How capacity assessments might incorporate a risk of, or history of, offending.

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Ethical Context

- Autonomy of P
- Protection of P
- Public Protection **(including care and hospital staff)**
- Victim vs Perpetrator dilemma:
  - P as perpetrator
  - P may be victim of abuse (past and present)
  - P likely to have had life long social disadvantage

The Offending Behaviour in Question

Some CoP Caselaw guidance:

- Sexual Behaviour (Re JB, DY v A City Council & An NHS Trust, Re: ZZ)
- Online Offending (Re A, Re B, Re C)
- Fluctuating capacity and offending behaviour: Wakefield Metropolitan District Council &Wakefield Clinical Commissioning Group vs DN & MN

Ignorance of the law is no defence?

- Starting point is deceptively simple.
- Criminal laws need to be understandable to the “man on the Clapham Omnibus” in order to be fair and acceptable.
- Medicolegally, a potential parallel is the “Insanity” Plea

Insanity Plea

In simple terms:

- A defect of reason
- The defect of reason must be caused by a disease of the mind
- The defect of reason must be such that the defendant did not know what he was doing or, if he did know, he did not know the act was wrong.

Insanity Plea and the MCA

In simple terms:

- A defect of reason
- Causative Nexus
- The defect of reason must be caused by a disease of the mind
- An impairment of, or disturbance, in the functioning of mind or brain
- The defect of reason must be such that the defendant did not know what he was doing or, if he did know, he did not know the act was wrong.
- Unable to understand, retain, weigh or use

Insanity

Someone can be floridly psychotic and still not be found insane.

- E.g. Patient of mine who set fire to her nursing home – complex paranoid delusions probably related to experience sexual somatic hallucinations and physical pain, set fire to her room, walked out into communal area, did not tell anyone, when the police arrived she admitted it saying she had done it as she did not like the nursing home and wanted to be moved to a specific hospital for breast surgery.
- Lacked capacity in relation to residence and care but not insane.

The Big Difference between incapacity and insanity:

- MCA is broadly based in the “here and now” and/or “forward looking”
  - Exception – where P is alleged to have been victim of abuse in a care setting and is someone is being prosecuted for this abuse – their incapacity needs to be established, and this may need to be done retrospectively.
- Insanity defence is always retrospective, though evidence from the present may support it.

Borderline Group in CoP

Many “offender” cases involve the “Borderline Capacity” group

- Relatively fluent communication
- Mild cognitive impairment
- Often present with a broadly plausible understanding of many of the issues
- Weighing up may be cited as the key problem
- “Offender” cases are more likely to be technically complex in a number of ways (assessment, diagnostically, safeguarding, medicolegally)

General Approach to Capacity and Offending

- The parallel with insanity is only an observation of mine, but is a useful guide to the “offence” element of the relevant information.
- The key capacity issues in such welfare cases are:
  - P’s understanding of the law and/or of right and wrong.
  - P’s purported risk of offending may be relevant.
  - What welfare provisions might mitigate the offending.
- Based on this you need to identify the relevant decision(s) and information.

What kinds of offences could P commit?

Commonly:

- Sexual offences - on or offline
- Harassment and stalking - on or offline
- Non sexual violent offences
- Other Online – hate crime, hacking
- Arson

Is it plausible that P does not realise the act is wrong?

- This question is not asked enough!
- From re: DY *"I note that DY told Dr Ince that if the DOLS was removed 'it would mean I am able to meet people in the community….make friends….maybe have a relationship with a woman….my ultimate goal is to live my life peacefully…….I don't know about making relationships….I've never made any friends in the community for the last ten years….wouldn't know how to do it…..I'm a bit rusty….obviously you'll meet them and taken them to a restaurant, maybe have a drink or a meal…discuss hobbies and interests' and then 'I don't want the DOLS completely removed..I want something like the DOLS… something that is similar to the DOLS but is less restrictive…to regain the life skills I need…I'd like to be happy and with having support…having support in the community on a one to one basis'.*

Is it plausible that P does not realise the act is wrong?

