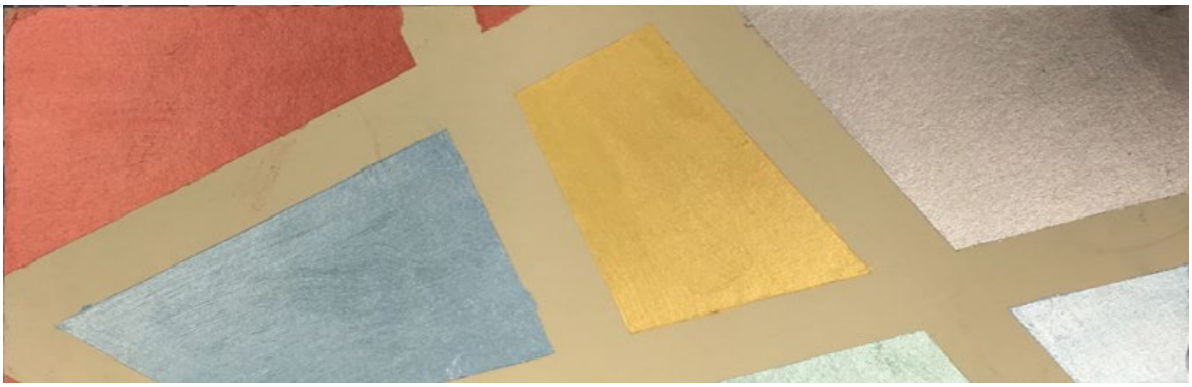

Welcome to the November 2025 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: *Cheshire West 2*, the return of LPS and where the buck stops with termination;

(2) In the Property and Affairs Report: accessing Child Trust Funds and LPA fee increase;

(3) In the Practice and Procedure Report: where (not if) brain stem death testing should take place;

(4) In the Mental Health Matters Report: progress of the Mental Health Bill and the duties owed by AMHPs;

(5) In the Children's Capacity Report: resources for children transitioning to adult in the palliative context.

(6) The Wider Context: the Terminally Ill Adults (End of Life) Bill before the House of Lords, and CQC despairs at the state of care.

(7) In the Scotland Report: an update on AWI reform.

You can find our past issues, our case summaries, and more on our dedicated sub-site here, where you can also sign up to the Mental Capacity Report.

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The picture at the top, "*Colourful*," is by Geoffrey Files, a young autistic man. We are very grateful to him and his family for permission to use his artwork.

Contents

HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

Cheshire West 2

From 20-22 October, the Supreme Court considered *The Reference by the Attorney General for Northern Ireland* (UKSC/2025/0042). The Reference considered whether people who lacked capacity to make decisions about their care and treatment can give valid consent to what would otherwise be an Article 5 ECHR deprivation of liberty. The Supreme Court was also invited by the Secretary of State for Health and Social Care to set aside the *Cheshire West* 'acid test' altogether.

The written cases for the parties can be found on the Supreme Court page for the case, as can recordings of the hearing. We do not have a date for judgment. Not least as members of the team were involved for two different parties (the Attorney General and the charities Mind, Mencap and the National Autistic Society) we will not give running commentary upon the case, but will, of course, do so when judgment is handed down.

Return of the LPS?

On 18 October 2025, DSHC announced that there would be a second consultation on the Liberty Protection Safeguards (or 'LPS') in the first half of 2026. The statutory framework for the LPS has been in statute in the MCA since 2019 and a consultation on revising the MCA Code of practice and implementing the LPS was previously undertaken in 2022. While it had been anticipated that the LPS would come into effect

in 2023, DHSC announced in April 2023 that their implementation would be delayed beyond the life of the Parliament (which dissolved in May 2024). In June 2025, Minister Stephen Kinnock stated to the Lords Mental Health Bill scrutiny committee:

> *We have made it clear that we are going to continue with DoLS. Basically, we have to look at whether replacing them with LPS will achieve the stated objectives of the exercise, and I am not entirely convinced about that. It is under review.*

DHSC's most recent statement appears to make clear that the LPS will be taken forward, and that these will strengthen the existing system and help to address backlogs. The announcement also sets out that the consultation "[c]*omes as Supreme Court reviews what counts as a deprivation of liberty in a case put forward by Northern Ireland*." The announcement stated that the consultation will be used to inform an updated MCA Code of Practice, updating the current edition from 2007.

For a recent example of the Ombudsman's reactions to severe backlogs in conducting MCA assessments and completing DoLS assessments, see the complaint determined in relation to Southampton City Council in August 2025, which found that, as at June 2025, the local authority had 382 outstanding Mental Capacity Act assessments and 404 outstanding DOLS applications, and robustly identified why this was not acceptable:

> *It is a concern some people may be unnecessarily deprived of their liberty or could be subject to less restrictive arrangements if the necessary safeguards and assessments were completed. Others may be left vulnerable if they do not have the capacity to make significant decisions about their lives and circumstances because the Council has not completed an MCA. If a person lacks the capacity to make a particular decision, measures need to be put into place to ensure any decision is made in their best interests. Delays leave those individuals vulnerable to poor or inappropriate decisions being made by them or on their behalf. The potential injustice in such circumstances could be significant.*

Termination, best interests and where the buck stops

Re KP (Termination of Pregnancy) [2025] EWCOP 35 (T3) (Poole J)

Best interests – medical treatment

Summary[1]

Even by the standards of the Court of Protection, *Re KP* is a difficult case. It concerned a 19 year old woman who, in Poole J's understated summary had "*experienced very many challenges in her life*," starting at birth when hypoxia led to an acquired brain injury. She was now 17 weeks pregnant. The questions before Poole J were:

(1) whether she had mental capacity (i) to decide whether to terminate or continue the pregnancy, and (ii) to consent to a contraceptive implant being inserted under her skin;

(2) If she lacked capacity to make either of those decisions, what decision was in her best interests.

[1] A judgment of Tor's being referred to in the comment section, she has not contributed to this note.

