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

1. I have been asked by CouncilA to make a determination under section 40 of the Care Act 2014 of the ordinary residence of X. The dispute is with the CouncilB, CouncilC and CouncilD.

The facts

2. The following information has been ascertained from the statement of facts, legal submissions and other documents provided by the parties.

3. X is a man of XXXX origin. It is unclear when he first came to the United Kingdom. At different times he has used at least three different names and given at least two different dates of birth.

4. Information from the UK Border Agency indicates that, in 1997, he changed his name by deed poll. In 2002 he made an application for right of abode in the United Kingdom which was refused. His address at the time was given as Address1D (in the area of CouncilD).

5. Further information from the Home Office Evidence and Enquiry Unit indicates that he had visit visas for periods between September 2004 to March 2005; September 2006 to September 2007; and August 2008 to August 2010. The address given on his arrival in 2008 was Address1C (in the area of CouncilC). X does not have any current right to remain in the United Kingdom.

6. There is very limited evidence as where X lived between 2008 and 2011. On 18 December 2011 he was admitted to Hospital1 having suffered a stroke. He was later transferred to Hospital2 in CouncilB. I have been provided with copies of two discharge notification forms sent from Hospital2 to CouncilB pursuant to section 2 of the Community Care (Delayed Discharge) Act 2003. They identify the admission date to Hospital2 10 January 2012. The first notification form, dated 16 February 2012, gives X's current address as "homeless (evicted from accommodation in CouncilB Borough)" and states he has no registered GP. The second, dated 24 April 2012, gives the current address as Hospital2 and GP details as "unknown", but it identifies Address1B CouncilB as the "permanent address".

7. A continuing healthcare checklist, completed on 23 February 2012, states *"he has no fixed abode and no paperwork ie passport etc, no registered GP. His last known address was in area of CouncilB".* I have also had sight of an undated document headed *"London specialist rehabilitation referral and assessment form"* which gives X's address as *"no fixed address"*, but identifies Dr Y1 of Health Centre as his GP. This document appears to be a referral from Hospital2 to the CouncilB Brain Rehabilitation Centre (BRU).

8. Although discharge notifications were sent to CouncilB, CouncilB PCT agreed to fund a package of rehabilitation at CouncilB BRU. X was transferred there, with health funding, on 9 May 2012. The transfer letter, discharge summary and initial assessment all give X's home address as Address1B CouncilB. The transfer letter and initial assessment identify X's GP as Dr Y1. However, an admission summary, dated 23 May 2012, states: *"In terms of social history, it's noted that he had been evicted from a property in CouncilB area"*.

9. The original intention was for X to be discharged from the rehabilitation unit to live with his cousin, Z1, in CouncilD. However, this plan did not materialise. On 12 July 2012, the community liaison coordinator at CouncilB BRU wrote to CouncilB notifying them of an intended referral. The email message referred to a Hospital1 discharge report (that I have not seen) which said that X had been evicted from Address1B CouncilB. It noted that health funding was due to come to an end on 15 August 2012.

10. A formal referral was made on 26 July 2012. The referral document gave X's address as Address1B CouncilB and home GP as A1, Health Centre. Under the heading "background" it noted that a home visit had been made to the cousin's house on 16 July 2012. The cousin said that: *"he did not know where 'X' had been living. He always visited them. He thought he had been living and working in the UK for 8 years".* This is important as the cousin was the main source for subsequent information asserting that X lived in the area of CouncilB.

11. On 27 July 2012, CouncilB BRU notified CouncilB PCT and CouncilE of the circumstances of the proposed discharge. On 2 August 2012 CouncilB BRU completed a continuing healthcare checklist and, on the basis of the scoring on the checklist, CouncilB PCT confirmed that X would not be eligible for a full continuing healthcare assessment.

