of elevating one individual to a special legal status. Working together will avoid the trap of imposing upon P an overly protective approach.

59. It is said by the Health Board that the deputyship as currently drafted is too wide in scope and of no finite duration, not even a review, that being the very antithesis of 16(4)(b). While there is a redraft submitted on behalf of C that I shall come on to, it is said that that redraft does not meet the concerns that are set out by them.

60. It is said by the Health Board that there are no immediate decisions that are to be made or are likely to be made requiring the exercise of the deputyship.

61. In respect of wishes and feelings, the Health Board recognise that respect has to be afforded to P's wishes and feelings where they can be obtained. However, it is said by them that the issue of deputyship is so conceptually complex that his wishes and feelings cannot be obtained or obtained reliably. The Health Board say that while the love that C has for P is not in question, it would not be right to extrapolate from that love that she has for P and P undoubtedly has for her, that he would want her to make any or all of the decisions that the deputyship provides for. They conclude that this is not a case where a deputyship is appropriate or necessary but that if the deputyship is discharged it does not detract from C's involvement in P's life, which is underscored by the deputy upon decision-makers to consult pursuant to section 4(7) and indeed the protocols that I have approved.

62. The Health Board's position is supported by the litigation friend.

63. C's position in respect of the deputyship is one where no formal concession on any of the points is made. However, a proposed variation was submitted and is said to meet any concerns the court might have. The variation again has the appointment lasting until further order. It authorises the deputy to make decisions on behalf of P. Paragraph (iv) is amended in the proposed draft to "consenting routine medical and dental examination and treatment on his behalf in line with the attached protocol to this order", being the medical protocol I have approved; (v) "making arrangements for the provision of care services" remains; (vii) "complaints which are specific to P's medical or therapeutic treatment or specific aspects of his care regime" now has attached to it "which don't involve interactions with the deputy and those caring or treating P"; and (viii) "decisions about his future care and education" remain.

64. "Where he should live, with whom he should live, decisions on day-to-day care including diet and dress and whether he should take part in social activities" is removed under the proposed variation, albeit the variation provides that those involved in P's care should consult and include C about day-to-day care including diet and dress and whether he should take part in leisure or social activities.

65. It may well be that the removal of (i) through (iii) and (vi) in the proposed draft submitted by C is a recognition that those decisions are not matters that C is in a position to make.

66. It is said on behalf of C that the court is not in a position to discharge the deputyship or certainly not discharge beyond the limited points made that I have outlined. The position statement submitted reads, at paragraph 37:

> "Consideration should be given to considering whether and to what extent P's values impact upon the issue of his mother retaining her deputyship, as was set out in the report of Mark Corfield [an independent social worker instructed in this case]:
>
> > 'It appears without contention that the two factors of magnetic importance within P's life are contact with the family and contact with the wider community he has developed with C's assistance over a number of years. It is submitted that the recognition of the importance of family should be part of considering whether it is in P's best interests for the deputyship to be varied or revoked.'"

67. The position statement goes on at paragraph 38 to say:

> "Removal of the deputyship would amount to a violation of C's article 8 rights even in circumstances where P is an adult. Her article 8 rights are not defined by the end of her parental responsibility, as defined in the Children Act 1989."

68. At paragraph 39:

> "The court should take into account the fact that C would be distressed if she were to have the deputyship revoked. She is the deputy to advance P's welfare. She acts only to protect him and

> further his best interests. Pursuant to section 4(6)(c), if P were to have capacity, he is most unlikely to want to cause distress to his mother."

69. At paragraph 40:

> "C is prepared to have a dialogue about limiting the exact nature of the health and welfare deputyship order, to narrow or circumscribe her duties to P and her rights as a validly appointed deputy."

70. Those submissions were expanded upon in oral submissions made to me by Mr McKendrick. He says there is no evidence before the court to enable the court to make a best interests assessment; there is no section 4 balance or assessment made; and there is nothing contained within the evidence submitted to enable the court to perform that assessment itself. He says it is for the Health Board to demonstrate that the continuation of the deputyship is not in P's interested and that the Health Board failed to overcome that hurdle. He notes that C has held the deputyship for a significant period of time and that she has played an extensive role in supporting P's access to medical care and attention. He provided me with a printout compiled by C of all the medical appointments P has attended in the last 12 months or so. I count 60 or so such appointments. It is said that it is C who has the most comprehensive knowledge of P and his medical needs and issues. His health needs, as demonstrated by the number of visits to clinicians, are incredibly complex and it is C who has that wealth of knowledge that nobody can replicate and that it is she that is best placed to liaise between the different professionals, informing the neurologist what the GP said and so on. It is submitted that one cannot even hope that a myriad of different carers, with the nature of the industry being such that consistency may not be achievable, could possibly take the role that C has hitherto. His overarching point is that there is no evidence before the court as to who the decision-maker or makers will be. If the deputyship is discharged there has to be clarity as to what is replacing it, and at the moment that is ill-defined.

71. Mr McKendrick points to the shifting nature of the application, in that it was an application that was commenced alleging poor conduct. Nowhere other than the position statement is the application as presented now outlined or set out in any detail. He says that the court should respect the decision of DJ Crowley (as he was) and that should be the starting point.

72. On behalf of V it is said that the court should retain that part of the deputyship that relates to subparagraph (d) of the proposed revised deputyship order only. In respect of the remaining parts, V takes a neutral stance. It is said on behalf of V that he has not always felt updated or involved in issues pertaining to P's medical treatment and that there are concerns that the health board, or more specifically M and those associated with M, will fail to keep him updated and informed. P, it is said, has very complex needs and C has proved to be a very effective point of contact.