If these issues were not ethically challenging enough, the evidence was that:

> *4.* […] *KP has not been diagnosed with Dissociative Identity Disorder (previously known as Multiple Personality Disorder) but she is known to have adopted a number of different personas. These personas or identities inhabit her. They have names and she lives as them for varying lengths of time. In 2024, her persona was that of a three year old girl. She stopped eating, drank from a baby's bottle, and required a pacifier to calm her. Currently she has the persona of a 13 year old girl, as explained below.*

KP, who lived in a residential placement, was the subject of Court of Protection proceedings in which she had been found to have capacity to make decisions as to contact and to engage in sexual relations. She met a man online, and started to engage in sexual relations; whilst she denied having vaginal intercourse and that she needed to use contraception, she became pregnant. Initially, KP was excited about her pregnancy. However,

> *8. Then, in early August 2025, KP experienced light vaginal bleeding (spotting) and became convinced that she had miscarried. She funded a further scan which showed a foetal heartbeat but KP struggled to accept that it belonged to the baby. She does now accept that she is carrying a live baby but she is clear that she wishes to have a termination of the pregnancy. She first asked for a termination on 8 August 2025.*
>
> *9. The experience of spotting and belief that she had miscarried appears to have triggered a significant deterioration in KP's mental health as well as a change in her stated wishes and feelings about continuing the pregnancy. Following the spotting and belief that she had miscarried, KP's persona became that of a 13 year old girl. She remains in that persona. KP has said that "a child cannot have a child" as a reason why she cannot continue the pregnancy. She believes that her child will be removed from her and taken into the care system which, given her own experiences in care, causes her great distress. She very much wants to avoid that happening. She has claimed to have tried to terminate the pregnancy herself by insertion of a coat hanger. This was not witnessed but blood was seen on her bedsheets. She says that her internet research has taught her that she could bring about a termination by taking a large quantity of a certain kind of over-the-counter medication. She has cut her abdomen. Incidents of self-harm and staff interventions have markedly escalated. She has expressed deep frustration that her wish to have a termination is not being followed*
>
> *10. Although it was rapid, KP's deterioration was not immediate. For a short while she appears to have had some insight that she was deteriorating and asked Ms B to stick by her and not to allow her to make unwise decisions. She reported that she had miscarried, without others knowing, when she was only 12 after being sexually abused. I should note that the Family Court has previously found allegations made by KP in relation to sexual and other abuse not to be proved. However, this recalled experience seems to have contributed to her deterioration and the adoption of the 13 year old persona.*

In the face of considerable concerns as to KP's capacity, and also real concerns about the potential impact on the relationship between KP and her treating team as regards the implications of KP having or not having the termination, an application was brought to the Court of

Protection. In the course that application, an attendance note was prepared by the solicitor instructed by the Official Solicitor on behalf of KP. As Poole J noted:

> *19. I have been provided with a very helpful attendance note by Ms Burridge-Todd, a solicitor instructed to represent KP in the COP welfare proceedings, who saw KP on 23 September 2025 to discuss the decisions before this Court. KP was very clear that "I want the abortion. I've always wanted it … it is pissing me off that I have had to wait for this, it should have been done weeks ago." She also stated that she wanted the contraception implant: "put it in when I am under." She said she had had an implant before. She described herself as "loud, gobby, opinionated and hilarious." She said, "I don't mind others making decisions for me, so long as they have my best interests at heart. They can't be snowflakes about it. I am sick of that game." She seemed to blame a lack of restrictions for her having become pregnant and now to want more restrictions to keep her safe. KP was sure that she did not want to speak to the judge hearing her case.*

In terms of capacity, the parties (in KP's case, the Official Solicitor as her litigation friend) were agreed that she lacked capacity to make the decision. Displaying his characteristic caution, Poole J did not just accept this:

> *29. The Applicant Trust and the Official Solicitor both contend that KP lacks capacity to make the decision to terminate her pregnancy and to have a contraceptive implant. I agree. This is a difficult issue and I do not intend to criticise Dr A's written assessment but it was only after hearing the oral evidence from her and Ms B that I was persuaded that KP lacks capacity in relation to these decisions. Dr A's written assessment was less compelling: she referred to KP's inability to understand and weigh up "decisions" rather than the information relevant to the decisions. She referred to an inability to retain information because of a possible change in persona by the time the termination procedure was commenced. However, a change of persona might lead to a change of decision rather than an inability to retain the information relevant to that decision. Nevertheless, having heard Dr A and Ms B give evidence, it is clear that KP cannot understand, or weigh or use, information about the reasonably foreseeable consequences of deciding to undergo termination of pregnancy or deciding not to do so. Information relevant to the decision regarding termination of a pregnancy includes information about what termination risks, and what continuation of the pregnancy risks. KP cannot understand information about the potential impact of termination (or of continuation of the pregnancy) on her mental health. She cannot understand that she might feel differently in the future about the decision than she does now or that the consequences of her decision might include a negative impact on her mental health. That inability is related to her changing personas. When in the grip of a particular persona she cannot foresee a change in persona and therefore cannot understand how, in a different persona or without any adopted persona, she will view or experience the outcome of a decision made earlier. For the same reason she cannot weigh or use such relevant information. A decision to terminate a pregnancy or to continue necessarily has long term consequences and so the relevant information includes information about those consequences. The same is true, albeit to a lesser extent, of the decision about contraception. No amount of support is capable of helping KP understand and weigh or use this*

> *relevant information. Her inability is because of an impairment of or a disturbance in the functioning of her mind or brain.*

Revealing, and poignantly:

> *30. The evidence of both witnesses established that KP had prepared hard for her capacity assessment with Dr A. She was determined to be found to be capacitous. She had carried out research and she had prepared answers. She is capable of retaining relevant information once she has understood it, at least for a sufficient period to enable her to make a decision. She stuck to her script and said to staff afterwards words to the effect that it was exhausting to do so. She was able to repeat information about the mechanics of termination but not about the impact on her of termination or of continuation of the pregnancy. Having heard the evidence of Ms B it is obvious that Dr A's perception that KP was defensive and giving only the shortest answers, was due to KP having prepared certain answers with a view to "passing" her capacity assessment, and then rigidly sticking to them throughout. As Dr A experienced, KP was unable to engage when asked about relevant information that she had not prepared for.*

KP lacking capacity to make decisions about termination or contraception, it fell to Poole J to make decisions of what was in her best interests. His analysis is sufficiently nuanced that it needs to be set out in full:

> *33. A termination of pregnancy would be lawful and, as Munby J noted, its lawfulness is not only a necessary requirement before any consideration could be given to making a best interests decision about undergoing a termination, but also indicates what medical opinion is of the balance of harm to the mother involved in the decision whether or not to terminate the pregnancy. However, I have a duty, outwith the ambit of the Abortion Act 1967, to consider KP's best interests in the widest sense and just because the termination would be lawful under the 1967 Act, it does not follow that the Court must give its consent on P's behalf.*
>
> *34. I know that Dr A and the clinicians at the Trust whose care KP is under, support the proposal for a termination. Her adoptive mother and her boyfriend, who is the father of the unborn baby, also support the proposal for termination. Their main shared concern is the adverse impact on KP's mental health from the continuing pregnancy.*
>
> *35. KP is suffering a mental health crisis as demonstrated by her escalating self-harm and dysregulation. She has long suffered from mental health challenges but, having demonstrated an improvement, she has more recently deteriorated during the pregnancy. On the evidence received there is no prospect of a sudden or marked improvement whilst she remains pregnant. That is not to say that she is likely to improve immediately upon termination of the pregnancy, but it is foreseeable that so long as she remains pregnant her mental health will continue to be poor and may well deteriorate further.*
>
> *36. Her current mental health state puts her at risk of physical harm. The evidence is that she has harmed herself due to the pregnancy. On the balance of probabilities, whether in a genuine attempt to produce a termination or not, she has inserted something into herself causing bleeding. She has cut her abdomen. She is distressed by not having her wishes to undergo*

termination respected. I was told by Ms B that KP has recently reported feeling the baby's movements and that this has added to her distress. As the pregnancy continues the physical impacts of it on KP will only become more evident to her and, in all likelihood, more distressing.

