IN THE COURT OF PROTECTION

Date: 25 July 2012

Before:

MR. JUSTICE MOOR

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Between:

Y COUNTY COUNCIL	**Claimant**
- and -	
ZZ	**Defendant**
(by his litigation friend, the Official Solicitor)	

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Aswini Weereratne (instructed by Y County Council) for the Claimant
Susanna Rickard (instructed by the Official Solicitor) for the Defendant

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JUDGMENT

MOOR J:

1. This is an application made by Y County Council in the Court of Protection in relation to Mr ZZ, a man of young middle age.

The Declarations sought

2. I am invited to make a number of declarations in relation to Mr ZZ. First, I am asked to find that he lacks litigation capacity on the issues in this case. Second, I am invited to declare that he lacks capacity to decide upon the restrictions relevant to supporting his residence and care. Finally, I am asked to declare that he is being deprived of his liberty, but that it is lawful as in his best interests pursuant to schedule A1 of the Mental Capacity Act 2005.

3. Mr ZZ is represented by the Official Solicitor. He has been present throughout the hearing and has conducted himself with dignity throughout. Indeed, he

gave unsworn, oral evidence before me in an entirely courteous and helpful way.

The Dispute

4. There is no dispute between the Official Solicitor and the local authority that I should make the three declarations sought. It is clear, however, that Mr ZZ himself is not happy about the third declaration and, in particular, the underlying basis on which he is deprived of his liberty. It is, therefore, necessary for me to examine critically the three declarations sought. It is also necessary for me to consider the one area of dispute between the local authority and the Official Solicitor, namely, the extent to which the restrictions on Mr ZZ could, in the foreseeable future, be relaxed.

The evidence and representation

5. I have heard expert evidence from Dr TR, a consultant psychologist, who has been responsible for the SOTSEC – Sexual Offenders Treatment Course – that Mr ZZ has just completed for the second time. I heard from Dr. RT, a consultant psychiatrist, who was called as an independent expert witness, having previously had no connection to the case, and from Dr BC, also a consultant psychiatrist, who is directly responsible for Mr ZZ'z psychiatric care at his current residential placement. I also heard from Mr MD, the local authority care manager for the Y Learning Disability Team, who has been responsible for Mr ZZ since 2008. Finally, as I have already noted, I heard from Mr ZZ himself.

6. The local authority has been represented by Miss Weereratne and the Official Solicitor by Ms Rickard. I am very grateful to everyone for the careful and considered way in which they have dealt with this difficult case.

7. I should make it clear from the outset that I have been very impressed by the quality of the care offered to Mr ZZ by the local authority. I realise entirely that Mr ZZ himself may not always appreciate or be happy with what they are doing for him, but I am quite satisfied that they give him a very high level of care and consideration. I make no criticism of them at all.

Mr ZZ's disability

7. Mr ZZ has a mild learning disability with an IQ of approximately 61 – 62. As a child he attended special schools. His learning disability affects his ability to understand complex concepts. He has traits of an autistic spectrum disorder, which impacts on his understanding of risk, but it is not possible to make a diagnosis of ASD due to features that point against such a diagnosis.

His family

8. He has had little contact with his father. Indeed, he has not seen him since 2010 and had only seen him on around four occasions in the previous two years. It is not known exactly where his father is, although he may be in a residential home in the H area. Mr ZZ sees his mother regularly. She lives in her own home in W. He goes there for the weekend once every three weeks from a Friday night to a Sunday evening. His mother supervises him whilst he is there. Although he is allowed into the garden on his own, he has to remain

in her line of vision. He only goes out accompanied by her. She has made it very clear that if he gets up to mischief, these visits, which he values greatly, will end. He, therefore, complies and there have been no difficulties reported. He has one married sister who comes to the mother's property to see him for supper on some Friday evenings.

