Neutral Citation No: [2023] NIFam 3 *Judgment: approved by the court for handing down (subject to editorial corrections)**	*Ref:* **ROO12061** *ICOS No:* **DJ 2022/67** *Delivered:* **14/02/2023**

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

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FAMILY DIVISION
OFFICE OF CARE AND PROTECTION

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Between:

BELFAST HEALTH AND SOCIAL CARE TRUST

Plaintiff:

and

KL (THE PATIENT)

First Defendant:

and

ML

Second Defendant:

and

OFFICIAL SOLICITOR

Third Defendant:

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COMMISSIONER FOR OLDER PEOPLE FOR NORTHERN IRELAND

Notice Party:

JUDITH HUTCHINSON, SOLICITOR,

Notice Party:

PATIENT'S FINANCIAL CONTROLLER,

NL, OP & QR

Notice Parties (Patient's Children)

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Michael Potter BL (instructed by Directorate of Legal Services, Solicitors) for the Plaintiff
The Second Defendant appeared as a Litigant in Person
Melanie Rice BL (instructed by the Official Solicitor) for the First and Third Defendants

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ROONEY J

Anonymity

For the purpose of this application the first defendant (the patient) and his children (the second defendant and notice parties) have been anonymised. Nothing should be published which would identify these parties.

Introduction

[1] The patient, KL, is 86 years old. On 7 March 2019, KL was formally assessed by Dr English who determined that KL, by reason of mental disorder/mental impairment (namely dementia), lacked the capacity to decide on his current and future place of residence and care needs. Dr English further stated that as dementia is a chronic and progressive condition, KL is not expected to regain capacity in the future.

[2] A further assessment was carried out by Ms Irvine on 23 June 2022. Ms Irvine determined that, on the balance of probabilities, KL was experiencing an impairment in the functioning of his brain from the diagnosis and onset of Alzheimer's dementia directly affecting his capacity to make decisions relating to consent to care and treatment. No dispute has been raised by any party concerning KL's lack of capacity.

[3] According to an affidavit of Ms Murphy, solicitor for the plaintiff, KL first came to the attention of the South Eastern Health and Social Care Trust when he was found wandering and at an increased risk within the community. KL was placed in Sir Samuel Kelly Residential Home on 17 January 2019. He was given notice to leave this placement due to significant family tensions and was placed in Laurelhill Care Home on 18 July 2019. On 26 August 2020, one of his daughters, ML, the second defendant, removed KL from the care home to reside with her at her residence. KL has remained with the second defendant since this date, except when he was admitted to hospital.

[4] The Belfast Health and Social Care Trust assumed responsibility for KL from 6 September 2020.

[5] The plaintiff Trust expressed concerns regarding KL's safety due to what is described as "unknown details of care being provided to him." In or around July 2022, the plaintiff Trust brought an application for declaratory relief, whereby it requested the court to exercise its inherent jurisdiction to authorise the plaintiff Trust to take responsibility for the care of KL and also an Interim Relief Order to allow the plaintiff Trust to remove KL to Oak Tree Manor Nursing Home, Dunmurry.

[6] The application for declaratory relief was lodged for two main reasons. Firstly, the plaintiff Trust was concerned that KL was not receiving the required care and the second defendant had failed to provide sufficient evidence of same. Secondly, as a result of conflict between the second defendant and her siblings, the latter had no contact with their father as they refused to visit him at the second defendant's home.

[7] The case has been reviewed by this court on several occasions and various directions were given. By Order of this court dated 2 August 2022 the Official Solicitor to the Court of Judicature in Northern Ireland (the third defendant) was appointed Guardian ad Litem for the patient.

[8] It was agreed at a review hearing on 3 October 2022 before McFarland J that the patient did not have the capacity to make relevant decisions concerning his place of residence and care plan and that the Trust were not required to provide an expert report on this issue. The application for declaratory relief was listed for hearing on 12 January 2023.

[9] On 12 January 2023, the court was advised that on 19 November 2022 KL had been admitted to the Ulster Hospital. The plaintiff Trust provided a report from Ms Jayne Adair, Interim Principal Social Worker, dated 9 January 2023. The hearing date was adjourned to allow the second defendant an opportunity to consider the contents of Ms Adair's report. A hearing date was fixed for 25 January 2023.