37. I have to contemplate the prospect of KP's pregnancy going to term, or almost to term, and her delivering a child. In her present mental state and given her present adamant wish to terminate the pregnancy and her distress that her wishes are not being respected, that is a very troubling prospect. A decision that it is not in her best interests to undergo a termination of pregnancy is a decision to continue the pregnancy. If a further application were made for a decision to terminate at a later stage in the pregnancy, that would have to be on the basis that KP had suffered even greater harm that she has suffered to date. The termination of pregnancy would be more problematic at a later stage and after 24 weeks termination would only be lawful if necessary to prevent grave permanent injury to KP. In the absence of any change rendering a later termination lawful and in KP's best interests, it is likely that KP would eventually give birth either by elective Caesarean section or after going into labour. Thus, one foreseeable consequence of overriding KP's present wishes would be to authorise - she and others might say to force - a mother against her will to carry a child for a further 20 weeks or so and then to give birth. A very strong justification would be required for such a significant interference with KP's Convention rights.

38. A termination would prevent further physical harm to KP caused by self-harm due to her unwanted pregnant state and/or attempts to self-induce a termination of pregnancy. There is a real risk of such physical harm occurring. It has already begun. As the pregnancy continues the risks of severe bleeding or other forms of harm from KP's own interventions will only increase. There is a real risk that KP could harm the baby by her attempts to induce a termination. If KP were to harm the baby then that in itself could have a severe adverse effect on her mental health both in the short and longer term.

39. In her current mental state KP could not look after a new born baby. As noted, there are no grounds to expect that her mental state will improve whilst she remains pregnant. It seems to me likely that if the pregnancy were to result in a live birth, then the baby would be the subject of an interim care order and be removed from KP's care. That is what she says she fears the most because she does not want to put another child through what she has gone through as a child in care. Having her baby removed from her would be highly detrimental to KP's welfare and her mental health.

40. Set against these considerations is the concern, articulated on behalf of the Official Solicitor, that it would be contrary to KP's best interests to terminate a pregnancy which, when she was not mentally unwell, she wanted to continue. There is a prospect of her regaining capacity in the future and being distraught that her wish to continue the pregnancy had not been followed. Her currently stated wishes must be treated with great caution since she is currently incapacitous and adopting the persona of a 13 year old girl rather than speaking for her 19 year old self, as previously she did. This was the concern expressed by Ms B at the MDT meeting on 28 August 2025 (paragraph 16 above).

41. This is not an easy issue but in my judgement these concerns, whilst

relevant to the best interests analysis, do not justify the weight the Official Solicitor has given them:

i) KP was keen on continuing the pregnancy only for about 17 days. The pregnancy was confirmed on 22 July 2025 and by 8 August she stated she wanted to terminate the pregnancy. The pregnancy was not planned and there was no indication prior to 22 July 2025 that KP wanted to become pregnant and have a baby. Her positive view of the pregnancy was short-lived. It cannot be said to have been deeply or long held.

ii) I have determined that KP now lacks capacity to make a decision on termination of her pregnancy but it is not clear to me (a) that when KP discovered she was pregnant and for 17 days thereafter, she did have capacity, nor (b) that she had lost capacity by the time she first stated she wanted a termination on 8 August 2025. Her capacity to make such a decision was not assessed at those times. The most recent assessments by Dr Rippon had concluded that she continued to lack capacity to make decisions about her residence and care. Those are very different decisions and I accept that a person is presumed to have capacity unless otherwise established, but the ebbs and flows of KP's mental health make it difficult to know what information relevant to termination of pregnancy she understood or could weigh or use before and at the time she changed her view about termination. In the transcript of the MDT meeting on 28 August 2025 it is recorded that KP had been assessed as having capacity to consent to an ante-natal scan on 27 August 2025. There was considerable uncertainty amongst professionals as to whether she did or did not have capacity to make a decision on termination of her pregnancy. Dr A's assessment was on 12 September by which time her mental health had deteriorated further. Hence, KP might have had capacity to decide to undergo a termination of her pregnancy over a month earlier on 8 August when she said she wanted a termination.

iii) Ms B's insights about KP lead me to conclude that KP adopts personas as a way of avoiding taking responsibility for her own actions and decisions when in great difficulty or crisis. It is a response to past trauma. It appears that her fear of having miscarried triggered the adoption of the persona of a 13 year old girl. This happened to be about the age she was when she recalls having previously miscarried after having been sexually abused. She now tells Ms B that she wishes her freedom to be restricted and to be treated as a child. The adoption of a child's persona frees KP from facing issues and making difficult, adult decisions. After her initial enthusiasm for the pregnancy she may well have become overwhelmed by the responsibilities the pregnancy brought with it. The persona of a 13 year old frees her real self from having to make a decision about termination. Someone else has to make that decision. It does not follow that her real self did want to continue the pregnancy or that what the 13 year old persona is telling us does not correspond with the real 19 year old KP's wishes and feelings.

iv) It would not have been irrational for KP to change her mind about termination of pregnancy as her mental health declined. She might have felt capable of continuing the pregnancy and looking after a baby

when well but later, when she deteriorated, realised that she was not well enough to do so.

v) I accept that the Court should not assume that the "real KP" would now choose termination. But, neither can it be a safe assumption that the "real KP", unburdened with the adoption of a persona or different identity, would now choose to continue the pregnancy.

vi) It is rather speculative to assume that upon an improvement in her mental health, KP will return to the view she briefly held from 22 July to 8 August 2025. No-one can say when her current persona will cease to inhabit KP, whether she will then adopt another persona, or what that persona will be. No-one can say when her mental health will improve, let alone what view she will have about a termination as and when her mental health is better or when she is inhabited by another persona.

vii) I accept that it is possible that if KP undergoes a termination of pregnancy now, then at some point in the future she may deeply regret that it has happened. On the other hand, it is also possible that if KP does not undergo termination now, then in the future she may deeply regret that the pregnancy was allowed to continue. KP's present views and wishes are clear but her future views and wishes cannot reliably be predicted.

42. I have no evidence that KP holds beliefs or values that would be likely to influence her decision if she had capacity and which should be taken into account when considering her best interests. I am not aware of her practising any religion or holding any ethical beliefs opposing termination or contraception in principle.

43. The Court does not have the luxury of time - there is no opportunity to wait and see if KP's mental health improves or if she can regain capacity to make a decision about termination.

