Medical treatment and 16/17 year olds: a working paper

Introduction

This paper[1] is prompted by the work done for the case of *Re D*, in which the Supreme Court gave judgment ([2019] UKSC 42) on 26 September 2019. During the – long – course of the case, it increasingly struck me quite how disconnected was the thinking of the courts (and indeed commentators) in relation to the position of medical treatment in relation to 16-17 year olds. This may be a function of the fact that these issues:

> *lie at the intersection of three different bodies of domestic law – mental health law, mental capacity law and family law – where judicial decision-making is spread over a variety of courts and tribunals which, by and large, are served by different sections of the legal professions too few of whom are familiar with all three bodies of law*.[2]

This disconnect does not just afflict lawyers and the courts, but also law-makers. This is evident in the current Mental Capacity Act Code of Practice which (in terms similar to that in the DH Reference Guide to Consent)[3] provides that:

> *12.16 Under the common law, a person with parental responsibility for a young person is generally able to consent to the young person receiving care or medical treatment where they lack capacity under section 2(1) of the Act. They should act in the young person's best interests.*
>
> *12.17 However if a young person lacks the mental capacity to make a specific care or treatment decision within section 2(1) of the Act, healthcare staff providing treatment, or a person providing care to the young person, can carry out treatment or care with protection from liability (section 5) whether or not a person with parental responsibility consents.*

In other words, the Code of Practice is telling health and social care professionals in relation to a 16/17 year old (i.e. a 'young person' in the language of the Code, which I will use here) who lacks mental capacity to make a decision relating to care and treatment that it is possible either:

1. To proceed by seeking the consent of a person with parental responsibility. If that person gives consent, then (assuming that they acting within the somewhat nebulous scope of their parental responsibility), there is no liability against which the professionals need to be immunised by operation of a defence. Conversely a **refusal** on the part of that person to give consent would constitute an **absolute** bar to – at least – to medical treatment, [4] absent an application to court; or

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[1] Deliberately entitled "working paper," because it contains thoughts that are still in train. I work dilemmas out best by writing about them. I am sharing it at this stage as much as anything else to solicit observations; it may well form the basis of a formal article in due course (and I reserve the right entirely to change my mind about anything contained within it upon the basis of further reflection and/or in the light of observations received).

[2] Speech by Sir James Munby to the Legal Action Group Community Care Conference on 12 October 2018, available at: https://www.lag.org.uk/article/205735/despatches-from-the-front-line--some-current-problems. Sir James was talking specifically about the *Re D* case, the hearing of the appeal against his decision in the Court of Appeal having just taken place before the Supreme Court.

[3] DH, Second edition, 2009, available at: https://www.gov.uk/government/publications/reference-guide-to-consent-for-examination-or-treatment-second-edition

[4] "*Since the parents are empowered at law, it seems to me that their decision must be respected and in my judgment the hospital would be no more entitled to disregard their refusal than they are to disregard an adult*

2. To proceed on the basis that they reasonably believe the 16/17 year old lacks the mental capacity to take the decision, and that they reasonably believe that they are acting in their best interests, taking into account the views of the parents through the prism of consultation under s.4(7) MCA 2005. At that point, and whilst prima facie assaulting the young person, the professional would be protected from liability under the defence in s.5 MCA 2005. Following *NHS Trust v Y*,[5] and at least in the case of life-sustaining treatment, an application to court would be required where "*at the end of the medical process, it is apparent that the way forward is finely balanced, or there is a difference of medical opinion, or a lack of agreement to a proposed course of action from those with an interest in the patient's welfare*" (see para 125). But it is suggested that there may be circumstances in which it would be legitimate to proceed with the treatment in the face of parental opposition, for instance if the young person, themselves, is indicating that they wish it, and the parent is giving no basis for refusing consent.