[10] Mr Potter BL, on behalf of the plaintiff Trust, at the hearing advised the court that there had been a deterioration in KL's health and that due to his increased care needs, the plaintiff Trust's application for declaratory relief would be based on Ms Adair's report. Accordingly, it was agreed between the parties, that Ms Adair would give oral evidence arising out of the contents of her report and that she would be subject to cross-examination by the other parties. The second defendant, and the Official Solicitor were invited to indicate whether they intended to call any evidence. Further directions were given in advance of the hearing date on 25 January 2023.

The Relevant Legal Principles

[11] The relevant legal principles have been detailed by Keegan J in the matter of *AK (Inherent Jurisdiction: Patient: Moved to Residential Care: Contact)* [2021] NIFam 9. In the course of her judgment, Keegan J referred to the decision in *Hillingdon London Borough Council v Neary* [2010] 122 BLMR which is authority for the proposition that declaratory relief is required regarding the question of whether or not it is in the best interests of the person to be in residential care at all. As stated by the court, Article 8 of the European Convention on Human Rights ('ECHR') is engaged. In *Hillingdon*, the court also said at paragraph 33:

> "Significant welfare issues that cannot be resolved by discussion should be placed before the Court of Protection, where decisions can be taken as a matter of urgency where necessary. The DOL scheme is an important safeguard against arbitrary detention. Where stringent conditions are met, it allows a managing authority to deprive a person of liberty at a particular place. It is not to be used by a local authority as a means of getting its own way on the question

> of whether it is in the person's best interests to be in the place at all. Using the DOL regime in that way turns the spirit of the Mental Capacity Act 2005 on its head, with a code designed to protect the liberty of vulnerable people being used instead as an instrument of confinement. In this case, far from being a safeguard, the way in which the DOL process was used masked the real deprivation of liberty, which was the refusal to allow Steven to go home."

[12] The plaintiff Trust submits that any deprivation of liberty can be dealt with under the Mental Capacity Act 2016, provided there is agreement. However, in the absence of agreement, Article 8 of the ECHR is engaged, and the inherent jurisdiction of the court is necessary to deal with the issue of residential care.

The Application

[13] In *NS* [2016] NI Fam 9 at paragraph [46], Keegan J outlined the legal tests to be applied by the court pursuant to an application for declaratory relief under the inherent jurisdiction of the court. The relevant questions are as follows:

> "(i) Is the patient incapable of making a decision regarding the particular issue put before the court?
>
> (ii) If so, is the plan/treatment proposed in the best interests of the patient?
>
> (iii) Is the intervention necessary and proportionate pursuant to Article 8 of the ECHR?"

[14] The first question is not controversial. Based on the medical evidence discussed above, McFarland J has already ruled that KL is incapable of making decisions concerning his care, treatment and place of residence.

[15] The second question, namely, the plan to provide KL care and treatment with nursing supervision in Oak Tree Manor Nursing Home is strenuously disputed by the second defendant. In order to decide this question, I heard evidence from Ms Jayne Adair, Interim Principal Social Worker. This evidence will be discussed in detail below. Having considered the report from Ms Adair and having heard her evidence, the Official Solicitor agreed with the plaintiff Trust's application that it would be in KL's best interests for him to have his care needs provided by the Oak Tree Manor Nursing Home. No evidence was called on behalf of the Official Solicitor.

The Evidence

[16] Ms Jayne Adair, Interim Principal Social Worker, gave evidence on 25 January 2023. As stated above, she had prepared a report dated 9 January 2023 which had been shared with the parties in advance of the hearing. Ms Adair requested that her

report be adopted as part of her evidence. In the said report, Ms Adair made specific reference to a Best Interests Meeting dated 22 December 2022 and to an Occupational Therapist Specialist Summary completed by Deborah Taylor, Occupational Therapist, dated 22 December 2022. The Best Interest Meeting was attended by the following professionals, Sarah Campbell (Senior Social Work Manager), Victoria King (Senior Social Work Practitioner), Heather Barnes (Senior Social Work Practitioner) and Ms Jayne Adair.

[17] At the Best Interests Meeting minutes, it was clear the professionals considered three possible options, namely:

(i) KL's return to reside with his daughter, ML, with a comprehensive package of care to meet assessed needs;

(ii) to move KL to an interim placement to allow court proceedings to take their course to inform future care planning, and

(iii) to allow KL to remain in hospital until a further court direction.

[18] It is significant that, when considering option (i), no adult safeguarding concerns were noted on admission to the Ulster Hospital. Also, no concerns were raised on admission to hospital relating to inadequate care.