44. KP's history of dysregulation and challenging behaviour is such that were she to have a live birth after this pregnancy, there is as very real prospect that she would be unable to care for the child throughout its infancy and childhood. She might in the future be in a better position to have a child and look after it safely and well but that is not likely in the present circumstances. It would be highly detrimental to her mental health for KP to have her child removed from her care.

45. The evidence satisfies me that if termination of pregnancy is to be performed then it would be in KP's best interests for it to be a surgical rather than a medical termination. That would be less distressing and difficult for KP. I have to take into account the possibility that KP will not be compliant during the processes necessary for a surgical termination and that elements of the care plan involving the brief use of physical restraint will need to be deployed. Such experiences will cause her distress.

46. Termination of pregnancy is a once and for all decision - a termination cannot be reversed. KP might become pregnant again and, in different circumstances, may continue a pregnancy to a successful birth but the baby she is now carrying will be lost forever. The consequences of deciding to terminate the pregnancy are profound and are liable to affect KP in ways which are not entirely predictable. Similarly, a decision not to terminate the pregnancy would have profound, lifelong consequences. The Court has to

> *consider the best interests of KP at this particular time but, in accordance with MCA 2005 s4(2), has to "consider all the relevant circumstances" which must include the potential long term impact on KP of deciding one way or the other.*
>
> *47. This is not a straightforward decision but having considered all the relevant circumstances, KP's past and present wishes and feelings, any views and values likely to influence her decision if she had capacity, and the views of those engaged in caring for her or interested in her welfare, I have decided that it is in KP's best interests for her termination of her pregnancy to be performed as soon as it can be arranged and in accordance with the care plan submitted by the Applicant Trust. Having analysed the relevant considerations I have concluded that particular weight should be given to protecting KP's current mental health. There is uncertainty as to what her longer term response to termination will be but there is certainty as to her current wishes and her current poor mental health to which her continuing pregnancy is clearly a very significant contributor. I am very concerned that KP would perceive any other decision as forcing her to continue an unwanted pregnancy. KP is a severely traumatised young woman and to compel her to continue her pregnancy and to give birth to a child against her will would be likely to cause further significant trauma. It is possible that she will respond very negatively to having had a termination but that cannot be reliably predicted. What is predictable is that her ongoing dysregulation and self-harm is likely to continue and worsen as the pregnancy continues.*

Poole J made a specific point of making clear that:

> *49. It is important that KP understands, now and in the future, that she is not currently capable of making a decision whether or not to terminate her pregnancy. The decision cannot wait and so it is being made now, on her behalf in her best interests. The decision maker is me, a Judge in the Court of Protection. I am responsible for the decision to consent on her behalf to a termination of her pregnancy. Her care team and Ms B are not responsible for the decision. They have given their full support to KP. The medical and nursing team at the Applicant Trust are likewise focused entirely on caring for KP. Many skilled and caring individuals are doing their best to help her but they have left the decision whether or not to terminate the pregnancy to the Court. That is the Court's role and a decision has to be made. For the reasons given I have decided that it is in KP's best interests for a termination of pregnancy to be performed.*

In a postscript to the judgment, Poole J noted that:

> *After the hearing but before the publication of this judgment, KP underwent surgical termination of her pregnancy and insertion of a contraceptive implant under her skin without complications. Physical restraint was not required. Although she became upset after the procedure this was reported to be consistent with the experience of many women who undergo a termination of pregnancy. She then returned home with no further issues reported.*

Comment

The complexities of this case are manifold, including as to the relative weight to be placed upon past and present (and possibly future) wishes and feelings.

One question is as to why this case came to court at all, given that until the Official Solicitor became involved, there was no dispute as to KP's best interests, and there was no suggestion that any treatment would take place against her wishes. In *Cardiff and Vale UHB v NN* [2024] EWCOP 61 (T3) in which Victoria Butler-Cole KC (sitting as a Deputy Tier 3 Judge) made:

> *43. A final observation: the application in this case was to authorise a possible future deprivation of liberty which did not, in fact, materialise. It would be reasonable for NN or her mother to ask what purpose was served by the proceedings and what benefit they had for NN. It is incumbent on those concerned with obstetric cases to give the most careful scrutiny at the earliest possible stage to whether orders are actually required from the Court of Protection, and if so, the substance of those orders. In this case, the minutes of various professionals meetings held in June and July 2024 suggest that there was a mistaken belief that any best interests decision about termination of pregnancy for a person without capacity required court authorisation. If there is a professional consensus about the treatment proposed, no intention to impose treatment on P against her wishes, and no disagreement from those concerned with P's welfare such as close family members, the provisions of s.5 and s.6 MCA 2005 permit medical best interests decisions to be taken without court involvement, having followed the requirements of the MCA and any associated professional guidance: **An NHS Trust v Y** [2018] UKSC 46.*

It is definitely not the case that assumptions should not be made about the need for court applications to be made just because of the nature of the treatment. However, it is understandable in this case why the clinicians did so (not least because KP's circumstances were already before the court), the primary reason being to seek to secure an ongoing relationship between KP and those working with her. In the circumstances, one presumes that the team were relieved that, by contrast with another situation in which a person lacking capacity was expressing ambivalence about termination, in which Hayden J expressly refused to make a best interests decision on her behalf, Poole J made it clear that the buck did stop with him, and that it was for him to do so.

Research corner: Evolving judicial approaches to longstanding anorexia nervosa

In a new article, Professor Emma Cave and Dr Jacinta Tan have built on an earlier article from 2017, at which point they identified three key criticisms of the cases decided to the Court of Protection as at that point, and offering corresponding recommendations. The new articles assesses a second, ongoing set of cases in light of those recommendations, while also considering new issues, including emergent treatment approaches and the debate surrounding the controversial 'terminal eating disorder' framework. Although judges in the Court of Protection do not adopt this framework, the authors note that they do recognise that prolonged, compulsory life-sustaining treatment may – under certain circumstances – conflict with the patient's best interests. Cave and Tan argue that recent approaches to both mental capacity assessments and determination of best interests indicate a meaningful shift towards a more individualised and ethically responsive approach and suggest ways to augment this approach.

PROPERTY AND AFFAIRS

Accessing trust funds for children upon adulthood

The Social Care Institute for Excellence has published Accessing your child's trust fund when they reach adulthood, written by Caroline Bielanska. This sets out the options open to parents who want to manage the finances of their adult child where that adult child lacks the capacity to manage their own finances. It explains when a parent can become an attorney under a Lasting Powers of Attorney, and when they will need to apply to the Court of Protection for orders including for their appointment as their adult child's deputy. It makes it clear that where a parent wishes to manage their child's money and there is no LPA in place, an order from the Court of Protection will be required even if the adult child's only money other than income from DWP welfare benefits comes from their Child Trust Fund.

LPA fee increase

With effect from 17 November, the fee for registering an LPA and an enduring power of attorney is rising from £82 to £92 and the fee to resubmit an application to register a LPA from £41 to £46.