Mr ZZ's history

9. There is a lack of information about Mr ZZ's early years due to the absence of detailed records, but the following history broadly emerges. In his early twenties, Mr ZZ started to exhibit sexualised behaviour towards children. He stole money and lit fires to draw emergency services to the scene. This appears to have occurred generally when he was angry or anxious. At some point, it seems that he was sexually abused by another resident of the establishment in which he was then residing. There were reports of him attempting to start a fire in a local building. Several hoax calls were made to the fire brigade. There was an incident of theft from another resident of a residential establishment in which he was then residing. He was, subsequently, moved to supported living. In his mid-twenties he had a series of encounters with the law. He was charged with theft in that it was said that he kept the proceeds of charity collections he was collecting. The following year he was arrested following an assault on a care worker at J Home in T and for damaging windows. The charges were dropped following an apology and compensation for the damage. The year after that, he was arrested following a further assault on a staff member who was trying to break up a dispute with his girlfriend whilst he was living in T. He was cautioned. Later that same

year he was arrested and charged with two counts of arson. In interview he admitted starting eight fires in places such as a caravan, cars and a shed. He also admitted an assault on a fire officer. He was remanded to X Prison for two weeks and then on bail to his mother's house. I should, perhaps, make it clear that fire-related concerns are now considered to be a low risk and I will not deal with this aspect again.

10. In January 1999 a hospital order was made pursuant to section 37 of the Mental Health Act to the B Hospital. He was there for 18 months.

11. In 2000 he moved into supported residential care at D House. He underwent counselling, but it was alleged that there was poor engagement. Attempts were made to reduce his staffing levels but without success. In 2003 further attempts were made to reduce his level of supervision, but there was an increase in inappropriate sexualised behaviour, so he returned to one-to-one supervision. In 2005 a guardianship order was made in favour of Y County Council under sections 7 and 8 of the Mental Health Act.

12. In June 2006 he married DZ, another service user at D House. I am told that she also has learning disabilities. In evidence, Mr ZZ told me that she is older than he is. Thereafter, Mr ZZ undertook a variety of treatment programmes looking at his sexual attraction to children and his sexual arousal from creating emergency situations.

13. In October 2006 there was an incident in which he was alleged to have spat at staff, attacked them and kicked one in the head and shoulder. It is clear that he was becoming increasingly unsettled at D House. He, therefore, moved to E Road, K, where he resided with two others. Mrs ZZ remained at D House. In

2010 she moved into independent living with two other women. There was contact between them, approximately every six weeks, but it is said that they both opted out of further opportunities to meet due to difficulties in their being able to manage each other's behaviours.

14. More recently, their relationship seemed to have broken down completely. It was said that Mrs ZZ had found a new partner, but I have heard that the relationship between them is now back on again, but Mrs ZZ does not feel ready to live with Mr ZZ at present. I will return to this in due course.

15. Later in 2006 there were further allegations against Mr ZZ of what I will describe as "low level assaults". More importantly, he was found to be dropping notes for children containing his telephone number. He was asking them to contact him for the purposes of sexual encounters for money. A relative of one child, who read one of these notes, attended at E Road to confront Mr ZZ. This scared Mr ZZ considerably. Mr ZZ made repeated requests to go into the community on his own, but it is clear that he had ulterior motives. For example, he would request to go to corner shops at times when children would be likely to be there. He would become aroused watching television programmes featuring children, such as *Waterloo Road* and masturbating at images of children.

16. In March 2007 there was a serious assault on a staff member and he returned to D House for four months. Thereafter, he went back to E Road and the restrictions on him were relaxed during 2010, but it appears that this was not successful. On 16th January he was reported as feeling excited at seeing young boys and girls in Tescos. On 23rd January, he saw children at the V Theatre

and reported feeling aroused. On 26th January he wrote in his journal about two girls in grey skirts doing handstands and arguing. The suggestion was that he found this sexually exciting. On 31st January he was found masturbating over children's TV programmes. On 7th February he reported feeling excited whilst watching a young girl from his bedroom window, imagining them having contact. On 21st February he wrote in his journal that he is "getting his feelings back about children. I think about them when I masturbate. It would be nice to have a relationship with a schoolgirl under age". He had also cut pictures from a newspaper of young girls in school uniforms and stuck them into his journal.