[19] However, in relation to the burdens associated with option (i), it was noted that previously there had been a lack of engagement by ML with the Social Work Team and the carers when a package of care was in place. It was also highlighted that there was no current package of care and no ongoing ability to safeguard KL. It was stated that previous offers of a care package had been rejected and that there was no family involvement due to a breakdown in the family relationships. Significantly, KL was confined to an upstairs room, and he lacked the ability to come downstairs to access other services. The conclusion reached was that these burdens contributed to the risk that KL's needs would not be met, thereby impacting on his wellbeing.

[20] With regard to option (ii), the main benefits were that the KL's care needs could be fully met, all family members could share access, he would be in the same home as his wife and the risk of acquiring infection in the hospital would be eliminated. The burdens were identified as the risk of a Covid outbreak in the home which would restrict family contact, possible distress with an unfamiliar environment, the possibility of quality of care issues and family dynamic impacting on the placement.
[21] Option (iii), namely, to remain in hospital, was not considered to be a real option. No issue appears to be taken by any parties with the rejection of this option.

[22] The multi-disciplinary team (MDT) advised that KL required full care. It was stated in the minutes of the Best Interest Meeting that KL's family were consulted on the option of an intermediate care placement. OP (KL's daughter) stated that remaining in hospital was not in the best interests of her father and she believed that

most of the family would support a move to Oak Tree Manor to be with his wife. On the other hand, ML, when spoken to prior to the meeting, stated that a care home would not provide the standard of care necessary to meet her father's needs and that she would wish to continue with his care.

[23] On 6 January 2023 KL was visited by Ms Melanie Hanna, Patient Advocate, Alzheimer's Society, to ascertain his views. Unsurprisingly, his responses were unclear relating to his future care arrangements, although he did say he would like to reside with his wife who was in a care home.

[24] On 9 January 2023 an update was provided on KL's health. Medical advice confirmed that the source of infection was in the gall bladder, but that surgical intervention would not be appropriate due to KL's general frailty and comorbidities. KL presented as more agitated on the Ward and resistant to care interventions, including pulling out cannulas delivering IV's. It is noted that KL had tested positive for Covid-19 and that, in tandem with his confusion and agitation, staff were attempting to deliver care despite the challenges.

[25] Turning now to the evidence at the hearing, Ms Adair updated the court on KL's current assessed care needs. The following was highlighted:

(a) **Mobility**:
Physiotherapists and occupational therapists had attended KL to carry out assessments. They advised that KL requires the full assistance of *two* carers for all transfer and the completion of personal care. It was stated that the therapists have attempted to use a STEDY hoist to assist KL to stand, but due to the deterioration in his health, he is unable to weight bear. The conclusion reached was that KL requires a hoist for all transfers. Also, although KL was assessed as able to sit upright in a chair, he was mostly nursed in bed. Drowsiness had impacted on the completion of a full assessment.

(b) **Skin Care**:
KL's skin was intact and did not require a specialist pressure relieving mattress. In hospital, it was necessary to re-position him at regular intervals to maintain skin integrity.

(c) **Nutrition**:
It was stated that KL requires individual assistance and encouragement to eat and drink. He was able to manage normal fluids but required a modified pureed diet. His intake remains poor. A speech and language therapist assessed KL's risk of choking as low provided he was fed the appropriate diet and was alert and sitting up when eating and drinking. It was also noted that KL had lost motivation to eat and drink. KL's daughters assisted with feeding on the ward to encourage his intake and it appears that he responded positively to the assistance of his daughters.

(d) **Mental Health**:
KL displayed symptoms of agitation associated with delirium on admission. According to Ms Adair, this resolved, and KL presented as settled on the Ward, albeit with some renewed delirium symptoms.

(e) **Continence Care**:
KL remains doubly incontinent. He requires regular personal care to change pads to promote dignity, comfort and to maintain skin integrity.

[26] Ms Adair highlighted the following in her report:

> "It is the responsibility of the Belfast Trust to ensure that [KL's] care needs are satisfactorily met. Given the recent health deterioration and increased care needs, the Trust is of the view that a nursing home environment is the most appropriate response to the current assessed need. [KL] has a diagnosis of dementia, and his symptoms are now assessed as severe. Dementia is characterised by a deterioration in cognitive function and in the later stages of illness motor skills, both gross and fine, are impacted. Dementia is a progressive condition and [KL] would appear to be in the terminal stages of his illness. Responsive and comprehensive palliative care is required to ensure that [KL's] needs are met and that he is comfortable in this stage of his illness."