PRACTICE AND PROCEDURE

Brain stem death testing and best interests

London NHS Trust v DT & Anor [2025] EWCOP 36 (T3) (Poole J)

Practice and procedure – other

Summary[2]

DT was a 42 year old woman who having collapsed following a flight, has never recovered consciousness. She was transferred to the UK by her family to a hospital in London in September 2025. Following tests and observations the clinical team looking after DT in London came to the view that she was brain stem dead. They therefore wanted to establish diagnosis and confirmation of death by brain stem testing performed according to the *Academy of Medical Royal Colleges 2025 Code of Practice for the Diagnosis and Confirmation of Death ("the 2025 Code").*

The family did not agree to the brain stem tests being undertaken in London. Instead, they wanted to fly DT to a hospital in the country in which she was born, raised and lived (her home country), so that the tests and likely subsequent withdrawal of treatment could take place there. This would allow the rituals following death to be carried out in accordance with DT's religious and cultural beliefs. That position was supported by DT's litigation friend the Official Solicitor as being in her best interests.

The evidence before the court from the clinicians set out their collective view that DT was dead (they expressed this as a certainty). No diagnosis of death could be made however in the absence of brain stem death testing.

It is not entirely clear from the judgment whether there was a dispute about whether DT was (as a matter of law), alive or dead. The Trust is recorded as having submitted that the legal position was nuanced, because where was a "*reality gap between the clinicians' clinical assessment of death and the diagnosis of death in accordance with the 2025 Code*." The family and the Official Solicitor were clear that as a matter of law, DT was not dead until such time as death could be diagnosed following brain stem death testing.

Theis J had no difficulty in reaching the view that "[p]*rior to the diagnosis of death through the 2025 Code the individual concerned is not dead as a matter of law. The legal consequence is that in the absence of agreement for the tests to be conducted under the 2025 Code, including the arrangements for them, there needs to be an application to the Court of Protection for the issue to be determined in accordance with the person's best interests.*" She therefore answered the question that had to be answered by the court (i.e. whether DT should be repatriated in circumstances where the purpose of her transfer would be for brain stem death testing to be carried out and treatment withdrawn or for the tests to be undertaken in the UK), by reference to the best interests test in the MCA 2005.

In determining where DT's best interests lay, Theis J weighed the benefits of DT being flown back to her home country for the tests to be carried out and for treatment withdrawn, against the risks. She described the evidence showing DT's connection to her home country as '*compelling*', and was satisfied that DT's wishes and feelings would have been for her to return to her home country for the brain stem testing to be undertaken there. Set against this was the fact

[2] Tor having been involved in the case, she has not contributed to this note.

that continuing to receive treatment was considered by the Trust to be futile. The Trust also relied upon the inherent risks in a complex transfer such that she may die in transit.

Theis J had no difficulty in finding that the benefits of DT returning to her home country to have the tests outweighed the risk.

Comment

The Trust was undoubtedly right to issue proceedings in the Court of Protection to determine the dispute between them and the family as to whether brain stem death testing should take place in the UK or not.[3] However it is difficult to understand why the Trust were in dispute with the family about this issue in the first place, given the 'compromise' they offered to the court and the family - namely that if brain stem death testing were to take place in the UK and a diagnosis of death made, they would continue to provide the medical treatment to DT in order to allow her to be repatriated to her home country. This was a position that Theis J understandably described as 'perplexing'.

CoP statistics – October 2025

The Court of Protection has published statistics on the applications made to the court, charting their trajectory over several years:

- Total applications under the MCA have had an upwards trajectory, and are currently around 9,500 applications per quarter.
- Applications for property and affairs deputyship have fluctuated more significantly, with a slightly decreasing trend, and currently stand at approximately 3,200 per quarter. The number of appointments has increased in the last year due to backlogs being addressed. As of October 2025, the turnaround for deputyship applications was 25 weeks.
- Applications for personal welfare deputyship are much lower, typically between 200-300 applications per quarter. Relatively few of these are made, with the most recently recorded quarter reflecting under 60 welfare deputyship orders made per quarter.
- Applications relating to deprivations of liberty have increased significantly since 2020, and continue to have an upward trend. They are now near 2,200 applications per quarter. However, changes in recording practices in 2024 make it difficult to determine long-term trends in orders relating to deprivations of liberty. Since March 2025, backlogs on COPDOL11 applications have fallen substantially.
- The total number of orders made has slightly increased since 2020, from approximately 12,000 to approximately 14,000 per quarter.

Reporting concerns to the OPG

The OPG has launched a new website to report a concern about an attorney, deputy or guardian. The new form is designed to make it quicker and easier for people to raise concerns, and to redirect people who are raising complaints which the OPG has no legal power to investigate. The form screens concerns with the following conditions:

> *Complete this form to notify us of your concerns if all of the following are true:*

[3] It may be that different issues arise in relation to the question of whether brain stem death testing should take place at all. The 2025 Guidance is (deliberately) silent as to whether this is a matter requiring the agreement of the family.

- *you have conducted your own initial safeguarding queries (this only applies if you are a public authority);*
- *you believe the donor or P lacks mental capacity to deal with the concerns themselves*
- *there is enough evidence to warrant further investigation.*

Position statements

As we went to press, we learned that the Court of Appeal has granted permission to appeal the decision of Poole J in *Re AB (Disclosure of Position Statements)* [2025] EWCOP 25 (T3) on the basis that it is important for the court to provide guidance as to the proper approach to disclosure of position statements to observers in Court of Protection cases.

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MENTAL HEALTH MATTERS

Mental Health Bill – the end game

The Mental Health Bill is now very firmly in its last stages, having cleared the Commons and heading towards likely 'ping-pong' with the Lords. At Third Reading, Stephen Kinnock, the Minister for Care, whilst not giving away a great deal of detail as regards the timeframe for implementation, made clear that:

> *The first priority once the Bill gets Royal Assent will be to draft and consult on the code of practice. We will engage closely with people with lived experience and their families and carers and with commissioners, providers, clinicians and others to do that.*

The Big Mental Health Report 2025

Mind's second annual Big Mental Health Report (2025), produced with the Centre for Mental Health, provides the clearest picture yet of mental health across England and Wales. Drawing on surveys of over 18,000 people, it highlights persistent inequalities, worsening outcomes for young people, and growing pressures on services. The survey revealed that, in the last 12 months:

- 82% said their mental health has negatively impacted their employment
- 40% reported difficulties building relationships at work due to their mental health
- 57% said their mental health has negatively impacted their finances
- 74% reported increased feelings of isolation due to their mental health

Current State of Mental Health

- 1 in 5 adults in England lives with a common mental health problem (e.g., anxiety or depression).
- Rates are higher in deprived areas (26%) and among women (24%).
- Young people's mental health is worsening, with 1 in 5 aged 8-25 with a probable mental health disorder.
- Suicide remains high (7055 deaths in 2023); self-harm among 10–24-year-old girls is three times higher than adult women.
- Mental and physical health are intertwined: one-third of people with physical health condition also have a common mental health problem.
- The economic and social costs of mental ill-health in England is around £300 billion per year.