Furthermore, if the matter does go to court:

1. If the decision has been made by reference to the MCA 2005, then the application would be made to the Court of Protection, in which a litigation friend – frequently, but not invariably, the Official Solicitor – would be likely to be appointed to act on their behalf. The court would apply the statutory test in s.4 MCA 2005 to determine what is in the young person's best interests and then to consent (or refuse) the treatment on their behalf[6];

2. If the decision has been made by reference to the common law operation of parental responsibility, then the application would be made to the High Court for a specific issue order under s.100 Children Act 1989 and/or for the exercise of its inherent jurisdiction.[7] Cafcass would be likely to act as the young person's litigation friend (the Official Solicitor as a matter of practice, not appearing in such cases). The court would determine what is in the young person's best interests; it would be bound not by s.4 MCA 2005 but by the common law conception of best interests as it applies to children. In many cases, the two may come so close as to be essentially indistinguishable in fact,[8] but in law they are not the same, and the courts have warned in cases under the Children Act 1989 against seeking to "*import wholesale, principles from the Mental Capacity Act 2005*."[9]

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patient's refusal. To operate in the teeth of the parents' refusal would, therefore, be an unlawful assault upon the child." *Re A (Children) (Conjoined Twins: Surgical Separation)* [2001] Fam 147 at 178 per Ward LJ.

[5] [2018] UKSC 46.

[6] See *Aintree v James* [2014] 1 AC 591 at para 22.

[7] See *Re JM (A Child)* [2015] EWHC 2832 (Fam).

[8] See for a recent summary of the principles *Raqeeb v Barts NHS Foundation Trust* [2019] EWHC 2531 (Admin) and [2019] EWHC 2530 (Fam) at paras 102-104 and 115-122.

[9] *Raqeeb* at para 123, addressing the position, in particular, of a very much younger child. MacDonald J noted at para 124 "[t]*o use ss 4(6) and 4(7) of the Mental Capacity Act 2005 to add a gloss to s 1(3)(a) of the 1989 Act* [the statutory requirement to have regard to the ascertainable wishes and feelings of the child concerned (considered in the light of his age and understanding)] *risks imputing to a young child matters beyond their comprehension and failing to take account of principle of evolving capacity (which is nowhere mentioned in s 4(6) of the 2005 Act), contrary to the express requirement by s 1(3)(a) of the 1989 Act. This is a particular risk where one is dealing with the complex area of religious belief, where the child's age and understanding is key to determining the weight to be attached to any such belief. Within this context, I again note the terms of Art 6(2) of Council of Europe's Convention on Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine, which stipulates that 'The opinion of the minor shall be taken into consideration as an increasingly determining factor in proportion to his or her age and degree of maturity.'*"

> The court would then not be consenting or refusing on behalf of the young person, but "to take over the parents' duty to give or withhold consent in the best interests of the child."[10]

In light of all these differences,[11] one might think that it was (a) mildly surprising that a statutory Code of Practice simply set out the two routes without giving any further guidance; and (b) that there has been an almost entire dearth of (reported) case-law in the area since 2007 when the MCA 2005 came into force.

It will hopefully be possible to do something about (a), although within the prescribed bounds laid down clearly by the Supreme Court in *NHS Trust v Y* [2018] UKSC 46, in which it made clear that a Code of Practice cannot purport to create law as opposed to reflecting law to be found either in statute (including the ECHR via the Human Rights Act 1998) or the common law.