[27] In her evidence, Ms Adair stressed that having assessed KL's needs, the Belfast Trust was of the opinion that the care arrangements provided to him in hospital can be best replicated in a nursing home with staff suitably trained in dementia. Ms Adair stated that a nursing home, wherein supervision can be provided by qualified nurses, would be the most appropriate setting to deliver the necessary care to KL.

[28] Ms Adair was of the opinion that it would be difficult to provide KL's current level of dependency in a safe and cost effective way in a domiciliary setting. In her report, Ms Adair stated as follows:

> "Domiciliary care is delivered in specific time slots and this can be problematic when dealing with a person with severe dementia. [KL] may be drowsy and unable to participate in his care at times. In a nursing home setting the 24-hour nature of the care means that if [KL] is not able to participate in care the staff will be able to return to meet that need after a short interval of time. This is not possible in a domiciliary setting and if [KL] is resistant to care due to distress or fatigue it could be a number of hours before staff can make the next call. Current domiciliary capacity

> issues combined with the previous challenges in providing a pattern of care which meet [KL's] needs and [ML's] expectations mean the Belfast Trust would not be confident that [KL's] needs could be satisfactorily met in [ML's] home."

[29] In conclusion, Ms Adair stressed that KL's care needs are complex and have increased to the point where his multi-disciplinary team believe that they would be best met in a care home. Ms Adair stated that it is likely that KL's health will continue to fluctuate and deteriorate and that the provision of care in a nursing home facility is in KL's best interests.

[30] ML cross examined Ms Adair. As a personal litigant, I gave ML considerable latitude regarding the subject matter of her questions and the manner in which the questions were formulated. Frequently (and this is not a criticism) ML's questioning descended into monologues. However, the court and Ms Adair was left in no doubt that the thrust of ML's questions was that she was in the best position to look after her father. ML was particularly annoyed by the fact that she had not been allowed to participate in the Best Interest Meeting. ML also raised concerns that the medical records which ought to have been made available prior to the Best Interest Meeting, were not disclosed by the Trust. In the end, apart from reaffirming her preference for domiciliary care for her father, ML was unable to refer to any evidence which directly challenged the view of the Trust that KL's immediate care needs could be best met in an interim placement in a nursing home.

[31] At the hearing on 25 January 2023 no evidence was called by the second defendant. During closing submissions, ML referred the court for the first time to statements from witnesses which she said supported her case. Accordingly, I adjourned the hearing to allow ML to produce the statements and call evidence if she wished. ML also requested that a report be obtained from KL's treating Consultant, namely Dr Aileen McSorley. I agreed and directed Dr McSorley to produce a report dealing with KL's condition on admission, inpatient care and updated assessment. A further hearing was then scheduled for 3 February 2023.

[32] The hearing resumed on 3 February 2023. Documents produced by ML included a statement from Dr Paul Corrie dated 26 January 2023. Dr Corrie was not called to give evidence. Mr Potter raised no objection to the admission into evidence of Dr Corrie's statement without formal proof.

[33] In his statement, Dr Corrie, indicated that he has been a general practitioner for over 35 years and has known ML for over 20 years. Dr Corrie described ML as a genuine hardworking, caring, and responsible individual. Dr Corrie further commended ML's decision and commitment to look after her parents in her home.

[34] With regard to KL, Dr Corrie states that:

> "He reacts very well to [ML] and he seems to engage with her most effectively and I can concur he would be better to be in a familiar setting at this stage of his life. I have no difficulty with her level of care from experience and understand the importance of consistency of routine and familiarity assists any older person with dementia."

[35] The court agrees with the general comments and observations made by Dr Corrie. However, the weight to be attached to Dr Corrie's statement is limited. Firstly, it is unclear when Dr Corrie last saw KL in his daughter's home. Secondly, the statement makes no reference to Dr Corrie attending at the Ulster Hospital and making an assessment as to KL's needs. Thirdly, it seems clear that Dr Corrie did not have access to the report from Jayne Adair, which included an assessment of KL's needs in light of a deterioration in his health.

