DETERMINATION BY THE SECRETARY OF STATE UNDER SECTION 40 OF THE CARE ACT 2014

1. I have been asked by CouncilA to determine the ordinary residence of X. The dispute is with CouncilB

2. In determining the issue, I have had regard to the agreed statement of facts; the submissions of both parties; and the bundle of documents provided.

3. For the reasons set out below, I find that X has been ordinarily resident in the area of CouncilA since the agreed relevant date 9 October 2014.

Factual Background

4. X is a young woman, born on XX XX 1988 and now 28 years old. X suffered asphyxia at birth as a consequence of which she suffers from profound and multiple learning difficulties. She has cerebral palsy and epilepsy. She is quadriplegic. She has no verbal communication. A CHC review dated 2012 states that she communicates by yes/no hand pointing but is not always consistent.

5. From 4 September 2000, at the age of 12, X attended the School1A, which is in the area of CouncilA. School1A is a residential special school. From the information provided, it appears that she did so as a weekly boarder, returning to her parents' home in the area of CouncilB for weekends and holidays. X was never a looked after child or provided with accommodation or other services under the Children Act 1989. X remained registered with a GP in the area of CouncilB. The placement was arranged by X's parents and CouncilB. X's parents funded the accommodation element of the cost of the placement at School1A, while CouncilB funded the educational element.

6. On 28 September 2006, X turned 18. She remained at School1A while a transition to adult services was planned. CouncilB Transitions team took responsibility for planning and implementing the transition. Her parents continued to pay the accommodation cost of attending School1A. On 24 October 2007, a placement review was carried out which confirmed that she would leave school in July 2008, aged 19.

7. In 2008, X was assessed as being eligible for continuing healthcare funding. I note that I have been provided with a copy of the CHC Decision Support Tool dating from around January 2008. I note that her level of need in respect of cognition is described as "High". That descriptor states:

“High level of cognitive impairment which is likely to include marked short-term memory issues and maybe disorientation in time and place. The individual has a limited ability to assess basic risks with assistances but finds it extremely difficult to make their own decisions/choices, even with prompting and supervision.”

8. The information in relation to cognition states:

   “X does have basic awareness and understands what is going on around her, when her dad played some music recently she laughed and got excited, this was music she used to listen to when she was a small child which she had remembered.

   X always knows when her family come to take her home on Friday and looks forward to seeing them.

   X will make basic decisions e.g. she will put her arm up or turn her head away if she does not want to eat.

   Due to her physical disability she relies on others to support her which makes her very vulnerable and at risk, she could not defend or support herself if faced with dangerous situations ie fire, physical abuse.

   X has no concept of Christmas or her birthday.

   More information relating to decision making is found in communication.”

9. As to communication, the DST described her needs as “Moderate”. The descriptor for moderate needs stated “Communication about needs is difficult to understand or interpret, even when assisted. Carers or care workers may be able to anticipate needs through non-verbal signs due to familiarity with the individual…”.

10. As to X specifically, the information in relation to communication stated:

    “X communicates with her hands at school. She will use her hands for yes and no and will also use a communication board where a range of options are displayed. When asked to give a question, X will point to the part of the board which has the answer she wants to give. Her OT, speech and language therapist and physio ae working with X developing her communication with this tool, they believe it is allowing to enhance her independence.

    X will make sounds if she is excited ie when her family come to collect her. And she understands what is being said to her. When she is asked to put the light on she will reach up to the light switch and try to turn it.

X needs time and patience from her carers as her responses to communication can be complex. X takes time to get to know people and build up trust.

Her carers feel there is a lot of work to do around communicating with X about her future needs and that she needs to be involved in all her reviews and given time to communicate with her communication tools regarding what she wants."

11. I note that the summary stated:

    "X needs to be involved in decisions and choices made regarding her future. She understands what is happening and needs support from speech and language to ensure her communication is understood. X has expressed a wish to remain at School1A but more work is needed to enable X to know that this will be her home in the future."