17. In the summer of 2010 it was again discovered that he was dropping notes covertly in the street inviting young boys to contact him on his mobile phone. This was happening even though he was being monitored by staff in the community. In August 2010 he was attempting to watch neighbouring young children playing in their garden and swimming pool through holes in the garden fence. It came to light that he was being left unsupervised for periods of up to 20 minutes in the front garden of the property. He applied to adopt a child with his wife. Inevitably, he was turned down but this, clearly, upset him.

18. On 23rd September 2010 he was given 28 days' notice to leave D Road. One of the reasons given was that he was continuing to drop notes for children. The situation deteriorated rapidly thereafter and a demand was subsequently made for him to move immediately. He, therefore, moved in September to reside at The J, in M. The J is managed by O. It is a locked environment for

managing people with challenging behaviours. He is not free to leave. He is escorted in the community at all times. He is supervised and monitored closely both in the home and in the garden. Mr ZZ was, initially, very pleased with the placement but he has since found it very restrictive. He complains that it is too big and noisy and that there are disturbances. I was told that there are several properties at the J. He is in one with a small number of other users. This property is the more restrictive of the properties housing male residents. If his level of supervision was relaxed substantially, he would move to a different property.

19. Mr ZZ has indicated a consistent wish to return to T or K, although he has given different reasons on different occasions. At times he has wanted to live with his wife; at others, to be close to his father, although his father appears no longer to live there. At others times he has said that he wants to reside in a smaller house with fewer residents. Unfortunately, the local authority, despite extensive efforts, has not been able to find anything that is suitable for him. Sensibly, he told me in oral evidence that he would be content to remain at The J until something more suitable could be found. Nevertheless, he continues in his express wish to leave The J in due course and, in any event, to have less supervision both in the garden there and in the community.

20. In the summer of 2010 Mr ZZ undertook his first SOTSEC Sexual Offenders' Treatment plan with a forensic psychologist, EM. Mr M's report is dated 9th December 2011. It says that Mr ZZ engaged well in a broad sense but there were concerns that he was just going through the motions. It was considered that he had a strong desire for deviant sexual activity with children. It added

that he required constant supervision in the community and should complete a further cycle of sex-offender treatment.

These proceedings

21. On 28th July 2011 a standard deprivation of liberty authorisation was made under schedule A1 of the Mental Capacity Act 2005 for six months. On 4th August 2011 a guardianship order was made under the Mental Health Act 1983. On 10th August 2011 the last decision was made by the first-tier tribunal not to discharge the guardianship order. It was noted that Mr ZZ had admitted being sexually aroused by children in school uniforms, that he had offered money to children for sex and had masturbated in public. On 1st December 2011 Y County Council applied to this court to determine whether the deprivation of liberty was lawful and in the best interests of Mr ZZ. It was supported on 5th December 2011 by a statement of Mr D, who stated that if Mr ZZ was in the community he would be quickly placed at significant high risk to himself and others.

22. District Judge Eldergill gave permission for the application to be made on 13th December 2011 and invited the Official Solicitor to act for Mr ZZ. He transferred the matter to the High Court. It came before Mostyn J. on 19th December 2011. He made interim declarations that Mr ZZ lacked capacity, an interim declaration that, in so far as there was a deprivation of liberty, it was in Mr ZZ's best interests, and that the standard authorisation was lawful, justified and in his best interests.

23. A further standard authorisation was made on 28th January 2012 for six months. On 30th March 2012, I directed a round-table meeting, on 8th May,

and I listed the matter before me, for this hearing, with a three-day time estimate commencing on 23rd July. I heard the matter again on 26th April. I made further directions including listing the case in this court to enable it to be easier for Mr ZZ to attend. I directed that the issues for the final hearing were: first, does Mr ZZ lack capacity; second, does the current care regime amount to a deprivation of liberty and, third, under what lawful authority can Y County Council require him to reside and be cared for at a particular place.