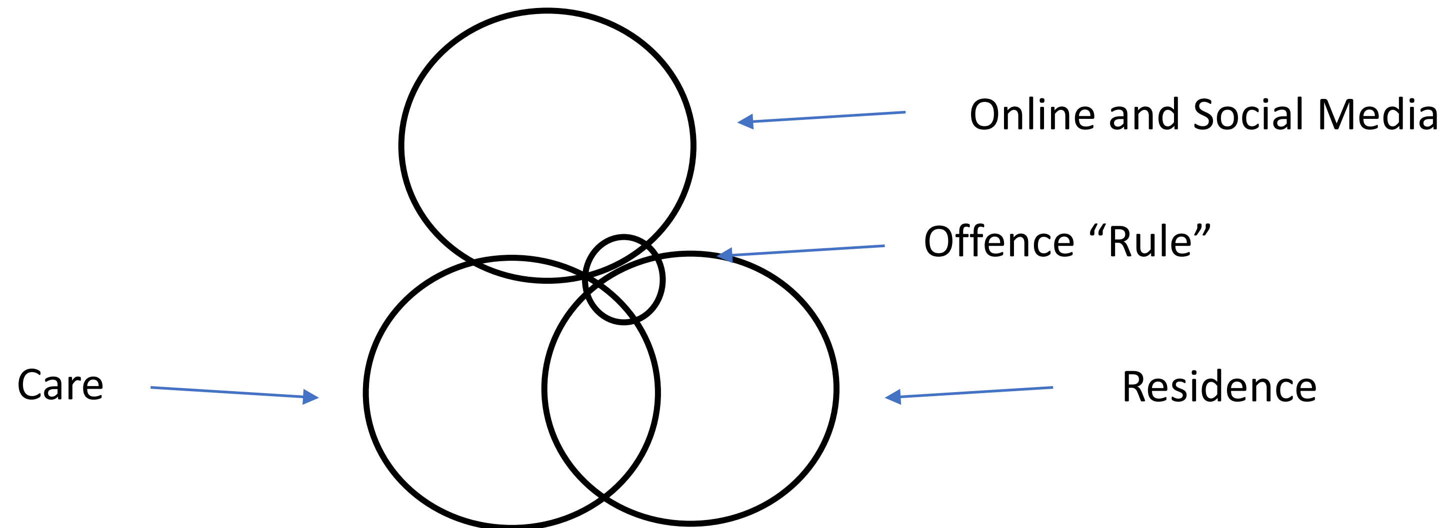
- When asked about the prospect of being unescorted in the community, DY stated ‘to be honest with you I don’t…I don’t want staff in the community but I’d say it is because I have been told…I know I am high risk but there has to be a point where things change…constantly having staff coming out with you…at the moment if there are no staff I don’t go out and it’s frustrating…my preference is to not have staff with me but I know that people will be worried about the risks…and I’ve never done it before…the risk of reoffending would be the number one risk..from my understanding reoffending is the only one I can think of…I know how to be civil with people in the community..I know if I broke the SHPO I’d go to prison…one way ticket to prison…I know I’d have to register my address if I moved house…I’d be terrified about going to prison…people with my convictions in prison they get killed or severely beaten up or killed’.”

Is it plausible that P does not realise the act is wrong?

- DY’s account is typical of many of the “offender” CoP cases I see where P has capacity.

Constructing the Matrix of Relevant Information

- There is a need to identify the “rule” that P is said to be at risk of breaking
- Do they understand this in basic terms?



Constructing the Matrix of Relevant Information: **Residence**

- Then link it to their (proposed) welfare provision:
  - Residence
    - Type of accommodation – single gender, single occupancy, 24 hour staffed
    - Area – is it near a school? Is there ready access to drugs or alcohol? Are there people around who increase offending risk (abusive family or “deviant” peer group)?
    - Are there other legal restriction on P: requirement of residence (MHA Guardianship, CTO, S17 leave, Sec 41, SOR, SHPO, bail conditions, civil order)?
    - Are there special rules about alcohol use, drug use, visitors in bedrooms?

Constructing the Matrix of Relevant Information: **Care**

Care often contains the supervisory elements of risk management:

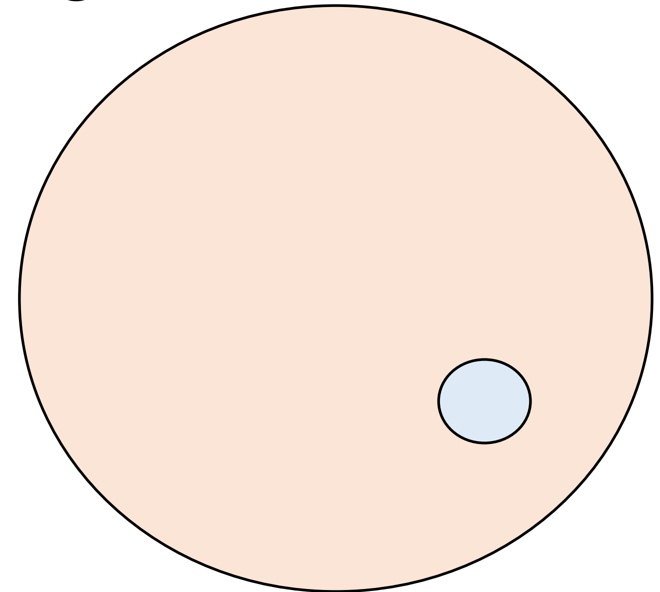
- 1:1 staffing in the community in all settings in order to prevent reoffending – fairly standard in risk of offending cases – beware of this being linked to solely or primarily to vulnerability.
- Understanding risks from alcohol and/or drugs
- Understanding risks mitigated by “big picture” of care provision – i.e. often whole package is broadly preventative of crises linked to offending.
- Overlaps – staff monitoring internet use, visits or contact arrangements, specific types of activity not normally considered to be care like gambling.