12. CouncilB case notes for the relevant period record that, on 7 August 2012, a person from CouncilB (who I assume was the allocated social worker) called

X's cousin and spoke to him about arrangements for discharge. The note states: *"[The cousin] has confirmed that [X] was residing in CouncilB area and that he received notification from his previous landlord (will need to see copy of any proof)"*. The notes then record that the allocated social worker spoke to the assistant team manager who suggested that written proof of address was required *("ie. the letter from the landlord to cousin detailing [X's] eviction"*). The cousin did not provide any documentary proof.

13. The agreed statement of facts says that, on 8 August 2012, CouncilB declined to assess X on the basis that there was no written evidence that he had been ordinarily resident in their area at the relevant time. From my reading of the documents it appears that date may be wrong. The case notes indicate that the allocated social worker visited X and carried out an initial (partial) assessment on 8 August 2012.

14. On 15 August 2012 CouncilB BRU wrote to CouncilB stating that funding would run out that day and that X might be a delayed discharge. They proposed a transfer to a brain injury centre in the area of CouncilA run by the same group as CouncilB BRU. The email noted that CouncilB BRU had a long waiting list and that they needed to move clients as soon as they had completed rehabilitation.

15. The CouncilB case notes record that, on 16 August 2012, the allocated social worker telephoned the Health Centre (the GP surgery identified in some of X's records) and spoke to an administrator. The note of the conversation states: *"they have no records for this gentleman under any of the variations of DOB, name or address".*

16. On the same date, the social worker also telephoned X's cousin to provide an update and again ask for documentary evidence of proof of address. The cousin provided contact details of a former housemate living in the premises of the previous address. The social worker phoned that number and spoke to an individual who confirmed that X was staying with him for a period of time but would not confirm dates or period of stay, and could not provide any proof or details of any GP. He suggested X might have had a GP in CouncilD where his cousin lived. The note states that: *"he confirmed that [X] was staying with him at the time that he had his stroke and he had been with him approximately a week at that time. He stated that [X] would go away and stay with the cousin or out of London to work".*

17. The social worker received a further call from the cousin that day. The cousin stated that X *"did most definitely live at the address in area of CouncilB"* and that the landlord had contacted him saying that he needed to evict [X] and make the room vacant and that he had several bags of [X's] personal belongings that were at the house. The social worker advised that there was "no proof" and that the cousin should also start trying to gather "empirical evidence". She advised the cousin to speak to the flatmate to seek to ascertain dates and gather evidence. There is nothing in the records that addresses the inconsistency with the cousin's earlier statement that he did not know where X had been living.

18. Later that day CouncilB wrote to CouncilB BRU declining to carry out an assessment. The letter stated:

> *"There is no written evidence that [X] was ordinarily resident in the area of CouncilB at the relevant time.*
>
> *Contrary to the information provided on your referral, my enquiries with the surgery, has proven that [X] has never been registered with them (Health Centre).*
>
> *We are also not satisfied with the identity of [X] because so far we have been presented with 3 different names and two different dates of birth…*
>
> *In addition we have spoken to cousin who originally stated he would care for [X] following discharge from his rehabilitation at CouncilB BRU. [The cousin] has also failed to provide us with any written proof of [X] living within the area of CouncilB. He did finally release a telephone number of a gentleman who allegedly lived with [X] prior to his stroke. This gentleman… was able to confirm that [X] had stayed at the home, but again no documentation to evidence this. The only current letter addressed to [X] at this address was from the hospital following his post stroke hospitalisation."*

19. On 21 August 2012 the cousin telephoned again. He provided contact details for a person he claimed was X's landlord and stated that they could confirm that X was not simply staying in the property but was renting a room for not months but years. The social worker advised that written confirmation would still be needed for CouncilB to take responsibility. The case notes indicate that the allocated social worker spoke to her manager about this matter and was

advised not to contact the landlord at this time. There is no further mention of the landlord in the case notes.