12. I have been provided with a copy of the final annual review from School1A, which is dated 14 May 2008. That describes X as having severe learning, communication and physical disabilities associated with cerebral palsy. It describes her receptive language skills as functioning at the one word level. It states that "she understands a range of familiar words without situation cues. She can communicate crudely by oral sounds or by a gesture but her most consistent means of communication is eye-gaze…". It states "She has severe learning difficulties, she has the ability to concentrate and learn and a desire to become as independent as possible…" It describes her use of symbols with the eye gaze which included some complex symbols such as evacuee and foot and mouth disease. It was reported that X could remember these from one week to the next. I note that she appears to have been working at P levels in all subjects.

13. It is thought that CouncilB Primary Care Trust began funding her placement from July 2008. That dovetails with when she left school. I note that it is not entirely clear to me whether X moved straight to Placement1 or whether she attended another placement before that.

14. In due course, CouncilB Clinical Commissioning Group took over funding.

15. Since around 2009, X has been accommodated at Placement1 for 52 weeks a year. The weekly cost of her care is £1751.42.

16. I have been provided with a best interest decision form from Placement1 dated 14 January 2011. The question for consideration is "Should X be offered 'difficult' foods, such as sandwiches to encourage her to eat more". There is a section asking whether a mental capacity assessment has been completed. Neither "Yes" nor "No" has been ticked. However, as the form makes clear that a best interest decision can only be made if the person is proven to lack capacity, and that the rest of the form should be completed only if the person is proven to lack

capacity, I infer that it was concluded that X did not have capacity to make that decision. The form was completed by a speech and language therapist and X's mother and key worker were involved in the decision.

17. I have also been provided with a mental capacity assessment form dated 1 February 2011. The details of the decision to be made were whether X understood the risk to her when eating a sandwich and whether she wanted to be offered sandwiches. The conclusion was that X did have capacity to make that decision. She was asked specific questions and offered yes/no answers and a picture symbol.

18. I have been provided with a School1A review dated 22 May 2014. That states that X is settled and appears happy at Placement1 Court. It notes that she likes to choose clothes and to buy and wear and will make a choice by touching the one she would like. The review notes that X "communicates by yes/no hand pointing. To achieve consistent answers staff must be patient and ensure questions are not too complicated…". The review notes that X has a communication book. Her mother was managing her finances.

19. On 9 October 2014, X's full eligibility for CHC funding ceased and she became the joint responsibility of CouncilA Clinical Commissioning Group and whichever local authority is responsible.

20. The parties agree that 9 October 2014 is the date from which the duty to accommodate under s. 21 of the NAA 1948 arose.

21. On 15 October 2014, CouncilB Clinical Commissioning Group wrote to CouncilA advising them of the decision with regards to CHC funding. CouncilA wrote to CouncilB Clinical Commissioning Group indicating that CouncilA considered that X remained ordinarily resident in CouncilB. There was then a hiatus until January 2016. Communication between CouncilA and CouncilB began on 5 May 2016.

22. I have been provided with an incomplete DST review marked 2015. I note that in the pen portrait that states:

    "…X communicates by yes and no hand pointing but this is wholly reliant on the questioner asking the relevant questions. She is unable to comprehend risk and relies on others to protect her from harm."

23. In the section regarding cognition, that review states:

    "Staff and Mum state it is indeterminable to assess if X has any long or short term memory impairment. She is unable to distinguish between days of the week and most days she frequently falls to sleep in her chair on her bed/mat during the daytime.

    X is given full opportunity to make her own decisions and capacity assessments are carried out each time X is needed to make a more

complex decision in her life. Support to do this is given by trained staff and support by the speech and language therapy time (SLT) although it is very difficult to measure her degree of understanding with any accuracy.

X recognises familiar family members and staff.

X can answer yes or no to closed questions by moving her hands although staff and Mum state that this is not wholly reliable as she cannot initiate the line of questioning. If the person asking her questions is not asking relevant questions or is using unfamiliar phrases or language she can disengage and totally ignore the questioner or she will touch an option i.e. yes or no randomly to terminate the conversation. Conversely she can become agitated and lash out and hold her body rigid if she is frustrated with the situation. (See behaviour).

X can touch an object to indicate her decision – choice of drink or pictures of activities. However X can be asked if she would like to drink for example, she can touch the yes option then go on to choose by hand pointing to the drink she selects. The drink can be made up and offered to her then she may repeatedly knock it away from her and not drink it (See communication).

Staff report that X is involved in planning the weekly meu but each day will be asked if she wants what she has chosen.