Care – the fudges

- The core fudge is most often “insight”
- However capacity is a very small subset of insight:
- Otherwise there would no unwise decision making.
- This is broadly MHA or CJS territory
- Neil Allen:

(PDF) Is Capacity “In Sight”? (researchgate.net)

- Insight has to be made explicit in CoP



Care – the fudges

- Beware of offender cognitive distortions when talking to P:
  - Denial
  - Minimisation
  - Rationalisation
  - Victim Blaming
  - Outright dishonesty
- These are not, in themselves, causes of incapacity

Care – the fudges – Theory of Mind

- No theory of mind = very unlikely to have no theory of mind. Established problems recognising consent when P is aware consent is required is not incapacity (c.f. Me driving a car after I have lost my sight).
- Does not have empathy – entirely irrelevant to capacity.

Care – the fudges – “in the moment”

- On their own: “Red Mist” or Impulsive = reckless or angry – not mental disorders.
- Consider fluctuating capacity
- Impact of crises and “meltdowns”
- Wakefield case – emphasis on P’s autonomy not protection of P.

Risk of offending - the grey area for “insight”.

- Often P will have said that there is no risk and this will be taken as evidence of incapacity. This needs to be examined carefully.
- This is where a non-confrontational approach and good rapport is key.
- Often P can have a discussion about what other people say their risks are. This is a good way in to explore why they disagree.
- P’s disagreement does not have to be sophisticated, primarily P needs to be able to recognise that they might be wrong in their opinion.
- P does not have to agree with the risk assessment

Contact Issues – A Vulnerable Group

- Much more nuanced and abstract test = may be 3rd party dependent and so need to be reassessed when concerns arise.
- Examples:
  - Exploitation into offending
  - Conflictual or abusive relationships that could trigger offending (e.g. impact of abusive relative on mood and behaviour).
- Often raises questions about Inherent Jurisdiction of the High Court

Online / Social Media

- Re: A and Re: B: "If you look at or share extremely rude or offensive images, messages or videos online you may get into trouble with the police, because you may have committed a crime" Risky territory!
  - Secretive behaviour and unguarded comments to carers may be a good contextual evidence of capacity.
- Adapt to include issues related to
  - Paedophile Hunters
  - Harassment Offences
  - Impact on behaviour?? (addiction explicitly excluded by Cobb J)
  - Hacking?

Approach to assessment

- Plenty of time including several assessments
- P’s background – more likely to be alienated from professionals
- Clarify your “matrix” in advance and work through the easy stuff first.
- Keep it conversational
- Build rapport, plan when you challenge P, minimise the need to do this.
- Use depersonalised examples – I often use myself as an example.
- Revisit the issues using practical examples to check P’s underpinning logic to ensure it is not rote learnt.

Uncooperative P at risk of offending

- Sometimes P is so unhappy with the process and or the system that it can be very difficult to achieve a meaningful discussion about risk of offending.
- In these cases then there needs to be a clear focus on their understanding of what is right and wrong, with examples, and why they think something is illegal.
- 3rd party accounts may be helpful for example “the police won’t do anything because I’ve got a disability.”

Uncooperative P at risk of offending

Complete (or near complete) refusal to cooperate.

- Persevere
- If that fails then: careful discussion with all parties about how to proceed
- Process of Triangulation of evidence is best
- Case of EOA
- I’ve used this approach in 3 unreported borderline and offender cases.

Formulating an opinion / analysis

- Relevant information = Offence + Associated care need(s)
- Weighing up focuses on risk but must be at a basic level and take account of P contesting or denying their risk – can they understand why people say they are a risk?
- Be clear in your summary and opinion about “overlap areas” and where the caselaw may not be sufficiently developed e.g. hacking, online stalking. This may mean you give a range of opinions depending on the interpretation of the law.

Decisions not related to offending?

For example:

- Original Re C case 1994 – C was transferred from prison to psychiatric hospital.
- JK v A Local Health Board [2019] EWHC 67 (Fam) where JK was on hunger strike in prison and wanted to refuse tube feeding.
- Parole Board appearance
- Consent to treatments related to offending (SOTP, anti-libidinals and medication that reduces aggression)

If P has capacity? Practical and Ethical Issues:

- CoP report cannot easily be disclosed in future criminal proceedings
  - RE AB (Court of Protection: Police Disclosure) and (1) A Police Force (2) WLCCG
  - Potential reverse double jeopardy if a different expert is used in criminal proceedings
- Is it paternalistic to provide P with a "soft landing?"
- What about the public interest?
- Is it right to use the system to protect a P who has capacity in relation to their care including risk of offending?
  - Limit their finances to prevent crises [Property and Affairs]?
  - Delay final hearing when finding of capacity is made until maximal support is put in place?

Thanks for listening

- Questions or comments?

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