20. On 23 August 2012 X was transferred from CouncilB BRU to Acquired Brain Injury Centre (in the area of CouncilA). The agreed statement of facts records that no capacity assessment or best interests process was undertaken prior to the move. There is reference in the correspondence that I have seen to a discharge summary, dated 31 December 2012, which states that *"whilst negotiations continue as to which agency will take responsibility for his accommodation and care in the long term, it has been agreed with the PCT that it would be in [X's] best interests to transfer to* Acquired Brain Injury Centre *…. [X's] cousin has stated that he is not happy with the move".*

21. However, a joint letter from and CouncilB CCG (the successor to CouncilB PCT), dated 19 CouncilB December 2013, states emphatically that the PCT was not consulted or involved in discharge planning and it did not commission the placement at Acquired Brain Injury Centre. An agreed amendment to the joint statement of facts records that NHS funding for X's care came to an end on 15 August 2012.

22. I note that the agreed statement of facts also says that CouncilB CCG provided "temporary funding" until 13 February 2014, but this may have been in response to pre-action correspondence in 2013 (referred to below). The letter of 19 December 2013 makes reference to some earlier on-going payments made in "good faith". There is no clear evidence, however, as to when these payments were made. Given that the parties have agreed an amendment to the statement of facts which records that NHS funding cased on 15 August 2012 (and a deletion of reference to NHS funding of the transfer to Acquired Brain Injury Centre), I will proceed on the basis that no funding was in place after 15 August 2012 for a period of time at least including when X moved to *Acquired Brain Injury Centre* on 23 August 2012.

23. On 15 August 2013, a letter before action was sent by Organisation1 (which runs CouncilB BRU and *Acquired Brain Injury Centre*) to CouncilA and CouncilB CCG, in relation to a debt for X's placement at *Acquired Brain Injury Centre*. I have not been provided with all of the pre-action correspondence. I am told that CouncilA disputed that it had any responsibility for X and (as stated above) CouncilB CCG provided "temporary funding" until 13 February 2014.

24. The agreed statement of facts records that a mental capacity assessment undertaken by *Acquired Brain Injury Centre* on 18 October 2013 concluded that X lacked capacity to make decision regarding his future care but had capacity to decide where he wished to live. I have not seen this assessment. I am told that, on 4 November 2012, an Individual Needs Portrait (assessment) was completed by CouncilA to inform a best interests meeting convened by Acquired Brain Injury Centre. Again I have not had sight of the assessment.

25. The best interests meeting took place on 8 January 2014. It was chaired by Acquired Brain Injury Centre and attended by CouncilA and CouncilB CCG. The agreed statement of facts says that the meeting concluded that it would be in X's best interests to be placed in London near his family. X expressed a wish to return to London to be near his family and associates.

26. On 26 February 2014 CouncilA directed CouncilB CCG to CouncilB. CouncilB CCG undertook an assessment of X's needs on 6 March 2014. The assessment determined that X did not have primary health needs and that continuing healthcare was not required. It concluded that X's needs could be managed in a residential care setting and recommended a residential placement with opportunity for interaction with other XXXX nationals.

27. On 19 March 2014 CouncilB CCG informed *Acquired Brain Injury Centre* that X's last recorded address on his UKBA record was Address1D in the area of CouncilD. Acquired Brain Injury Centre accordingly referred X to CouncilD for assessment. On 6 May 2014, CouncilD declined the referral noting that the last recorded address was, in fact, in the area of CouncilC. A further referral was made to CouncilC. On 13 May 2014 CouncilC declined the referral on the grounds that responsibility should rest with CouncilB.

28. Organisation1 wrote to all four authorities, on 28 February 2017, in relation to the debt and need for assessment. After some further correspondence, on 19 April 2017, CouncilA agreed to accept interim responsibility for assessment on a without prejudice basis.