Drivers of Poor Mental Health

- Poverty, poor quality housing, debt and insecure work remain major contributors.
- Public-service cuts since 2010, especially youth services (-70%) and local-authority budgets (-18%), have weakened community support.
- Child poverty in the UK has reached 4.5 million and is projected to rise further.
- The Covid-19 pandemic left a legacy of anxiety, loneliness and economic insecurity.
- Young people face new pressures from social media, sleep loss, and academic stress.

Experiences of Support

- Waiting lists continue to grow; many report deterioration while waiting for help.

- A third of adults say GP or third-sector support did not meet their needs.
- Access to ADHD and autism assessment is uneven, with some waiting for up to 10 years.
- Despite the government's manifesto, the share of NHS funding for mental health fell to 8.78 % in 2024-25 and is projected to fall to 8.71% this year.

Stigma and Discrimination

- Public understanding of mental health has regressed to pre-2009 levels.
- Stereotypes about conditions such as schizophrenia are increasing.
- Only 1 in 5 people with ADHD has told their employer, with stigma and fear of discrimination persisting.

Key Recommendations

1. Ensure timely access to quality mental-health care through sustained investment and reform.
2. Prioritise young people, expanding early-help hubs and school-based support.
3. Tackle stigma and discrimination via national education campaigns and better data.
4. Address social determinants - poverty, housing, employment - through cross-government action.

'Investigating Deaths under the Mental Health Act: The Need for Independence and Parity'

The Independent Advisory Panel on Deaths in Custody (IAPDC) has issued a report, 'Investigating deaths under the Mental Health Act: The need for independence and parity.' The report considers the role of investigations (as distinct from inquests) which consider these deaths, noting that inquests may take months or years to include. The investigations also assist in providing information for inquests and provide an independent source of information.

Core Finding

The report found that deaths of patients detained under the Mental Health Act 1983 are not independently investigated, unlike deaths in prisons, police custody, or immigration detention. This lack of independent scrutiny creates an inequality between detention settings and undermines Article 2 ECHR (right to life) obligations. The report calls for a new independent investigative mechanism to review all deaths in MHA detention - both 'natural' and 'unnatural' - to ensure accountability, transparency, and learning.

Scale of the Issue

- Deaths in MHA detention occur at three times the rate of those in prisons.
- Between 2023–24, there were 225 deaths in MHA detention (162 natural, 71 unnatural).
- Yet only prison and police deaths receive automatic, independent investigation.

Key Problems Identified

- Investigations currently rely on ad hoc internal NHS reviews, often of variable quality and lacking independence.
- Families report exclusion and mistrust, describing current processes as 'hospitals marking their own homework'.
- Coroners have repeatedly raised concern that poor internal investigations impede effective inquests and risk future deaths.
- Data quality is inconsistent - hundreds of deaths may have gone unreported to

coroners between 2011–14.

- The current Patient Safety Incident Response Framework (PSIRF) is useful for learning but not equivalent to an Article 2-compliant investigation.

Legal and Human Rights Context

- Article 2 ECHR requires deaths in state detention to be independently and effectively investigated.
- The Wessely (2018) MHA Review urged Government to revisit independent investigations within five years if no progress was made.
- Seven years on, the IAPDC concludes that progress has been insufficient and reform is now essential.
- Deaths under the Mental Capacity Act 2005 are not automatically treated as state detention; however, the IAPDC notes that parity arguments may extend to such cases in future.

Recommendations

1. Create an independent mechanism (within or across existing bodies) to investigate all deaths under MHA detention.
2. Include both natural and unnatural deaths to avoid missing systemic failings.
3. Embed clinical leadership in the new investigative body.
4. Work collaboratively with the Parliamentary & Health Service Ombudsman (PHSO), Care Quality Commission (CQC), and the Health Services Safety Investigations Body (HSSIB).
5. Publish comparable data and thematic learning to improve prevention and transparency.

AMHPs and duties of care

Khamba v Harrow London Borough Council and others [2025] EWHC 2803 (KB) (High Court (King's Bench Division) (Foster J)

Other proceedings – civil

Summary

This was a local authority's application to strike out a negligence and HRA claim against an AMHP for whom it was responsible, following a violent attack by a son on his mother causing her catastrophic injuries, and the psychiatric injury of his sister who discovered the aftermath. The son was later found not guilty by reason of insanity and detained under a hospital order (ss. 37/41 MHA 1983) with a diagnosis of paranoid schizophrenia.

Following his mental health deteriorating, a private psychiatrist considered the son was detainable and made an urgent referral for a MHA assessment due to the high risk to family members. After the son was initially arrested, a MHA assessment took place on 14 August 2018. The outcome was that he did not meet the criteria for s.2 and the AMHP advised his mother that any further threatening behaviour should be dealt with through the criminal justice system and that no follow-up was needed. On 23 December 2018, he violently attacked the family members.

The various claims were struck out or dismissed for the following reasons:

- Section 139(2) MHA 1983 rendered the proceedings a nullity because the claimants had not obtained the required leave of the High Court. The claimant's argument that this case concerned an 'omission' rather than an 'act' was rejected: the legal protection was substantive, not procedural. The court also refused to read down s.139

under the HRA. The AMHP was doing "any act purporting to be done in pursuance of" the MHA" and so permission to bring the claim was required for which either bad faith or without reasonable care must be proven.

- Even if permission had been granted, no common law duty of care arose on the facts, applying the cases of *Poole BC v GN* (2019, *HXA v Surrey CC; YXA v Wolverhampton CC* (2023), and *Tindall v Chief Constable of Thames Valley Police* (2024). In particular, Foster J held that the AMHP did not assume responsibility for the patient's safety, nor exercise a sufficient degree of control to become liable for injury caused. Accordingly, she held there could be no liability for a failure to prevent harm to a third party.

- The human rights claims (Articles 2, 3 and 8 ECHR) would also have failed. Applying *Osman v UK* and *Rabone v Pennine Care NHS Trust*, the local authority did not know, nor ought to have known, of a real and immediate risk to life. The son was not detained or under the State's control and so the Article 2 operational duty did not arise. The alleged ill-treatment did not meet the Article 3 threshold, and Article 8 added no broader protection to Article 3.

Accordingly, Foster J held that:

1. Section 139(2) operated to render the proceedings brought by the claimants a nullity.

2. In any event no common law duty of care arose as argued by the Claimants.

3. The claims in respect of rights arising under the HRA would likewise have failed.

Comment

This is a significant case, particularly in relation to the decision regarding omissions. Whether the protection of s.139 MHA applied to omissions, such as a failure to detain a person, was previously undecided. Foster J held that:

> *85. Consideration of the meaning and scope of section 139 has recognised it is unusual for a failure in a procedural requirement to invalidate a substantive claim, but has nonetheless analysed the statutory intention of this section as being to provide substantial protection for the putative defendant, and not a mere procedural hurdle. As Lord Bingham said in Seal at para 20, the section was designed to protect "those responsible for the care of mental patients from being harassed by litigation…".*

The decision demonstrates that the purpose of s.139 "*reflects a strong policy of protection of those responsible for the care of mental patients*" (para 90).