[36] ML made a submission to admit into evidence a statement from Mr David Curry. Mr Potter raised no objection. The statement was not signed. Since Mr Curry was present in court, I gave permission to ML to call him to give evidence. Mr Curry indicated to the court that, although he had no professional qualifications, he had worked in domiciliary care for over 35 years and held roles as a Quality Assurance Manager and Service Manager associated with domiciliary care.

[37] Mr Curry acknowledged that he was a personal friend of ML. He confirmed that he knew and had visited KL at ML's home. Mr Curry gave an opinion, without citing any authority, that experts are of the view that persons suffering from dementia are best looked after at home.

[38] Mr Curry stated that he last saw KL in October 2022 in ML's home. He commended ML on the care that she had provided to her father. After KL was taken into hospital, Mr Curry's evidence was that he had "face timed" KL on two occasions.

[39] A major aspect of Mr Curry's evidence was that, when he visited KL and his wife in their daughter's home, he witnessed safe and compassionate care delivered to the highest calibre together with utmost respect and dignity. It was Mr Curry's opinion that it would be unfair to remove KL from hospital to another institutional environment.

[40] This court, without reservation, agrees that if the best interests of the patient are equally balanced between care in a home environment on the one hand, and institutional care on the other hand, then the former should prevail. However, on the evidence produced by the Trust, it is the opinion of the professionals responsible for the care of KL that he should be moved to Oak Tree Manor Nursing Home in his best interests. In fairness to Mr Curry, he stated that if the opinion of the professionals was that KL's condition had deteriorated, he would not take any issue with their decision to move KL to the nursing home.

[41] Quite correctly, in my view, Mr Curry did not seek to undermine or challenge the care provided to KL in hospital and the decision to transfer him to Oak Tree Manor Nursing Home. In this regard, it was recognised by Mr Curry that he did not have the relevant professional qualifications and expertise. Nor did he have access to the medical notes and records, including the care and needs assessments. For these reasons, only limited weight can be attached to the evidence of Mr Curry.

[42] ML also produced a statement from Ms Stephanie Green, Developmental Manager, Dementia NI. The statement was not signed. Ms Green was not called to give evidence. The statement provides no assistance in my determination in this case.

[43] ML called Ms Heather Barnes, Senior Social Worker, to give evidence. It seems that ML's purpose in calling Ms Barnes to give evidence was twofold. Firstly, to persuade Ms Barnes that all previous meetings and engagements between them had been cordial and professional. Although Ms Barnes held back from giving precise details, it was clear to this court that previous engagement between ML and the caring professionals had been less than harmonious.

[44] The second purpose for calling Ms Barnes to give evidence was, in effect, to allow ML another opportunity to challenge the conclusions reached in the Best Interest Meeting on 22 December 2022. In her capacity as a personal litigant, I permitted ML considerable latitude with this line of questioning. ML was plainly aggrieved by the fact that she had not been asked to participate in the Best Interests meeting and the fact that she was only contacted afterwards. In her evidence, Ms Barnes stated that at the Best Interests meeting, the attendees had access to the assessments made by the relevant professionals, including nursing, speech and language, occupational therapy, physiotherapy, and social work. ML questioned why the medical notes and records were not available for scrutiny. Mr Potter BL stated that the said records were confidential but would be made available to the court if so directed. Ms Barnes was clear that she stood by the assessment and decisions made in the Best Interests meeting.

[45] The court directed a report from Dr Aileen McSorley, Consultant Physician, in respect of KL's inpatient care at the Ulster Hospital since 18 December 2022. In a report dated 1 February 2023, Dr McSorley detailed that KL had been admitted to hospital with an acute onset of abdominal pain. The diagnosis was dehydration leading to hypernatremia (high sodium), delirium (acute confusional state) and infection of the biliary tract secondary to gallstones. It is noted that KL had a significant medical history of Alzheimer's Dementia, a previous CVA stroke, left hip avascular necrosis.

[46] While in hospital, KL had a second episode of infection of the biliary tract and a gallbladder perforation. His case was discussed with the gastroenterology team who felt that he was not fit for surgical intervention.

[47] Dr McSorley concluded as follows:

> "[KL] is frail and requires full assistance with all personal care and bed transfers. He has been immobile and has been bed bound for most of this hospital admission. I do not anticipate that this will improve significantly. This is on the basis of repeated infections and neurodegenerative condition which is a progressive disease and leads to increased dependency. He also remains at risk of repeated biliary sepsis and infections secondary to underlying gallstones, and each repeated infection is likely to leave him more frail and more deconditioned that previous."