29. On 16 May 2017 Acquired Brain Injury Centre assessed X's capacity and concluded that he lacked capacity to make decisions about his residence and care. On 18 May 2017 CouncilA assessed X's capacity and care needs. The assessment records that X wanted to stay at Acquired Brain Injury Centre. However, it concluded that X's needs should be met at a residential care

placement. On 19 October 2017 X moved to the Residential Home1A in the area of CouncilA.

30. The dispute about X's ordinary residence was referred to me by CouncilA, as the lead authority, on 13 December 2017. All parties filed legal submissions. CouncilA and CouncilB filed supplementary submissions.

The Authorities' Submissions

31. CouncilA submits that:

    a. It is necessary to consider where X was ordinarily resident before he was admitted to hospital on 18 December 2011. There is "sufficient evidence" that X was residing in the area of CouncilB at, or shortly before, his admission, and documentary evidence of a permanent home address is not essential to determining that X was living in CouncilB for settled purpose.

    b. CouncilB should have carried out an assessment and provided services to X (at least on an interim basis) when the referral was made to them in July 2012. Any reasonable assessment would have concluded that X was in need of community care services.

    c. The transfer from CouncilB BRU to Acquired Brain Injury Centre in CouncilA, in August 2012, was inappropriate in circumstances where all X's family and community ties were in London. X should have been placed in London.

32. CouncilA rely on the decision of Charles J in *Greenwich* (cited below), and the guidance in force at the time, to argue that CouncilB cannot escape responsibility on the basis of their failure to make necessary arrangements. They assert that it is highly unlikely that X would have been placed in their area had a proper assessment been undertaken at the time and, even if he had been transferred to Acquired Brain Injury Centre, deeming provisions would have applied.

33. CouncilB disputes that it has any responsibility for X. Its primary submission is that:

a. When X moved to Acquired Brain Injury Centre the placement was not an NHS placement or a placement under Part 3 of the National Assistance Act 1948, so the deeming provisions do not apply; and

b. On the facts, X did become ordinarily resident in the area of CouncilA when he moved to Acquired Brain Injury Centre.

34. Its supplementary submissions address the issue of X's ordinary residence prior to his admission to hospital, and application of the *Greenwich* case. In short, CouncilB asserts that:

a. X was not ordinarily resident in its area prior to his hospital admission; and

b. In any event, the *Greenwich* approach can only apply where it is clear that a local authority acted unlawfully in failing to make provision under the 1948 Act.

35. CouncilC submits that X was ordinarily resident in the area of CouncilB before his hospital admission and that he should be deemed as remaining ordinarily resident in that area. Alternatively, it submits that X was of "no settled residence" and responsibility should fall on CouncilA.

36. CouncilA does not address where responsibility should lie. It states simply that X has had no connection to its area for over 15 years.

The Law

37. I have considered all the documents submitted by the parties; the provisions of Part 1 of the Care Act 2014 ("the 2014 Act") and the Care and Support (Disputes Between Local Authorities) Regulations 2014; the provisions of Part 3 of the National Assistance Act 1948 ("the 1948 Act") and the Directions issued under it[2]; the Care and Support Statutory Guidance and the earlier guidance on ordinary residence issued by the Department[3]; and relevant case law, including *R (Cornwall Council) v Secretary of State for Health [2015] UKSC 46 ("Cornwall"), R (Shah) v London Borough of Barnet* (1983) 2 AC 309 ("*Shah*"), *R (Greenwich) v Secretary of State for Health and LBC Bexley* [2006] EWHC 2576 ("*Greenwich*"), and *Mohammed v Hammersmith & Fulham LBC* [2002] 1 AC 547 (*"Mohammed"*). This dispute spans the coming into force of the 2014 Act. It is, therefore, necessary for me to set out below the law as it applied both before and after relevant provisions came into force.

Transitional Provisions

38. Article 5 of the Care Act (Transitional Provision) Order 2015/995 requires any question as to a person's ordinary residence arising under the 1948 Act, determined by me on or after 1 April 2015, to be determined in accordance with section 40 of the 2014 Act.