The law

24. There are two statutes with which I am concerned, namely, the Mental Health Act 1983 and the Mental Capacity Act 2005. So far as the Mental Health Act 1983 is concerned, section 7(2) provides that a guardianship application may be made on the grounds that: (a) he is suffering from mental disorder…of a nature or degree which warrants his reception into guardianship under this section, and (b) it is necessary in the interests of the welfare of the patient, or for the protection of other persons, that the patient should be so received.

25. Section 8 of the Act provides that, where a guardianship application is duly made, the application shall confer on the guardian "to the exclusion of any other person (a) the power to require the patient to reside at a place specified by the authority or the person named as guardian; (b) the power to require the patient to attend at places and times so specified for the purposes of medical treatment, occupation, education or training; (c) the power to require access to the patient to be given at any place where the patient is residing to any registered medical practitioner…or other persons so specified." If the patient absents himself from the place of guardianship without the permission of the

guardian, he may be taken into custody and returned to that place by an officer on the staff of the local authority, any constable or other person authorised by the guardian or local social services authority – section 18(3).

26. Turning to the Mental Capacity Act 2005, section 2 provides the gateway provision defining people who lack capacity. "A person lacks capacity in relation to a matter if, at the material time, he is unable to make a decision for himself in relation to the matter because of an impairment of or a disturbance in the functioning of the mind or brain." "A lack of capacity cannot be established merely by reference to (a) a 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 his capacity" [sub-section (3)].

27. In proceeding under the Act or any other enactment, any question of whether a person lacks capacity within the meaning of this Act must be decided on the balance of probabilities [sub-section (4)].

28. Section 3 provides that: "For the purposes of section 2, 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 waive that information as part of the process of making the decision; or (d) to communicate his decision whether by talking, using sign language or any other means" [sub-section (1)].

29. The information relevant to a decision includes information about the reasonable foreseeable consequence of (a) deciding one way or another, or (b) failing to make the decision [sub-section (4)].

30. The Mental Capacity Act does not permit any person to deprive any other person of his liberty [section 4A(i)], but a person may deprive someone of their liberty if the deprivation is authorised by schedule A1 of the Act: hospital and care residence, deprivation of liberty, section 4A(5) of the Mental Capacity Act. The deprivation of liberty safeguards are contained in schedule A1.

31. The use of guardianship under the Mental Health Act, together with a deprivation of liberty authorisation under either section 4A(5) and schedule A1 of the MCA, or by the Court of Protection as a consequence of a welfare order, is made permissible in certain prescribed circumstances by the provisions of schedule 1A (see section 16A(4) and schedule A1, paragraph 17).

32. By schedule 1A, case (d), and paragraph 3 of schedule 1A, a person subject to guardianship under the Mental Health Act is ineligible to be deprived of their liberty under the Mental Capacity Act only if the proposed Mental Capacity Act deprivation of liberty does not accord with any requirement of the guardianship, including where he is or is not to reside. A person would also be ineligible for Mental Capacity Act deprivation of liberty if the proposal was for them to be accommodated in a hospital for the purposes of being given treatment for mental disorder. The latter is not applicable in this case.

33. As a consequence, if Mr ZZ is found to be subject to a deprivation of liberty, that deprivation of liberty could be given authorisation under schedule A1 to the Mental Capacity Act as an addition to the guardianship as long as it does not conflict with the requirement of residence under the guardianship.

34. There is no doubt that, where the Mental Health Act applies, it has primacy over the Mental Capacity Act. In *C v. Blackburn & Others* [2011] EHC 3321, Peter Jackson J. said at paragraphs 34 – 40, that: "decision makers should take all practical steps to ensure that the primacy of the Mental Health Act is recognised and given effect to." It follows that this court does not have jurisdiction to make decisions with regard to Mr ZZ's place of residence whilst the guardianship order specifying his place of residence under section 8 of the Mental Health Act is effective.

The first issue: Does Mr ZZ lack litigation capacity?