Staff show X items of appropriate clothing as she would not know that she needed to wear clothing to suit the weather, she will touch or point to the items she wants to wear.

Staff and Mum state that X has no understanding of danger that a knife is sharp and would cut her or something hot would burn her. She enjoys rolling around on her mat although this has to be supervised as she could roll into surrounding objects and would not be aware that she could injure herself or others. She has no awareness that she can suffer from carpet burns when she comes off the mat.

She has no understanding of what the fire alarm is for. She cannot communicate independently when she is in pain, hungry, thirsty or needs to urinate or defecate or if she needs changing (see continence). She would not know that she needs medication. She would not know if she needed a shower or her teeth cleaning. She has no concept of money.

Staff and mum state that X is unable to assess basic risks and is totally dependent on her carers for all her health and wellbeing needs and to keep her safe.

With regard to any infection for example her PEG, she does not understand implications if she pulled on it, it could cause her injury. She has no concept of keeping wounds covered or how they could become infected. She would not realise to be careful not to catch it."

24. I have been provided with a School1A Annual Adult Review dated 13 April 2016. Under "cognition" that states:

    "X likes to make her own choices – what clothes she wants to wear, drinks, snack activities etc. She appears to be aware when she requires personal care and may fidget and make negative noises to indicate there is something that needs addressing. X appears to be unaware of risks and must be assisted by 2 staff members when showering/bathing, hoisting etc. for safety reasons as she can 'flip' herself over without warning.

    X is given full opportunity to make her own decisions and capacity assessments are carried out each time X is needed to make a more complex decision in her life. Support to do this is given by trained staff and support by the speech and language therapy team (SALT) although it is very difficult to measure her degree of understanding with any accuracy…"

25. Under communication, it states:

    "X has no verbal communication. X will usually answer questions providing they are not too complicated. She has a communication book using symbols/pictures. She will answer yes/no using eye pointing, and she can also touch a carers hand or an object to indicate her choice. X needs a quiet environment with no distractions to help her communicate effectively…"

26. I note that X's mother manages her finances.

27. I also note that under MCA/Deprivation of Liberty Safeguards, that review states:

    "School1A provides a range of resources and professional support to help people to understand the decisions which affect them. If a person is then deemed not to have the capacity to make the decision, a best interest decision is made.

    Currently there is no DOLs authorisation in place at this time; a request for a Standard Authorisation was made by Placement1 27th April 2015."

28. I pause to note that a standard authorisation would not be necessary if X had capacity to consent to the arrangements in place. Following a request for further information from the parties, I understand that there is no indication that an application was made for a standard authorisation in the end although I do not know the reason for this.

29. There was some disagreement as to whether X's communication needs should be characterised as High or Moderate. As to cognition, there was disagreement as to whether X's needs should be characterised as High or Severe. The review states:

> "Cognition – X is able to make basic choices but they are not reliable. She is assisted at meal times and encouraged to choose what she would like from what is offered – at these times you may get varying responses or no response depending upon her mood.
>
> X does not always answer to her name but her facial expression would show recognition when mum is around and she will look around when she says hello.
> It is believed X recognises familiar staff and family members.
>
> X appears to recognise her own bedroom and where she is within the home. X would not know to wear a coat when outside in the cold weather and staff offer appropriate choices of clothing.
>
> If X does not want to eat she can turn her head away. If giving her personal care or a wash X may become fidgety and staff will put on music to calm her or chat to her about what is going on.
>
> X uses a symbol book and has lots of photographs in her bedroom. X likes to go on holiday and will be going to the same place as last year with family and familiar staff supporting her.
> …
> Level of Needs: Sarah stated High; Placement1, Alex and Janis advised Severe from reading the DST domains as X is unreliable under this section (Under the severe domain it describes that an individual is 'unable to assess basic risks even with supervision, prompting or assistance and is dependent on others to protect them from harm, neglect or deterioration – this describes X accurately)."

30. I note that in the written submissions the parties indicated that there may be further capacity assessments available from School1A. I asked for these but am informed that none are available.