Given that the terrain of duties of care owed by the AMHP in the discharge of their functions was also new, it would not be surprising at all if the case went to the Court of Appeal (assuming that the procedural bar of s.139(2) could either be remedied or circumvented).

CHILDREN'S CAPACITY

The Re-launch of My Adult Still My Child Website

On 24th September young people, their families and professionals came together at a re-launch event held at Rainbows Hospice for Children and Young People.

"My Adult Still My Child" is a pioneering based website designed to support parents and carers of young adults aged 16 and over in England & Wales who may not be able to make decisions for themselves, providing legal guidance, advice on health and care decision-making, and resources for transitioning to adult services.

The website was developed to help parents of young adults with life-limiting or life-threatening conditions, particularly as they transition from children's to adult services however will also be of use to young people themselves and anyone needing to know more about decision making after the age of 16.

"My Adult Still My Child" provides:

- Legal guidance, including explanations about parental responsibilities, the Mental Capacity Act 2005, and the role of deputies or best interest decision-makers.
- Information on best interest decisions, helping parents participate in collaborative decision-making with healthcare professionals.
- Practical advice on navigating adult services, consent issues, advocacy, and planning for future care.
- Resources for transition, including checklists and guides for moving from children's healthcare to adult services.
- Personal stories and co-produced content, reflecting real experiences of parents dealing with adult children requiring ongoing care.

Background and Development

The website was created following feedback from parents and with funding provided by NHS England via Leicester, Leicestershire & Rutland Integrated Care Board.

The website addresses challenges parents face when their children reach adulthood but still require significant support in decision-making and enables parents to understand what legal rights they retain after their child turns 18. It also provides guidance on how to be involved in medical or care decisions even when their adult child cannot provide consent.

The website is accessible online through My Adult Still My Child, where parents and carers can find FAQs, guides, and links to relevant legal and healthcare resources for supporting their adult children.

THE WIDER CONTEXT

The Terminally Ill Adults (End of Life) Bill

A further Committee has been convened – this time by the House of Lords – to consider the Bill. The progress of the Committee (before whom Alex has given evidence) can be followed here. Progress more generally can be followed on Alex's resources page here.

Restrictive practice and PRN medication

Two useful guidance documents have recently been published. NHSE has published guidance on identifying restrictive practice. Although it is stated to be for the use of those in inpatient mental health services, it is equally applicable in other care settings. CQC has also published updated guidance on PRN ('as needed') medication for adult social care providers.

CQC State of Care report 2024/25

The CQC's 2024/25 'State of Care' report was published on 24 October 2025. We note some of the general findings regarding the 'state of care' in adult social care, mental health and healthcare for people with dementia and learning disabilities and autistic people.

- *In adult social care, the demand for support funded by a local authority continued to rise – new requests for care were 4% higher in 2023/24 than in the previous year, and 8% higher than in 2019/20. For adults of working age, there has been a large growth in demand for support, with requests per 100,000 people 14% higher than 4 years earlier. But, over the last 20 years, the proportion of older people who receive local authority-funded long-term social care has fallen from 8.2% to 3.6%....*

- *In 2024/25, people were still waiting too long for mental health care and were unable to access the care they need when they needed it. During the year, there was an average of 453,930 new referrals to secondary mental health services every month – an increase of 15% from 2022/23. Furthermore, a third of the respondents (33%) to our Community mental health survey reported waiting 3 months or more.*

- *Issues with recruitment, retention and understaffing in some areas are affecting people's care. Vacancy and turnover rates in adult social care have continued to fall but, at the same time, international recruitment has declined rapidly, and ending new work visas for care workers is a cause for concern. Vacancy levels for adult social care staff are currently 3 times higher than those of the wider job market. Rising financial pressures continue to be a risk for the sustainability of some adult social care services, including in the homecare sector. Despite an 11% growth in the sector during the last year, we are concerned that some homecare providers have said they are handing back local authority contracts due to rising costs. We are also concerned about the burden on unpaid carers.*

- *Mental health services continue to face systemic recruitment and retention challenges as staff feel burnt out and overworked. Hospitals are also facing workforce challenges. We continue to hear how persistent understaffing and a poor mix of skills, along with pressure to admit patients to hospital despite a lack of capacity, affects the wellbeing of staff and therefore the care that people receive.*

- *There are significant challenges around funding and system working, as poor communication and collaboration between services, and problems with shared care protocols can have a negative impact on people's experience of care, the co-ordination*

of their care and transitions between care pathways….Navigating the care system remains challenging, especially for people with needs that are more complex to meet or who have limited advocacy – this includes people living with dementia, autistic people and people with a learning disability and people living in more deprived areas.

- *Although more people in England are being diagnosed with dementia, staff in health and social care do not always understand the specific care needs of these people and providers do not always have the necessary knowledge of person-centred approaches and dementia-friendly environments.*
- *Autistic people and people with a learning disability can find it challenging to get an appointment with their GP, because booking systems may not offer the flexibility and choice that they need. Our research also suggests that there are not always the right reasonable adjustments to make primary care a positive experience.*
- *In 2024/25, we delivered a series of Independent Care (Education) and Treatment Reviews (IC(E)TRs) into the care and treatment of autistic people and people with a learning disability who are in long-term segregation. Reviews for some people noted there was no discharge plan in place, or even that they had not had discussions about being discharged or leaving long-term segregation.*
- *Longstanding inequalities in mental health care for Black men continue. Staff must be properly trained to fight racism and support Black men with respect and understanding, and services need to be held accountable when they fail to do the right thing.*
- *Our joint targeted area inspections with Ofsted, His Majesty's Inspectorate of Constabulary, Fire and Rescue Services, and His Majesty's Inspectorate of Probation looked at serious youth violence. They showed that children with special educational needs or disabilities are waiting too long to have their needs assessed, which makes them more vulnerable to the consequences of serious youth violence.*
- *Although local authorities have worked to increase and improve their homecare capacity through reviews and new approaches to commissioning, insufficient homecare capacity often affects the ability of hospitals to discharge people safely, which affects the flow of the system and leads to long delays for care and waiting lists, and then affects people's health and wellbeing.*

In relation to the Deprivation of Liberty Safeguards, the report painted a very bleak picture.