As to (b), it is to me a matter of considerable regret that the Supreme Court declined to address these issues when put to them in *Re D*. The Supreme Court did, though, make a number of observations which may help to join the dots in due course. In the balance of this paper, I set out some observations seeking to assist that process, although against an overarching position that the question of how to approach (1) legal; and (2) mental capacity in relation to those under 18 (not just between 16 and 17) is one that touches upon so many areas of the law that it is a matter crying out for a root and branch consideration by the Law Commission.[12]

I would be particularly interested in terms of developing the thinking in this paper to hear of (1) unreported examples of judicial consideration of any of the matters concerned; (2) reported examples that I have missed; (3) judicial consideration from other jurisdictions shedding light on these matters; and (4) academic commentary which grapples squarely with the issues.[13]

The test for assessing decision-making capacity from 16 onwards

It might seem strange to start with a discussion of this proposition, as most would assume (and, frequently, in that assumption, make reference to s.8 Family Law Reform Act 1969) that the test is mental capacity, applying the test in the Mental Capacity Act 2005 ('MCA 2005').[14]

It was for this reason that many found it jarring when Sir James Munby P in the Court of Appeal in *Re D* proceeded on the basis that *Gillick* competence ran to age 18, did not limit himself in so doing to questions of confinement, and expressly drew upon case-law relating to medical treatment. [15]

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[10] See the summary of the principles in *Raqeeb* at para 116(i).
[11] This list is not exhaustive – it does not, for instance, take into account the different public funding tests applicable to proceedings before the Court of Protection and in relation to the Children Act/the inherent jurisdiction.
[12] As, of course, it did recommend in its Mental Capacity and Deprivation of Liberty report (Law Com No 372).
[13] One example, albeit not published, being the PhD thesis of Camilla Parker, looking at these, and related, issues in the context of mental health: see "The Legal Aspects of the Mental Health Care of Adolescents": https://orca.cf.ac.uk/106484/1/2017parkerchphd.pdf
[14] That assumption is reflected in the DH Reference Guide to Consent (2nd edition, 2009), at para 4.
[15] *Re D* [2017] EWCA Civ 1695 – see, in particular, paras 83-4:
"*What for convenience, and in accordance with settled practice, I shall refer to as 'Gillick capacity' or 'Gillick competence' is not determined by reference to the characteristic development trajectory of some hypothetical 'typical' or 'normal' child (whatever those expressions might be understood as meaning). Whether a particular child has 'Gillick capacity' is determined by reference to the understanding and intelligence of that child.*
[…]
This has an important corollary. Given that there is no longer any 'magic' in the age of 16, given the principle that 'Gillick capacity' is 'child-specific', the reality is that, in any particular context, one child may have 'Gillick

Sir James' conclusion must be wrong in relation to the test to apply in relation to confinement given the decision of the Supreme Court in *Re D*, all the Justices (including those in the minority) proceeding on the basis that it was mental capacity, not *Gillick* competence, that was in issue.[16]

However, it could still be correct in relation to medical treatment which, arguably, raises different issues.[17] As noted above, there is a dearth of case-law in this area. However, in *An NHS Foundation Hospital v P* [2014] EWHC 1650 (Fam), Baker J (as he then was), considering the position of a 17 year old who was refusing treatment for a drug overdose, held that the "*first question is whether or not P has capacity to make decisions concerning her medical treatment. Capacity is determined under the provisions of the Mental Capacity Act 2005 which applies to persons over the age of 16*" (para 8).[18] It is perhaps fair to say that this was not the most detailed of judgments, given that it resulted from an emergency application to court in the middle of the night.[19] But it is perhaps telling that Baker J appeared to take it as axiomatic that he was to apply the MCA 2005. Further, and whilst not addressing herself to medical treatment, Lady Hale observed in *Re D* (at para 26(iii) that "*the Act, including the presumption of capacity in section 1(2) and the test for incapacity in sections 2(1) and 3, applies to a person who has reached 16.*"

Taking a step back, it is also important to note the differences that flow from an approach predicated upon *Gillick* competence as opposed to one predicated upon the MCA 2005:

1. As Cobb J identified in *Re S*, most notable of the "*fundamental*" differences between the assessment of a child's competence at common law, and the assessment of capacity of a person over the age of 16 under the MCA 2005[20] is that "*the assumption of capacity in a person aged 16 or over in section 1(2) of the MCA 2005 does not apply (in relation to the equivalent issue of competence) to a young person under that age*."[21] If, therefore, the conventional understanding is wrong, and the test to apply to age 18 really is *Gillick* competence, then it would always be for **any** 16/17 year old to prove their own (legal) capacity to give consent – inter alia – to medical treatment. This would be a somewhat startling proposition, not least as it would stand directly contrary to what is generally understood[22] (including at para 12.11 of

capacity' at the age of 15, while another may not have acquired 'Gillick capacity' at the age of 16 and another may not have acquired 'Gillick capacity' even by the time he or she reaches the age of 18: cf, In Re R (A Minor) (Wardship: Consent to Treatment) [1992] Fam 11, pages 24, 26.'" *Re R* related to a 15 year old, so the observations of the Court of Appeal in that case were, in fact, dicta.

[16] See Lady Hale (with whom Lady Black and Lady Arden agreed) at paras 26(iii) and 49, and Lord Carnwath (with whom Lord Lloyd-Jones agreed) at para 123.

[17] Lady Black in *Re D* considered this to be the case: see para 69.

[18] In *University Hospitals Plymouth NHS Trust v B (A Minor) (Urgent Medical Treatment)* [2019] EWHC 1670 (Fam), the only other reported case I can find, MacDonald J simply noted that there was no evidence that the young person (aged 16) lacked capacity (see para 2).

[19] This might then explain why, in then deciding to override the young person's capacitous refusal, Baker J did so on the basis that the High Court could do so even where the young person was *Gillick* competent. The judgment did not address how *Gillick* competence and MCA capacity interact (a question that has not been addressed in any case of which I am aware since the MCA came into force). I would suggest that the real position is that the High Court retains an ability to impose treatment in the face of a refusal by a child of 16/17 year even if that child has mental capacity (applying the MCA) to make decisions about medical treatment.

[20] In passing, it is again, of note, that Cobb J appeared to proceed on the basis that it was axiomatic that the MCA 2005 applies post 16.

[21] *Re S (Child as Parent: Adoption: Consent)* [2017] EWHC 2729 (Fam), [2019] Fam 177 at para 16.

[22] In fact s.8 does not say anything about what constitutes 'consent' on the part of a 16 year old. It simply says that such consent is legally effective. Cases such as *Re W (a minor) (medical treatment: court jurisdiction)* [1993] Fam 64, in which s.8 have been considered, pre-date the MCA and do not ask this question; it is striking, however, that even in *Re W*, the Court of Appeal observed that the wording of s.8(1) shows "*quite clearly that it*

the current version of the MCA Code) to be the effect of s.8 Family Law Reform Act 1969 in relation to such treatment.

2. Linked to the fact that the *Gillick* test is, in origin, a test designed to examine whether an **unusually** mature child is be recognised as having decision-making authority 'early,' there is no requirement in the test for the decision-maker to provide support to that child to make their decision. This is in stark contrast to the position under the MCA 2005: see s.1(3).

It may, of course, be the case that the test for purposes of deciding – at common law – whether or not a parent can exercise their parental responsibility to consent on behalf of a young person to medical treatment post-16 requires consideration of whether that young person is *Gillick* competent or incompetent. However, we might query how relevant that question actually is (even before we come to the MCA 2005):

a. If the clinicians had no doubt as to whether the young person is able to give a consent that served their purposes under s.8 Family Law Reform Act 1969, they would simply take that young person's consent;

b. If they had a doubt, they could obtain the consent from the parent on the basis that they did not consider that they had an effective consent from the young person;

c. If (which is the position which in practice troubles clinicians more) the young person was refusing the treatment then, at least on the basis of pre-HRA 1998 case-law[23] they could simply get consent from the parent **whether or not** the young person was *Gillick* competent. The stakes would be higher if the young person was considered to be *Gillick* competent (and Lady Hale described in *Re D* as "*controversial*" the proposition that a parent could override a capacitous refusal[24]), but on a strict analysis, the question of the young person's decisional competence is not relevant at common law.