Legal Framework

31. The parties are agreed that in accordance with the Care Act 2014 (Transitional Provision) Order 2015, I should make this determination in accordance with the National Assistance Act 1948 since that was the law in force are the relevant date on which ordinary residence falls to be determined, in this case July 2014. The relevant guidance was the 2013 Guidance "Ordinary Residence: Guidance on the identification of the ordinary residence of people in need of community care services, England" ("the 2013 Guidance"), subject to further guidance given as a result of the decision of the Supreme Court in the *Cornwall County Council* case.

32. Article 6 of the Care Act 2014 (Transitional Provision) Order 2015 provides:

    "(1) Any person who, immediately before the relevant date in relation to that person, is deemed to be ordinarily resident in a local authority's area by virtue of section 24(5) or (6) of the 1948 Act (authority liable for provision of accommodation) is, on that date, to be treated as ordinarily resident in that area for the purposes of Part 1 of the Act.
    (2) Section 39 of the Act (where a person's ordinary residence is) does not have effect in relation to a person who, immediately before the relevant date in relation to that person, is being provided with—
    (a) non-hospital NHS accommodation (within the meaning of article 12 of the Health and Social Care Act 2008 (Commencement No. 15, Consequential Amendments and Transitional and Savings Provisions) Order 2010) which has been provided since immediately before 19th April 2010;
    …
    for as long as the provision of that accommodation continues."

33. There is no dispute that the placement at Placement1 amounted to non-hospital NHS accommodation in the relevant sense.

34. At the relevant time, section 21 of the National Assistance Act 1948 provided:

    "(1) Subject to and in accordance with the provisions of this Part of this Act, a local authority may with the approval of the Secretary of State, and to such extent as he may direct shall, make arrangements for providing—
    (a) residential accommodation for persons aged eighteen or over who by reason of age, illness, disability or any other circumstances are in need of care and attention which is not otherwise available to them; and…
    …

35. The relevant direction by the Secretary of State directed local authorities to make arrangements under section 21(1)(a) of the 1948 Act in relation to persons who were ordinarily resident in their area and other persons who were in urgent need thereof.

36. Section 24 provided:

(1) The local authority empowered under this Part of this Act to provide residential accommodation for any person shall subject to the following provisions of this Part of this Act be the authority in whose area the person is ordinarily resident.
[...] [2]
(3) Where a person in the area of a local authority—
(a) is a person with no settled residence, or
(b) not being ordinarily resident in the area of the local authority, is in urgent need of residential accommodation under this Part of this Act,
the authority shall have the like power to provide residential accommodation for him as if he were ordinarily resident in their area.
…
(5) Where a person is provided with residential accommodation under this Part of this Act, he shall be deemed for the purposes of this Act to continue to be ordinarily resident in the area in which he was ordinarily resident immediately before the residential accommodation was provided for him.

37. Subsection 24(6) was concerned with a deeming provision in relation to the situation in which accommodation is provided by the NHS.

38. I note that when X moved to Placement1, subsection 24(6) provided:
"…(6) For the purposes of the provision of residential accommodation under this Part of this Act, a [patient in a hospital vested in the Secretary of State [, a Primary Care Trust] [7] [, an NHS trust or an NHS foundation trust] [8] shall] [6] be deemed to be ordinarily resident in the area, if any, in which he was ordinarily resident immediately before he was admitted as a patient to the hospital, whether or not he in fact continues to be ordinarily resident in that area."

39. However, subsection (6) was subsequently amended by section 148 of the Health and Social Care Act 2008. From 19 April 2010, subsection (6) was amended to apply not only to accommodation in a hospital but to other NHS accommodation:
"(6) For the purposes of the provision of residential accommodation under this Part, a patient (*"P"*) for whom NHS accommodation is provided shall be deemed to be ordinarily resident in the area, if any, in which P was resident before the NHS accommodation was provided for P, whether or not P in fact continues to be ordinarily resident in that area.
(6A) In subsection (6) *"NHS accommodation"* means–
(a) accommodation (at a hospital or elsewhere) provided under the National Health Service Act 2006 or the National Health Service (Wales) Act 2006, or
(b) accommodation provided under section 117 of the Mental Health Act 1983 by a Primary Care Trust or Local Health Board, other than accommodation so provided jointly with a local authority."