[48] At the conclusion of the hearing on 3 February 2023 I asked ML whether she intended to produce a domiciliary care plan for her father. The hearing recommenced on 10 February 2023 when ML explained her proposed care plan. It was clear that ML's proposal for care of her father had not been formalised. She had approached a number of individuals whom she believed had the qualifications and experience to assist her to look after her father.

[49] In view of the fact that the Trust had only received ML's care plan, I permitted the Trust to recall Jayne Adair for her comments. Ms Adair stated in plain terms that the proposed care plan was simply not adequate to care for KL, whose health will continue to fluctuate and deteriorate. Ms Adair reaffirmed her opinion that a nursing home, with supervision from experienced and qualified nurses, was the most appropriate and responsive option to cater for KL's care needs. It was emphasised that KL required 24/7 care and that the proposed domiciliary care plan was inadequate in this regard.

Conclusion

[50] I have carefully considered the evidence of the Trust, and in particular, the evidence of Ms Jayne Adair, Interim Principal Social Worker, and the report from Dr Aileen McSorley. I have also considered the documentation produced by ML, to include the statement of Dr Paul Corrie and the oral testimony of David Curry. Throughout this hearing, I have listened carefully to all submissions made by ML.

[51] At this stage, I will reiterate my views expressed to ML during the course of the hearing, namely that she has my admiration for the care, devotion, and compassion that she has provided to her elderly father. At all times, ML has treated him with the greatest respect and dignity. I admire her determination to provide devoted care to her father.

[52] I agree with the sentiment advanced by ML and the care professionals that, so far as it is feasible, a patient suffering from dementia and other medical conditions should live at home with their family. In these situations, I am cognisant that KL's Article 8 ECHR rights are engaged and any interference with this right must be in accordance with the law, for the protection of his health and must be proportionate.

[53] Pursuant to section 2 of the Chronically Sick and Disabled Persons (Northern Ireland) Act 1978 and Article 15 of the Health and Personal Social Services (Northern Ireland) Order 1972, the Trust is under a duty to provide social care for KL. The decision for this court is whether the care recommended by the Trust is in the best interests of KL.

[54] In *JR138* [2022] NIQB 46 Scoffield J stated as follows:

> "[56] From the foregoing authorities, I draw the following general conclusions in relation to Section 2 of the 1978 Act:
>
> (a) The first step is for the trust to assess the individual's needs, which involves the exercise of judgment.
>
> (b) Once a need has been identified, the trust has a measure of discretion as to how that need should be met.
>
> (c) In considering how the need should be met, the trust is entitled to take into account:
>
> (i) the individual's own conduct (past or expected), insofar as this is relevant to the way in which the need can or will be met;
>
> (ii) the means of the individual or, in the case of a child, their parents;
>
> (iii) the assistance of others – including, but not limited to, other public authorities – which is reasonably expected to be available to the individual in order to assist with the meeting of their need; and
>
> (iv) the cost to the trust of providing the necessary services.
>
> (d) Accordingly, there is an element of discretion and judgment on the part of the trust in formulating the appropriate care package. In the absence of Wednesbury irrationality (including the leaving out of account of a clearly material consideration or taking into account of an irrelevant consideration), which is a high threshold, the court is very unlikely to upset the determination of the public authority with both the experience and expertise,

> and indeed the express statutory function at the legislature's behest, to set the appropriate care package."

[55] In reaching my decision, I have applied the principles of law as detailed above to this application for declaratory relief under the inherent jurisdiction, and in particular, the legal tests formulated by Keegan J in *NS* [2016] NIFam 9 at para [46] which I have referred to at para [13] above. Firstly, there is no dispute that KL is incapable of making a decision whether it is in his best interest to be discharged from hospital into residential care or to return to the home of ML. Secondly, having carefully considered all the evidence, I find myself persuaded by the oral evidence and the report of Jayne Adair, the review and the analysis contained in the Best Interests meeting on 22 December 2022 and the report from Dr McSorley. Accordingly, it is my decision that KL's condition has deteriorated, and he now needs longer term residential care. Returning to the care of ML is not an option and is not in KL's best interests. Thirdly, in my view, the intervention is necessary and proportionate pursuant to Article 8 ECHR.

[56] Accordingly, I make a declaratory order allowing the transfer of KL to Oak Tree Manor Nursing Home for long term residential care. The terms of the order are attached to this judgment.