73. As noted, the litigation friend supports the position of the Health Board.

74. In my judgment, it is appropriate to discharge the deputyship in entirety. Many of the decisions in respect of which authority is provided under the deputyship are now matters that are firmly before the Court of Protection or are otherwise matters in respect of which C is no longer the decision-maker, in particular residence, with whom P should live, the day-to-day diet and dress, leisure and social activities, provision of care, services and future care. To retain a deputyship in respect of those matters would be disproportionate and unnecessary and would represent an unjustifiable intrusion into P's life and decision-making. Such an order would be contrary to the principles of section 16(4) and the guidance thereto and the principles echoed through the case law.

75. Likewise in respect of medical treatment, the circumstances are now such that the current deputyship seems to me to amount to a request for a deputyship to enable C to continue to be informed. That is provided for by the section 4(7) duty. Indeed, should any party be unaware or mistaken as to the extent of their duty under 4(7), it is now fortified by the protocols that I have proved.

76. Further, the current deputyship and proposed variation in those circumstances would, in my judgment, run contrary to the guidance provided by Keehan J in *YH v Kent*

County Council & Ors [2021] EWCOP 43. The relevant paragraph is helpfully set out at paragraph 41 of the Health Board's position statement, where Keehan J said that YH's position in that case was one where, in effect, the applicant seeks the deputyship so that she has a label, a status and so that she would be listened to and consulted. That, in the view of Keehan J, was not an appropriate basis upon which to found an application for deputyship. He went on to say this at paragraph 32 of his judgment:

> "I would be content for this order and/or the care plan to set out clear indications of the importance of the role of YH in being involved in decision making about the care and life of her sister, CB, but welfare deputyship is about making decisions for an incapacitous person. They are to be limited in time. The reality of the application is it is not to seek authority to make decisions, it is in relation to status and a desire to be taken seriously and listened to by professionals …"

77. Paragraph 33:

> "That is not, as the Official Solicitor submits, an appropriate use of deputyship. In any event, were this application based on making decisions for CB … deputyship would be required for years to come and not, as decided by Baker J in *G v E*, on a very time limited basis and restricted scope … if there was the collaborative and cooperative approach taken by all involved in making decisions about CB … such an order and remedy would not be required. I also take account of the fact that there has been a very substantial change in circumstances in recent times."

78. Paragraph 35:

> "Accordingly, I am not persuaded that it is appropriate for me to appoint YH … The reasons for it being sought do not fall within the framework of section 16 of the 2005 Act, and it would be for an inappropriate and impermissible use of section 16 …"

79. I also note and adopt the observations of the Health Board at paragraph 60 of the skeleton argument submitted, where they say this:

> "Mark Corfield the independent social worker's observations in his first addendum report are relevant here, at paragraph 1.37.3 of Mr Corfield's report:
>
> > 'Whoever is responsible for providing day-to-day care to P will be responsible for undertaking MCA assessments surrounding decisions which arise and subsequently best interest decisions where P may lack the capacity to make decisions. It would be impractical for C to be consulted about every decision and those supporting P will be responsible for maintaining his overall safety. They therefore must be empowered to take responsibility for his overall care as they will undoubtedly be held accountable to ensure his safety and promote his autonomy.'"

80. It seems to me that a deputyship as contended for by both C and supported by V would run contrary to those principles and indeed would amount to that impermissible use identified by Keehan J. The appropriate approach is for consultation to be pursuant to section 4(7), supplemented by the protocols that I have approved and for that collaborative approach that Keehan J highlighted.

81. I reject the contention there is nothing before the court on which the court can make a best interests assessment. It is clear that best interests requires consideration of all the circumstances, an assessment of matters including the extent to which an order or decision intrudes into P's life. I accept the Health Board's assessment of the actual circumstances surrounding the provision of P's needs in relation to P. The fact that this order is not limited in time is one factor that the court can consider. The order provides for decision making to be vested in C when she is not in a position to make those decisions. That is a factor that the court can weigh. The effect that an order or the continuation of the deputyship would not enhance the collaborative approach required

in this case with clinicians and indeed might, at worst, be detrimental to it, are relevant factors to the section 4 assessment.

82. In arriving at the conclusion that it is in P's best interests for this deputyship to be discharged, I have had regard, as Mr McKendrick encourages me to do, to the fact there is no analysis of wishes and feelings in this case, with wishes and feelings, of course, being an important factor. But, in my judgment, the submission by the Health Board and the litigation friend is a sound one in this regard: wishes and feelings on a conceptually complex matter such as this deputyship is difficult, if not impossible. One cannot extrapolate from the love that P has for his mother that he would wish for her to be deputy.

83. While the decision to discharge the deputyship may well infringe upon rights held by C, in so far as it does, it is an appropriate infringement. In arriving at the decision that I have, I have also had regard to the United Nations Convention on the Rights of Persons with Disabilities, article 12.4. But ultimately I conclude that the deputyship should be discharged since the overwhelming majority of the matters in respect of which C has authority under the deputyship are matters in respect of which she is not the decision maker, and those matters that remain are such that the role that is proposed by C under the deputyship falls foul of the guidance given in, in particular, *YH v Kent* by Keehan J and represent an order that is not the least restrictive that the court can make or decision the court can arrive at in this case.

84. For those reasons, I consider it to be in P's best interests that the deputyship is discharged.