It is also undoubtedly the case that there will be the situations outside the scope of the MCA altogether to which the test under s.2 MCA 2005 would not be relevant when it comes to asking whether or not the young person is able to give a relevant consent or make a relevant decision.[25] There is an interesting question as whether this would encompass situations outside the scope of 'surgical, medical and dental treatment' falling within the scope of s.8 Family Law Reform Act 1969 – i.e. (for instance) organ donation. It might be that the question to ask at that point is whether the young person in question is *Gillick* competent to make that decision[26] (although given that there is no restriction upon the Court of

is addressed to the legal purpose and legal effect of consent to treatment, namely, to prevent such treatment constituting in law a trespass to the person, and that it does so by making the consent of a 16- or 17-year-old as effective as if he were "of full age" . No question of "Gillick competence" in common law terms arises. The 16- or 17-year-old is conclusively presumed to be "Gillick competent" or, alternatively, the test of "Gillick competence" is bypassed and has no relevance" (para 75).

[23] And, interestingly, case-law in which the issue did not actually fall for consideration, the courts making obiter observations alone in the leading case: *Re W (a minor) (medical treatment: court jurisdiction)* [1993] Fam 64.

[24] See para 26(i). She did not elaborate on the meaning of the term "*capacitous*."

[25] There is an analogy with the position in relation to those over 18 in relation to making wills, giving gifts and entering into contracts, which fall outside the scope of the MCA, and hence are governed by common law tests.

[26] Note, though, that there is no restriction upon the Court of Protection's powers to make decisions under s.16 MCA 2005 on behalf of 'P' dependent upon the age of the person, so, again, if there were doubts as to the young person's ability to make the decision it would be possible to approach the Court of Protection, which would apply s.2 MCA 2005.

Protection's powers to make decisions under s.16 MCA 2005 on behalf of 'P' dependent upon the age of the person, it would be entirely possible for the court to be approached in such a situation, and questions of *Gillick* competence at that point would be irrelevant).

Whatever the position around the edges of the MCA 2005, it is clear that, where any person is deciding whether they can provide care and treatment on the basis of s.5 MCA (and, in due course, where they are deciding whether or not an authorisation can be granted under the Liberty Protection Safeguards), the test to apply is that contained in s.2 MCA 2005, not *Gillick* competence.[27] For present purposes, therefore, the **practical** relevance of *Gillick* in relation to the majority of decisions about medical treatment for those aged 16 and above will depend upon which route health and social care practitioners choose to use.

One consequence of this, I should note, is that if MCA 2005 capacity is the test, and the same approach is taken as it is in relation to adults there would be no difference between the test for capacity to consent and the capacity to refuse treatment. There has been much discussion in the literature as to whether the tests are different in relation to young people but in relation to adults, the case-law of the Court of Protection has not drawn such a distinction (see, for a useful summary, *King's College Hospital NHS Foundation Trust v C* [2015] EWCOP 80). Again, whilst not seeking to place too much weight upon a judgment reached in urgent circumstances, I note that Baker J in *An NHS Foundation Hospital v P* did not draw such a distinction in relation to the 17 year old before him but simply that she "*ha*[d] *capacity to make decisions concerning her medical treatment*"[28] (i.e. the same test as would be applied to an adult).

In *Re P*, Baker J went on, having found that P **did** have this capacity, to override her refusal of life-saving treatment in the exercise of the inherent jurisdiction notwithstanding her capacitous refusal. Notwithstanding everything set out above, it is undoubtedly the case that, whether or not parents can properly do so,[29] the courts[30] retain a power to override treatment refusal by young people – because they are minors – that they do not have in relation to adults.