35. The legal test is to be found in *Masterman-Lister v. Brutton & Co.* [2003] 1 WLR 1511, as recently considered by the Court of Appeal in *Dunhill (a protected party) v. Burgin* [2012] EWCA Civ. 397. The test is whether or not a party to the legal proceedings is capable of understanding, with the assistance of such proper explanation from legal advisers and experts in other disciplines as the case requires, the issue on which his consent or decision is likely to be necessary in the course of the proceedings. He needs to be able to understand the relevant issues and be able to give instructions thereon. There is now a consensus amongst all the doctors that Mr ZZ does lack litigation capacity in relation to the issues in this case. It is also agreed that he lacks capacity to decide upon the restrictions relevant to supporting his residence and care. Dr. BC has never been in any doubt about these two aspects of capacity. At first sight, it appeared as thought Dr RT disagreed, at least in part (see his first report at I/93 of the bundle). However, he was asked some follow-up questions. He responded on 19th April 2012 to the effect that: "On

balance, given Mr ZZ's learning disabilities, his memory problems and his problems with social interaction and considering the complexity of the current court proceedings, I conclude that he does not have capacity to litigate and he, therefore, requires assistance from the Official Solicitor." He went on to indicate that Mr ZZ was "not able to give due consideration to all the relevant information required for the decision-making process, specifically, that he is over-estimating his abilities to manage his risks and under-estimating the importance of staff support". In other words, he cannot weight the relevant information in the balance. Dr RT did, however, add that Mr ZZ has a basic understanding of the litigation and he is able to express his wishes with regard to the litigation. Dr RT, therefore, said that it would be desirable for the Official Solicitor to consult him regularly about his wishes in the proceedings and to take those wishes into account when acting on his behalf. I make it clear that the Official Solicitor has done exactly that. Moreover, I moved this case from London to M to facilitate Mr ZZ attending throughout and to enable him to present his views to me directly.

36. A roundtable meeting took place between all the professionals on 8th May 2012. The agreed Minutes confirm, first, that it was agreed that Mr ZZ does not have capacity to understand how to progress this litigation because of the complexities of it and his learning disability. The Minutes also deal with capacity in relation to risk and residence/care. So far as risk is concerned: "The risk of fire setting is low. There remains a risk of sexual offending because he remains a paedophile risk. It was agreed that although Mr ZZ understands the risks that he poses and the consequences of offending for himself and others, he lacks the capacity to retain or understand the level of

support he needs to manage the risk of offending or re-offending. His decision is impaired by his learning disability."

37. Turning to residence/care, the Minutes say as follows: "Mr ZZ has capacity to decide basic care tasks and to decide where he lives on a basic level. It was agreed that he lacks capacity to make decisions as to the support he requires to manage his risks as above." Both doctors confirmed their evidence in the witness box. It follows that I am satisfied, applying the *Masterman-Lister* test that (a) Mr ZZ does lack litigation capacity in relation to the issues in this case and (b) he lacks capacity to decide upon the restrictions relevant to supporting his residence and care.

Deprivation of liberty

38. I have considered carefully the various authorities on whether or not Mr ZZ is currently being deprived of his liberty within the meaning of article 5 of the European Convention on Human Rights, and section 64(5) of the Mental Capacity Act. I have formed the clear conclusion that, whether or not the test is the strict test enunciated in *P&Q (by his litigation friend, The Official Solicitor v. Surrey County Council & Othrs* [2011] EWCA Civ. 190, and *Cheshire West and Cheshire Council v. P (by his litigation friend, The Official Solicitor)* [2011] EWCA, Civ. 1257, or some wider test that may or may not be formulated in the future by the Supreme Court, there is no doubt that Mr ZZ is currently being deprived of his liberty within the meaning of article 5.