39. Article 6(1) states that any person who, immediately before the relevant date (i.e. the date on which the person's case is first reviewed under provision of the 2014 Act or 1 April 2016 if no review has taken place before that date), is deemed to be ordinarily resident in a local authority's area by virtue of section 24(5) or (6) of the 1948 Act is, on that date, to be treated as ordinarily resident in that area for the purposes of Part 1 of the 2014 Act.

The 1948 Act

40. The following provisions were applicable when X moved to Acquired Brain Injury Centre and at all times up to 1 April 2016 (no review under Part 1 of the 2014 Act having taken place prior to that date).

Accommodation

41. Section 21 of the 1948 Act empowered local authorities to make arrangements for providing residential accommodation for persons aged 18 or over who by reason of age, illness or disability or any other circumstances were in need of care or attention which was not otherwise available to them**.**

42. By virtue of section 26 of the 1948 Act, local authorities could, instead of providing accommodation themselves, make arrangements for the provision of the accommodation with a voluntary organisation or with any other person who was not a local authority (subject to certain limitations that are not material to this case).

The relevant local authority

43. Section 24(1) stated that the local authority empowered to provide residential accommodation under Part 3 of the 1948 Act was, subject to further provisions of that Part, the authority in whose area the person was ordinarily resident. The Secretary of State's Directions provided that the local authority was under a duty to make arrangements under section 24 in relation to persons ordinarily resident in their area and other persons in urgent need.

The deeming provision

44. Under section 24(5), a person who was provided with residential accommodation under Part 3 of the 1948 Act was deemed to continue to be ordinarily resident in the area in which he was residing immediately before the residential accommodation was provided.

45. Under section 24(6), a person for whom NHS accommodation was provided was deemed to be ordinarily resident in the area, if any, where he was ordinarily resident[1] before the accommodation was provided.

46. In *Greenwich* (cited above) at [54] Charles J said:

> *"if the position is that the arrangements should have been made — and here it is common ground that on 29th June a local authority should have made those arrangements with the relevant care home — that the deeming provision should be applied and interpreted on the basis that they had actually been put in place by the appropriate local authority".*

47. In the following paragraph, Charles J noted that (i) failure to provide accommodation could found a claim for judicial review; and (ii) if the court found that the local authority had acted unlawfully in not providing the accommodation arrangements would be put in place retrospectively. I proceed on the basis that that the *Greenwich* approach can apply only where I am satisfied that an authority has *unlawfully* failed to provide accommodation in the sense that would found relief in judicial review.

<u>The 2014 Act</u>

48. The above sections of the 1948 Act were repealed and replaced by relevant parts of the 2014 Act, subject to transitional provisions (material parts of which are set out above).

Duty to meet need for care and support

49. Section 18 of the 2014 Act imposes a duty on local authorities to meet the assessed eligible needs for care and support of adults ordinarily resident in their area (or present in their area but of no settled residence). Examples of what

[1] The statute uses the word "resident" but for the reasons set out at paragraphs 64 and 65 of the 2013 Ordinary Residence Guidance, I interpret this to mean "ordinarily resident"

may be provided to meet such needs are set out in section 8. These include provision of accommodation in a care home or in premises of some other type.

Ordinary Residence

50. "Ordinary residence" is not defined in the 1948 Act or the 2014 Act. Guidance has been issued to local authorities (and certain other bodies) on the question of identifying the ordinary residence of people in need of community care services.

51. In *Shah* (cited above), 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 settled purpose as part of the regular order of his life for the time being, whether of short or long duration"*

52. In *Mohammed* (cited above) Lord Slynn said:

> *"So long as that place where he eats and sleeps is voluntarily accepted by him, the reason why he is there rather than somewhere else does not prevent that place from being his normal residence. He may not like it, he may prefer some other place, but that place is for the relevant time the place where he normally resides."*

53. The Care and Support Statutory Guidance, updated following the decision of the Supreme Court in *Cornwall*, states:

> *"with regard to establishing the ordinary residence of adults who lack capacity, local authorities should adopt the Shah approach, but place no regard to the fact that the adult, by reason of their lack of capacity cannot be expected to be living there voluntarily. This involves considering all the facts, such as the place of the person's physical presence, their purpose for living there, the person's connection with the area, their duration of residence there and the person's views, wishes and feelings (insofar as these are ascertainable and relevant) 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.