In other words, irrespective of mental capacity, the law does not recognise that those below 18 have the legal capacity absolutely to refuse treatment. Nor, because it would be inconsistent with this, does the MCA 2005 allow a young person under 18 to make an advance decision to refuse treatment. To that – important – extent, young people are treated differently when it comes to questions of medical treatment. Importantly, they are so treated (in law) not because of questions of competence of mental capacity, but simply chronological age.

The 'overwhelmed' young person

As with the DH Reference Guide to Consent[31] and the (English) MHA Code of Practice,[32] the current version of the MCA Code of Practice provides that a young person may not be able to make a decision

[27] Lady Hale directly tied s.5 MCA 2005 to the s.2 test in relation to those aged 16 and above in *Re D* at para 26(iii).
[28] *An NHS Foundation Hospital v P* [2014] EWHC 1650 (Fam) at para 8.
[29] See Lady Hale's characterisation of the proposition as "controversial" in *Re D* at para 26(i).
[30] Which must be the High Court under its inherent jurisdiction, the Court of Protection not being able (for most purposes) to exercise any jurisdiction in relation to those with decision-making capacity. One nuance to this is that if the young person's capacity fluctuates, it may be possible for the court to make 'contingent' declarations under s.15(1)(c) MCA 2005 to address the position and their best interests at the points when they lack capacity: see *United Lincolnshire Hospitals NHS Trust v CD* [2019] EWCOP 24.
[31] Ch 3, para 4.
[32] Para 9.30. The Welsh Code, interesting, does not include this category, but proceeds on the basis that the

not because they lack capacity applying the MCA 2005, but for some other reason – in particular because they are overwhelmed by the implications of the decision.[33] However, as far as I am aware, there has never been a case in which this category of person has, in fact, been identified as existing. On the basis of *NHS Trust v Y*, therefore, there must be a question-mark over whether it is legitimate for these documents to purport to create a legal category, especially if the creation of such a category carries with it particular consequences for the rights of the young person (and their parents).

More fundamentally, in any situation where the MCA test applies, I would suggest that it is difficult to see that there is a justification for either creating or maintaining such a category of individual:

a. If there is a 'clinical' justification, it would apply equally to those over 18 given the body of neuroscientific evidence which suggests that adolescence, in the sense of continuing development in maturity and understanding, extends into the early 20s, especially in the case of men;[34]

b. If the question relates to care and treatment within the scope of s.5 MCA 2005, then concepts of reasonableness (emphasised by the Court of Appeal in *ZH v Cmr of the Police for the Metropolis*[35]) will permeate the consideration of whether it can go ahead on the basis of the defence. This provides the necessary calibration for the urgent situation; conversely, the principle of support also requires steps to be taken – e.g. – to deliver information to the person in an appropriate fashion. If a young person is unable to make a decision following support complying with the steps set out in the Code and case-law, this is a very strong pointer towards them lacking capacity applying ss.2-3 MCA 2005. If the reason that they cannot make the decision is down to the undue influence of a third person, then the inherent jurisdiction of the High Court is available to assist;

c. If the question relates to confinement, I would suggest then the reality is that, now there is very little room to suggest that such could sensibly be undertaken by health and social care professionals outside the scope of (1) DoLS/(in due course) the LPS; (2) the MHA 1983; (3) s.25 Children Act 1989 (secure accommodation); (3) by invoking the jurisdiction of the Court of Protection; or (4) by invoking the inherent jurisdiction.

Conclusion: which route should be used?

Whilst it would have been open to the Supreme Court in *Re D* to hold that the passage of the MCA 2005 had led to the **exclusion** of the operation of parental responsibility where s.5 applies,[36] Lady Black was undoubtedly correct in *Re D* to observe that there is an overlap between the reach of the Children Act 1989 and that of the MCA 2005 in the context of 16/17 year olds.[37] It is odd, but not entirely unprecedented, for there to be two entirely separate parallel legal routes to bring about the same outcome. An example from a not-unrelated sphere is the choice which has to be made as to whether

MCA 2005 applies to those aged 16 and above: para 16.9.