39. In essence, I accept that complete and effective control is being exerted over him. I have formed this clear conclusion for the following reasons: (a) The J is a locked environment; (b) he is checked hourly throughout the day; (c) he is not allowed to leave the property, save as agreed by the staff, and then only on the basis of being accompanied by a one-to-one escort who must either walk alongside him or closely behind him at all times; (d) he consistently expresses his objections to residing there; (e) he consistently objects in writing to the restrictions upon him; (f) his use of his mobile telephone is restricted to one hour per day; (g) he is not at present allowed unsupervised access to the garden because of the children living in the adjacent property; (h) the purpose of the restrictions is, in significant part, designed to protect others in the community and, in particular, children as well as to protect Mr ZZ.

Is this deprivation of liberty lawful as in his best interests, pursuant to schedule A1 of the Mental Capacity Act 2005?

40. In this regard, I have considered very carefully the evidence of all three doctors and Mr D. I note that Dr RT said in his first report that Mr ZZ told him he had to move to The J as he could not manage his behaviour around children at the time. However, he said he had learnt to control his feelings and not to become sexually excited by children. In his second report, dated 12th June 2012, Dr BC wrote that: "In relation to the sexually inappropriate behaviour there was some evidence of Mr ZZ using self-control at least some of the time, but the urges remain strong, and that good evidence of progress was needed in this area to reduce the risk to children. He needs to continue to be escorted until such time that there is good evidence that the sexual urges have

consistently abated and/or he has greater control." Following the completion of his first SOCSET Sexual Offenders' Treatment course, it was recommended that he complete the course a second time. On this occasion it was to be under the supervision of Dr TR. Mr ZZ has recently completed this second course. On 12th June 2012 the psychology progress review noted that Mr ZZ had had a positive six months. He had continued to engage but he remains strongly attracted to children with little investment in contributing to managing the risk. There was, therefore, a continuing necessity for close supervision without which children would be at considerable risk.

41. Indeed, the recommendation, when he completed the plan, was that he do the course a third time. Mr ZZ agreed with me in evidence that he should do so and will do so. Again, this is to his credit.

The evidence I heard

42. In his evidence to me, Dr TR accepted that Mr ZZ had a good knowledge of the treatment model. There had been a high level of engagement during the second year of treatment in contrast to the first year. There had been a shift in the level of Mr ZZ's disclosure and honesty, but Dr TR considered that the evidence was still indicative of a continuing risk to children. He said that there had been and has been an element of systematic planning in Mr ZZ's activities. He added that external supervision and management remained the key. He feared that there might be a more impulsive aspect to Mr ZZ's behaviour. The aim was to develop an intention not to offend and for Mr ZZ to be able to cope with the opportunities that arose. Dr. TR was concerned that Mr ZZ might offend impulsively, even though he was intending not to.

The doctor was clear that this needed to be addressed with external controls until the likelihood of this happening was lower. It was right that on one recent occasion Mr ZZ had seen a girl in school uniform and had become aroused, but he had recognised the problem and had utilised the skills he had acquired at SOCSET to talk to staff and distract himself. It goes without saying, that he was only able to do this because the staff member was there supervising him.

43. Dr TR was quite clear that it was too soon in the programme to change the way Mr ZZ was managed. Mr ZZ was still not sufficiently aware, and continued to have a frequent pre-occupation with children. Dr TR mentioned that one of the staff observed Mr ZZ looking at a child outside The J a couple of weeks ago. The changes in openness have not yet led to an understanding of different behaviour. When someone engages properly, he told me, it is possible to get a good understanding of their sexual fantasies. It allows him to construct a relapse prevention plan which can be managed jointly with Mr ZZ. That is why he took the view that he could not relax the control yet. Mr ZZ was not ready yet. He added that he would need to see more consistency in changes in Mr ZZ's distorted thinking. To feel confident, he would look for clinical evidence that Mr ZZ was not as interested in looking at magazine pictures of children. He said that Mr ZZ remains strongly attracted to children but he needed to enable him to manage that attraction and contain it. He reminded the court that sexual offending behaviour is driven by a powerful biological motivation. It does not go away. I accept his evidence.