54. This is the approach that I adopt here.

Application of the law to the facts

Ordinary residence prior to hospital admission

55. In order to consider the parties' competing legal submissions, it is necessary for me first to determine, as a matter of fact, where (if anywhere) X was ordinarily resident prior to his admission to hospital in December 2011. This is an extremely difficult task given the paucity of evidence. However, I must do my best, on the evidence available, to decide the issue on the balance of probabilities.

56. I find at the outset that X was not ordinarily resident in the areas of CouncilD or CouncilC. The only evidence to connect him to these areas is the addresses in the Home Office records for 2002 and 2008 respectively. There is nothing to suggest an ongoing connection with either of these areas.

57. The crucial issue for me to determine is whether it is more likely than not that X was ordinarily resident in the area of CouncilB. The fact that an address in the area of CouncilB was recorded in some of his hospital records is highly significant. However, there are numerous references to X having been evicted from this address. Whether the eviction took place before or after his admission is not clear. Some of the earliest document that I have seen describe X as being "homeless" or of "no fixed abode", and "had been evicted" in the 23 May 2012 admission summary could be read as referring to events prior to admission. None of the documents provide clear evidence that X was still living in CouncilB at the date of admission.

58. The most unequivocal evidence that X was living in the area of CouncilB came from his cousin. However, accounts given by the cousin were fundamentally contradictory and, for this reason, I cannot place significant weight on them. When asked on 16 July 2012 about X's residence the cousin said that he did not know where X had been living as X always visited him. The cousin could have made enquiries after this date. However, when he spoke to the social worker on 7 August 2012, the cousin did not just give details of X's residence, he also claimed to have received notification of the eviction from the landlord.

This assertion is extremely difficult to reconcile with the earlier statement. All the documents indicate that the eviction took place before 16 July. Therefore, if what the cousin said about notification from the landlord was true, he surely would have known, when asked on 16 July, where X had been living.

59. The other evidence comes from the individual identified as a housemate. This individual said that X had been living with him only for about a week before his hospital admission. He also said that X would go away to his cousin's and out of London to work. He said that X might have a GP in area of CouncilD. These comments do not suggest settled residence in CouncilB.

60. The cousin also provided details of a landlord which were not followed up. The local authority had a duty to carry out reasonable enquiries and they should have acted on this information. However, I must assess the facts on the basis of the evidence that is available. I do not consider the cousin to be a reliable witness for the reasons set out above and one can only speculate as to what, if any, further evidence the purported landlord might have provided. The cousin was asked on a number of occasions to provide documentary proof of X's residence but failed to provide anything.

61. I agree with CouncilA that documentary proof of a permanent address is not a prerequisite for establishing ordinary residence. There are some people who, for a whole range of reasons, do not have signed tenancy agreements, and do not send and receive official correspondence. A person with no leave to remain in the United Kingdom may be less likely to have documentary proof of residence. CouncilB's reasons for refusing an assessment did focus very heavily (arguably too heavily) on the absence of documentary evidence. However, this must be considered in light of the unreliability of the other (oral) evidence.

62. CouncilA emphasise the fact that a named GP is identified in some of the medical records and the fact that CouncilB PCT assumed responsibility for X. However, I can place limited weight on these factors in circumstances where enquiries were made with the relevant GP surgery (apparently giving all of X's various aliases and dates of birth) and the practice administrator confirmed that they had no record of X. There is no evidence as to what enquiries, if any, the PCT undertook before funding the original admission. As CouncilB rightly note in their supplementary submissions, PCT responsibility at the time was determined by "usual residence" which, under regulation 3 of the National Health Service (Functions of Strategic Health Authorities and Primary Care

Trusts and Administration Arrangements) (England) Regulations 2002, was defined much more broadly than ordinary residence under the 1948 Act.