40. I need not set out subsequent amendments to that provision. However, I note that Article 12(1) of the Health and Social Care Act 2008 (Commencement No. 15, Consequential Amendments and Transitional and Savings Provisions) Order 2010 provided:

"(1) The amendments made to section 24 of the National Assistance Act 1948 [1] (authority liable for provision of accommodation) by section 148(1) of the 2008 Act do not have effect in relation to a person for whom non-hospital NHS accommodation is being provided immediately before the appointed day, for as long as the provision of that accommodation continues.
(2) For these purposes, "non-hospital NHS accommodation" is NHS accommodation that is elsewhere than at a hospital vested in—
(a) the Secretary of State;
(b) a Primary Care Trust;
(c) a Local Health Board;
(d) a National Health Service trust; or
(e) an NHS foundation trust.
…

(4) In this article—
"appointed day" means the day appointed under article 11; and
"NHS accommodation" has the meaning given by section 24(6A) of the National Assistance Act 1948 [3]."

41. "Ordinary residence" is not defined in the 1948 Act. The Department of Health has issued guidance to local authorities (and certain other bodies) on the question of identifying the ordinary residence of people in need of community care services[1] ("the guidance"). Paragraph 18 of the guidance onwards notes that the term should be given its ordinary and natural meaning subject to any interpretation by the courts. The concept involves questions of fact and degree. Factors such as time, intention and continuity have to be taken into account.

42. In *Shah v London Borough of Barnet* (1983) 1 All ER 226, Lord Scarman stated that:

"unless…it can be shown that the statutory framework or the legal context in which the words are used requires a different meaning I unhesitatingly subscribe to the view that "ordinary residence" refers to a man's abode in a particular place or country which he has adopted voluntarily and for a settled purpose as part of the regular order of his life for the time being, whether of short or long duration"

43. Additional considerations apply where the relevant person lacks capacity to determine (and thus to "voluntarily adopt") his abode. This issue was addressed by the Supreme Court in the *Cornwall County Council* case. The Supreme Court

[1] From 19th April 2010, this guidance was contained in "Ordinary Residence: Guidance on the identification of the ordinary residence of people in need of community care services in England" issued on 15th April 2011 reissued October 2013. Save where expressly stated otherwise, this determination refers to this guidance as the guidance in force at the relevant time for which the determination falls to be made.

held that the focus must be on the nature of the residence of the subject of the decision (paragraph 51) which may include having regard to the duration and quality of that residence (paragraph 49). The published guidance on ordinary residence notes that all of the relevant circumstances must be considered including the person's physical presence, the purpose of living there, the person's connection with the area, their duration of residence and their views, wishes and feelings (so far as ascertainable) to establish whether the purpose of the residence has a sufficient degree of continuity to be described as settled, whether of long or short duration. Revised guidance was issued following the decision in the *Cornwall County Council* case and I have had regard to that guidance in making this determination.

The submissions of the parties

44. CouncilA submits the following:
    - Section 24(6) of the National Assistance Act 1948 applied to X immediately before the relevant date because she had been provided with residential accommodation by an NHS trust since 2008. Article 12(1) of the Health and Social Care Act 2008 (Commencement No 15…) Order did not apply
    - Alternatively, if X's ordinary residence falls to be determined without reference to the deeming provision under section 24(6), the weight of the evidence is still in favour of X's ordinary residence being in the area of CouncilB because her family were still there; she was registered with a GP in the area of CouncilB; her transition was arranged by the manager of the CouncilB adult learning disability team; her healthcare was being provided by a CouncilB NHS Trust
    - X did not have capacity to decide where to live. While there is no specific capacity assessment in relation to that issue, the evidence from her annual reviews and decision support tools is sufficient to rebut the presumption of capacity
    - The reasoning in the *Cornwall* case supports the proposition that an authority should not be able to export its responsibility by providing necessary accommodation by exporting the person who is in need of it (with reference to paragraphs 51, 54 and 59)
    - The reasoning of the Secretary of State in determination OR 1/2015 does not assist as it predates the *Cornwall* case

45. CouncilB submits the following:
    - X's non-hospital accommodation was provided to her since before 19 April 2010 and by reason of Article 6(2) of the Care Act 2014 (Transitional Provision) Order 2015, the deeming provisions of the National Assistance Act 1948 do not apply
    - The starting point is that there is a general presumption that individuals such as X do not usually acquire ordinary residence whilst in NHS funded accommodation