44. Dr RT took a slightly different view. He felt that Mr ZZ had not been given an opportunity to test his resolve. He said that supervision was as comprehensive as when it first started. There had been no significant changes to the care plan for over 18 months. He thought that Mr ZZ would benefit from clear goals as to what he needs to achieve to make progress. He viewed this as a reward for making progress. If he achieved these goals he should get a higher level of independence, such that there was a clear progression. He favoured slowly reduced levels of supervision. For example, he favoured gradually reducing the shadowing out of the home; at first a few metres, and then if it went well, 10 metres and so on. He added that he considered The J to be an ideal environment to implement this given the very experienced staff. If necessary, the supervision could go back a step if required. The big difficulty with this is that Dr RT had to concede that the move to The J had been precipitated by the situation at E Road where there had been a less restrictive regime with reduced supervision, which led to problematic behaviour. Dr RT accepted that Drs TR and BC had the advantage in that they have worked with Mr ZZ on a regular basis, but Dr RT thought that the risk was slowly reducing. Although he supported another period of SOCSET treatment, he said that Mr ZZ could not stay for ever in this situation and needed targets. He did not believe that these changes should necessarily be implemented today or tomorrow but they should be put in train within months. Having said all that, he agreed with the treatment plan but did not want to retain all the restrictions until the very end. Although we should be cautious, he said we should not be too cautious. He added that we should be prepared to take some risks. I regret to say that I do not agree with him in the latter regard.

45. Finally, I heard from Dr. BC. He explained that Mr ZZ's first year of therapy had ended in the summer of 2011 and the second cycle about a month ago. During the first year, Mr ZZ's engagement had been too superficial for him to gain benefit. Mr ZZ's view appeared to be that all he had to do was to turn up and the restrictions would be relaxed. Mr ZZ found it difficult to understand that he might need to do some hard work. The second time around, however, Mr ZZ did do some hard work. This indicated some movement from Mr ZZ, but in the view of Dr BC, not to a degree where they could significantly relax the restrictions. Dr BC was very supportive of a further period of therapy. He thought there was very little between himself and Dr RT but his one concern was that, if the restrictions were relaxed too early, Mr ZZ may offend again. The impact for him and for others in the environment would then be catastrophic. He said that they had given thought to alternative ways of managing the risks presented and had developed a new way of measuring progress called *The Life Star*. This measures progress around the points of a 10-pointed star, which deal with different aspects of life. Progress would be dependent on how far each resident progressed in relation to each star point. Some of these stars are, clearly, not relevant to Mr ZZ, such as substance abuse but, overall, Dr BC thought that this system would give Mr ZZ the targets that Dr RT was taking about to enable adjustments to be made to the care plan when justified. I have to say that I was particularly impressed by Dr BC.

46. So far as the local authority was concerned, the final witness was Mr D. He confirmed his view that it was necessary to have sufficient support to manage the risks that Mr ZZ presents. He was clear that he did not want the current

placement and treatment programme to break down as had happened at E Road. He reminded me that when Mr ZZ was at E Road, the local authority began to think about reducing supervision so that Mr ZZ had less contact with staff. Supervision would move to being further and further away to give Mr ZZ increasing space. It was at that point that Mr ZZ increased the note dropping. Progressively, the plan failed.

47. Finally, I heard from Mr ZZ himself. He has written a letter, effectively, to me, headed: "Questions for my court hearing". The letter is written clearly and well. It goes to his credit. It says that he promises that, if the deprivation of liberty safeguards were to be lifted, he will stay out of trouble. He promises me that he will not re-offend, saying that he has learnt his lessons. I have no doubt that he means what he says. The issue, however, is whether he can actually stop himself from doing so at this stage. I take the view that he needs strong support to enable him to do so at this point in his life. Mr ZZ goes on to remind me that he has kept out of trouble since he has been at The J. That is, of course, correct, but I find that it is the safeguards that have enabled him to do so safely. He says that he has learnt a lot from the group, that he has been more honest, and he promises me that he will continue to see the psychologists and psychiatrists. I accept this, but I take the view that he needs to do so under the protection of the current safeguards.