[33] See para 12.13.

[34] See here. in particular, the work of Sarah-Jayne Blakemore: https://sites.google.com/site/blakemorelab.

[35] [2013] EWCA Civ 69, [2013] WLR 3021.

[36] By analogy with the position in relation to the common law defence of necessity, in which it has been held that "where the provisions of the Mental Capacity Act apply, the common law defence of necessity has no application": *ZH v Commissioner of the Police for the Metropolis* [2012] EWHC 604 (Admin) at para 44 (this decision being upheld on appeal without specific reference to this passage, but on a basis that impliedly endorsed it).

[37] At para 71. Lady Hale also noted at para 28 that "[i]*t may well be that, as a general rule, parental responsibility extends to making decisions on behalf of a child of any age who lacks the capacity to make them for himself*."

the MCA 2005 or the MHA 1983 is to be used to bring about in-patient admission for mental health treatment in the case of a patient lacking capacity to consent to that admission, and where that admission will give rise to their confinement.[38] Where the person is not objecting either to the admission or to all or part of the treatment for mental disorder, there is a choice as to which route to use.[39] That choice is widely perceived as problematic, not least because of the qualitative differences between the factors are to be put in the scales when balancing the choice,[40] leading the Independent Review of the MHA 1983 to propose eliminating it.[41] It might be thought that that there has not been the same level of discussion and discontent in relation to the MCA 2005/Children Act 1989 overlap reflects the fact it is not a real problem. I would, perhaps, suggest that it is because it is an issue which has not been squarely addressed to date and, in many cases, resolved without an entirely clear understanding by those involved of the legal frameworks in play. The decision in *re D*, even if limited on its face to confinement, means that the question of the application of the MCA 2005 to those aged 16/17 – including in the hospital setting – is (or should be) very much higher up the agenda.[42]

If there does remain a choice between the MCA and the common law, that does not mean that it is not a choice which can be **guided**. Simply stating that there is a choice, as the current Code does, seems to me inadequate given that the choice has implications which professionals, parents and young people need to understand.

Having found herself unable to accept the argument that the MCA 2005 provides a complete decision-making framework, Lady Black in *Re D* nonetheless went on to observe that it seemed to her that "*the deliberate choice of the legislature to include children of 16 to 18 years within the scope of the 2005 Act, and now (by virtue of the recent amendment to the Act* […]*) to extend a regime of administrative deprivation of liberty safeguards to them, indicates an appreciation of the different needs of this particular age group*."

Responding to these different needs, it will not come as a surprise that my view is that the approach set out in the MCA 2005 is to be preferred in any situation to which it applies, so that the focus remains clearly on (1) supporting the young person to make their own decision; and (2) if they are unable to make that decision, to constructing a decision around them through application of the principles and structure of the Act. We will see whether the revised Code of Practice grapples with these matters, and also whether the courts rise to the task of joining the dots.

ALEX RUCK KEENE

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[38] From 1 October 2020, with the coming into force of the LPS, this choice will fall to be made in the case of those aged 16 and above, not just (as at present) in relation to those aged 18 and above.
[39] *AM v (1) South London & Maudsley NHS Foundation Trust and (2) The Secretary of State for Health* [2013] UKUT 0365 (AAC). If the person **is** objecting, there is no such choice.
[40] For instance, which is more important – avoiding the stigma that is conventionally said to be attached to detention under the MHA 1983 by using DoLS or being in receipt of s.117 MHA 1983 aftercare which attaches to detention under s.3 MHA 1983 but not to DoLS?
[41] *Modernising the Mental Health Act: Increasing choice, reducing compulsion* (2018), available at https://www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review, at pp. 126 onwards.
[42] Since the first instance decision of Keehan J (now, in essence, restored) in 2015 ([2015] EWHC 922 (Fam)), I have certainly seen a step change in the number of questions being asked of me as to the relevance of the MCA in relation to those aged 16-18.