- That presumption is rebutted in this case. X had not lived in AreaB for 8 years prior to losing eligibility for CHC funding. The focus of her life and local links are in AreaA
- The decision of the Supreme Court in the *Cornwall* case does not apply because the relevant date predates the judgment and the case did not refer to placements pursuant to the National Health Service Act 2006
- In any event, the presumption that X had and has capacity to decide where to live cannot be rebutted. The fact that she suffers from profound and multiple learning difficulties does not mean she does not have capacity
- Even if X did not have capacity, she was ordinarily resident in the area of CouncilA having regard to the length of time she has lived there, the nature of the links she has developed and her views, wishes and feelings so far as they can be ascertained

Application of the law to the facts

46. There is no dispute that X remained ordinarily resident in the area of CouncilB during her time at School1A.

47. The issue is whether X became ordinarily resident when subsequently placed in the area of CouncilA. There appears to be no dispute that that subsequent placement involved accommodation funded by the NHS.

48. The first question that arises is whether there is any deeming provision that applies as a consequence of the fact that X's placement was NHS-funded.

49. At the time that her placement commenced, the deeming provision in section 24(6) applied only in respect of hospital accommodation. It did not apply to the current placement, which was non-hospital accommodation. As a result, by virtue of Article 12 of the Health and Social Care Act (Commencement No 15) Order, the amendments to section 24 of the NAA 1948 did not have effect in relation to X's placement. That in turn means that Article 6(1) of the Care Act 2014 (Transitional Provision) Order 2015 did not apply (because X was not deemed to be ordinarily resident in an area by reason of sections 24(5) or (6) of the NAA 1948); and by virtue of Article 6(2) of that Order, section 39 of the Care Act 2014 would not apply.

50. In these circumstances, it is clear that no deeming provision applies. Under the law as it applied prior to 19th April 2010, the Department's general approach was to make a starting, but rebuttable, presumption that a person would not acquire an ordinary residence while in NHS funded accommodation but to consider the application of that presumption in light of all the relevant facts of the case.

51. In that regard, I note that there is a dispute as to X's capacity. I have not been provided with an assessment of X's capacity to make decisions with regards to her residence and care and I must therefore do the best I can on the material

that is available. I remind myself that a person is to be presumed to have capacity unless the contrary is shown on the balance of probabilities. Nonetheless, on the basis of the evidence as to X's cognitive abilities, I consider it more likely than not that X did not and does not have capacity to decide where to live. I note that the 2008 decision support tool refers to X having "a limited ability to assess basic risks with assistances but finds it extremely difficult to make their own decisions/choices even with prompting and supervision"; and states "X will make basic decisions e.g….if she does not want to eat". While the summary states that X has expressed a wish to remain at School1A but "more work is needed to enable X to know that this will be her home in future" it does not refer to her making or being able to make a decision or choice amongst options. Her receptive language is described as being at the one word level. The incomplete decision support tool of 2015 states that X is "unable to comprehend risk" and there are statements to the effect that she has no understanding of risk or danger. The description of choices that X makes are in respect of clothing, drinks, snacks etc but not of more complex decisions like residence and care. In these circumstances, I consider it more likely than not that X lacks capacity to make decisions about her residence and care.

52. I have been referred to my decision in ordinary residence determination OR 1/2015. I note that that decision preceded the decision of the Supreme Court in the *Cornwall* case. I also note that the *Cornwall* case is to be taken as declaratory of the law at the relevant date even though the judgment was not given until after the relevant date. However, the Cornwall case was not concerned with NHS funded accommodation and I do not consider that it undermines the approach adopted in OR 1/2015 of applying a presumption that is rebuttable on the facts.

Conclusion

53. While there are factors that weigh on both sides, I have concluded that in the circumstances of this case, the presumption referred to at paragraph 50 is rebutted. There is some, albeit limited, evidence to suggest that X expressed a wish to remain at School1A in 2008. She has lived in that area for many years including all of her adult life. There is no indication that her residence was, or is, intended to be temporary. Nor is there any evidence that the area of CouncilB can be said to remain the main focus of her life and activities since her move. In these circumstances, I have concluded that X is in fact ordinarily resident in the area of CouncilA and has been since the relevant date.