48. In his oral evidence he told me that he does not like The J. He said it is very noisy. There is banging and shouting by other people, both from his floor and from the floor above. He would like to live somewhere similar to The J but closer to his wife. He confirmed to me that he knows that she is not ready to

live with him at the moment. He is happy to remain at The J, even though he does not like it there, until something else becomes available, whereupon he would like to move. Again, I think this goes to his great credit.

My conclusions

49. I have come to the clear conclusion, for all the reasons given by the various doctors, that it is lawful as in Mr ZZ's best interests to deprive him of his liberty in accordance with the local authority care plan, pursuant to schedule A1 of the Mental Capacity Act 2005. I make that declaration. In doing so, I am following the advice of the expert professionals who know Mr ZZ so well. Indeed, the Official Solicitor accepts, on his behalf, that I should do so. I make it clear to Mr ZZ that I have no doubt that the restrictions upon him are in his best interests. They are designed to keep him out of mischief, to keep him safe and healthy, to keep others safe, to prevent the sort of situation where the relative of a child wanted to do him serious harm, which I have no doubt was very frightening for him, and they are there to prevent him from getting into serious trouble with the police.

50. I am quite sure that the team that treats him is fully alive to his needs and wishes. I have confidence in them. I take the view that I should not interfere in the excellent job that they are doing of caring for him. I know that the local authority will continue to look for alternative safe homes for Mr ZZ in accordance with his wishes, but I accept, as does he, that until such a safe environment is found, he will have to stay at The J. The local authority is aware that he does not like it there, and I am quite satisfied that they will take all reasonable steps to examine appropriate alternatives.

51. I make no findings in relation to Mrs ZZ. I have not heard from her. Moreover, it is clear that her wishes and feelings have fluctuated, as indeed have those of Mr ZZ. The local authority has indicated that they intend to set up weekly meetings between Mr and Mrs ZZ so long as both want these to take place. I am sure that the local authority will do what is right for both of them, taking into account the wishes and feelings of both of them from time to time.

52. There were, really, only two real areas of dispute; namely, in relation to Mr ZZ's use of the garden at The J and the level of his supervision when he leaves the property. In relation to the first, I am pleased that the issue appears to have resolved itself in a very satisfactory way. The problem was that the wall around the garden was not high enough such that Mr ZZ and other residents could see into the neighbouring property where there are children living. He, thus, had to be supervised in the garden at all times. The Local Authority has however recently addressed this through the building of a new fence around the garden which prevents the unauthorised viewing of neighbouring gardens. On this basis, all are agreed that Mr ZZ can have unsupervised visits to the garden. The care plan should be amended to permit this. However, Mr ZZ must be aware that he has to be on his best behaviour in the garden. There must be no mischief otherwise this concession will be withdrawn and it will have consequences for any future relaxation of his supervision in the community. I repeat, therefore, that he must keep out of mischief in the garden.

53. I now turn, finally, to the second issue, namely, supervision when out of The J. From everything I have heard, I am sure that it is right and in Mr ZZ's best

interests for him to continue to have someone with him at all times that he is outside the home, as at present. Drs TR and BC are the best people to determine when the time is right to relax the supervision. I have no doubt they will do so as soon as they consider it is safe and in everyone's interests to do so. Mr ZZ is to undertake a third year of treatment. The doctors were clear in their evidence that three years is really the maximum that he can do this course. It follows that it is the last chance to make real progress via the treatment. If it works, I very much hope that it will be possible to relax the supervision, but I am equally sure that it would be totally disastrous for him to relax it too early. If this year fails, it will be very serious. There would be nothing else to try. Dr. BC did mention a possibility of medication, but it would be far better for the treatment to make a real difference, such that the restrictions can be safely reduced, gradually, than to do so now with the real risk of failure. In short, I trust Drs TR and BC in this regard as the best people to manage the treatment and the restrictions.

54. It follows that I make the declaration sought and I endorse the care plan subject to the small change to be made as to supervision in the garden.