63. Overall, given the paucity and unreliability of the evidence that X had been living in the area of CouncilB; the suggestion that he may have been evicted before his admission to hospital; the evidence from the housemate that he stayed in different places; and the lack of any clear evidence as to when X lived at the address in the hospital records; I am unable to conclude that it is more likely than not that X was ordinarily resident in the area of CouncilB on the date of his admission to hospital.

64. In reaching this conclusion I take account of the fact that there is very little evidence to suggest that X was ordinarily resident anywhere else. The guidance makes clear that a finding of "no settled residence" should be rare. However, in light of the particular evidential difficulties in this case, I am reluctantly compelled to find that X did not have a settled residence.

Deeming provisions

65. It follows from this conclusion of fact that the deeming provisions under section 24 of the 1948 Act cannot apply in this case. The relevant provisions, as set out above, allow a person provided with NHS accommodation or accommodation under Part 3 of the 1948, to be treated as ordinarily resident in the place they were ordinarily resident prior to provision of that accommodation. Sections 24(5) and (6) do not apply to individual of no settled residence.

66. It is, therefore, unnecessary for me to consider in detail the broader submissions of the parties on the application of *Greenwich* and the lawfulness of CouncilB's actions. The argument that CouncilB should have assessed X's needs and provided accommodation is only relevant insofar provision of that accommodation could have led to application of the deeming provisions.

67. CouncilA invited me to consider joining CouncilE (in response to a point raised in CouncilB's supplementary legal submissions) on the grounds that (i) X was present in their area before he moved from CouncilB BRU to Acquired Brain Injury Centre, and (ii) they might have been under a duty to assess and/or provide accommodation for X.

68. I do not consider that it is necessary for me to take this step. It is not my function to consider the lawfulness of the actions of public authorities generally. I must determine ordinary residence on the facts. In doing so, I have to consider

whether the deeming provisions apply. An authority cannot escape the deeming provisions where they have unlawfully failed to provide accommodation under Part 3 of the 1948 Act (per *Greenwich*). However, for the reasons set out above, those deeming provisions can have no application here where the relevant person was of no settled residence.

Ordinary Residence

69. Therefore, it falls to me to determine X's ordinary residence at the date he moved to Acquired Brain Injury Centre applying the approach in *Shah* and *Cornwall* cited above. The evidence as to whether or not X had capacity to decide his place of residence at this time is unclear. The agreed statement of facts refers to an assessment undertaken in 2013 that concluded that he had capacity to make decisions about where he wished to live, but not about his care. Later capacity assessments have found that he is not able to make decision about his residence, but capacity is always time specific.

70. CouncilA argue that Acquired Brain Injury Centre was an unsuitable placement. They complain about the absence of adequate assessment prior to the move. All X's family and community ties were in London. However, the issue for me is not whether an alternative placement would have been better but whether, on the facts as they were, X became ordinarily resident in the area of CouncilA. Regardless of whether or not X had capacity, I do not consider that any of the factors identified by CouncilA can outweigh the fact that he moved to Acquired Brain Injury Centre to live. There is no evidence of any alternative home or placement available to him.

<u>Conclusion</u>

71. It follows from the above that X became ordinarily resident in the area of CouncilA when he moved to Acquired Brain Injury Centre in 2012 and he continues to be ordinarily resident in that area to date.

72. This outcome may appear harsh on CouncilA who had no knowledge of X until after he was placed in their area. It should be stressed, however, that this is a highly unusual case. Circumstances in which individuals are found to have no settled residence should be rare and it is a notable feature of this case that X

appears to have been moved unilaterally by a provider without the direct involvement of any public authority.