- *The number of applications to authorise the deprivation of a person's liberty have continued to increase significantly over the last decade – far beyond the levels expected when the safeguards were designed, which often results in lengthy delays.*
- *Since April 2020, we have seen year-on-year increases in the number of notifications we receive. In 2024/25, we received over 185,000 notifications, a 15% increase on the previous year.*
- *Issues with the Deprivation of Liberty Safeguards (DoLS) system continue to disproportionately affect certain groups of people. Our survey of Mental Capacity Act leads in hospitals highlighted particular concerns around older people, including those with dementia.*
- *The wider policy landscape in health and social care is changing – the introduction of*

the Mental Health Bill in Parliament and the government's recent announcement that it intends to take forward the consultation on the Liberty Protection Safeguards are likely to have implications for the DoLS system.

- *Another issue we have raised consistently in many State of Care reports is the variation in the way staff understand and apply the safeguards. This year, we continued to find examples of staff not properly understanding when DoLS is needed or failing to recognise and review restrictions appropriately.*

- *While some local authorities reported not having any DoLS backlogs, others were struggling to meet demand and a few hospital providers told us that local authorities were not completing timely assessments or providing adequate feedback on the application process. According to the Association of Directors of Adult Social Services (ADASS) Spring Survey, directors have the least confidence that their adult social care budgets will be sufficient to meet their legal duties in relation to DoLS in 2025/26, compared with other legal duties. Local authorities with no waiting lists for DoLS applications or renewals told us about investing resources to cover the increase in applications in recent years and ensure levels of Best Interest Assessors were sufficient… For example, staff at one local authority outlined that lower risk assessments could take 2 to 3 years to complete. This poses a significant risk of people being unlawfully deprived of their liberty while they wait years for an authorisation. It may also increase inequalities for people who are more likely to be deemed lower risk, such as people with a learning disability or those living with dementia, as we highlighted in our 2023/24 report.*

Book Review

János Fiala-Butoria, *Implementing the Right to Decide under the Convention on the Rights of Persons with Disabilities: Supporting the Legal Capacity of All Persons with Disabilities* (Bloomsbury, 2025, 167 pp, hardback / ebook, £81.00 / £64.80)

I should start this review with a confession. I asked to be provided with this book for review out of a slight sense of duty, so as to keep myself abreast of the literature in this area. The title made me think that I might be going to be reading (yet) another argument in favour of supported decision-making based upon (in essence) the assertion that this is what the Committee on the Rights of Persons with Disabilities has said is necessary. I was, I have to confess, mentally preparing myself for the sound of distinctly ill horses being flogged.

I was completely wrong.

This is quite the most interesting and useful book that I can remember reading in relation to this issue for a very long time.

To start with the base level reason it is interesting; it serves as a state of the art review of the (extensive) debates about the meaning of the right to legal capacity in Article 12 of the CRPD. The body of the text summarises positions fairly and accurately, and the footnotes provide a ready-made reading list.

But the book is much more than that, and that it is I think has a considerable amount to do with the author's background. He is a practising lawyer, having been the first legal officer at the Mental Disability

Advocacy Centre (now Validity), an NGO which has, through directly supporting, and intervening in, cases before the European Court of Human Rights, done more than any other body to shift the dial in the thinking of the Strasbourg court. He is also an academic, having studied at Harvard, and now Lecturer at the Centre for Disability Law and Policy, University of Galway, Ireland, carrying out his legal work now on a part-time basis through this firm he has established with his wife.

The book combines the twin streams of practice and academia to powerful effect, ensuring that the book remains clear-eyed about what both law and theory can, and cannot, do.

After a chapter discussing the concept of legal capacity, the book moves to a clear exposition of how neither those advocating for the 'absolutist' or the 'constricted' position regarding legal capacity are able to find definitive support for their position in the language of Article 12 CRPD itself. The book then turns to delineating the inherent features of guardianship and its alternative – supported decision-making – but, importantly, and unusually, without seeking to denigrate the good faith of those wedded to either approach.[4] By taking both at their ideal, and then their 'actual' (although, in the case of supported decision-making, recognising the extent to which it is often theoretical, so 'actual' is perhaps more difficult to analyse), Fiala-Butoria allows the reader to think for themselves as to whether, on balance, the harms from guardianship outweigh the potential harms from supported decision-making. He also, importantly, allows readers to see for themselves how the nature and scale of those harms may vary in subtle ways depending on the perspective adopted.

In the last chapter, Fiala-Butoria lays out his proposed model for addressing the case of persons with high support needs, addressing the shortcomings in both the 'support only' framework advocated by abolitionists, and the 'some guardianship' framework advocated by those who take a 'constricted' position. His model of a modified support framework is upfront as to the fact that some decisions made by supporters will be substitute decisions, the 'cut-off' being as to whether the person is able to make their wishes known to an outside person.[5] He is also upfront that it is not a perfect solution – and his modesty in this regard is refreshing in a field too often dominated by confident assertion – but lays out with clarity his case for it being no worse than, and in significant ways better than either of the alternatives.

Readers familiar with the Mental Capacity Act 2005 might instinctively react to the

[4] I should, perhaps, declare an interest in that the book engages on several occasions in a thoughtful and nuanced fashion with this article I co-wrote in 2023 which lies in the 'constricted' camp.

[5] Through a very strange coincidence of timing, this model is, in some ways, precisely the model that is being considered by the Supreme Court in the context of the Attorney General for Northern Ireland's reference, as it is being asked to consider whether the test for consenting to confinement is that set out in the relevant domestic capacity legislation, or whether it can be answered in a broader fashion focusing on the reliability of the person's wishes and feelings. I will not comment further on that here, given my involvement in the case.

analysis of guardianship to the effect that 'this has nothing to do with us, because our model is not based on guardianship.' This is not entirely true, especially in the sphere of property and affairs, but it would be interesting to think further about (and I hope to be able to do in a conversation with Fiala-Butoria in due course from the shed) how the 'relative harms' arguments apply to a model such as the MCA 2005 which is much less reliant on guardianship in the health and welfare field. But I would absolutely emphasise that this is a book which challenges, or should challenge, those familiar with the MCA 2005 just as much as those who operate 'old-style' guardianship frameworks.

Overall, therefore, this is an excellent book, explaining why I immediately asked King's College Library to order copies for the Masters' students on my Mental Health and Capacity Law course, as well as recommending it to all the policy makers, law reformers and academics that I have seen in the weeks since reading it.

Alex Ruck Keene

[Full disclosure: I am grateful to the publishers for providing me with a copy of this book. I am always happy to review works in or related to the field of mental capacity (broadly defined)]

SCOTLAND

AWI reform: still rolling, but so slowly!

In the October Report, we narrated the progress at that point of what we called "the massive and carefully constructed way in which a programme of improvement and reform is now being rolled forward". We narrated the establishment of a Ministerial-led Oversight Group ("MOG"), which had held the first of its planned quarterly meetings in September: and of the Expert Working Group ("EWG"), which had its first monthly meeting also in September, and has now met again in October. We confirmed that we intended to report more fully on the remits of the EWG, and of the twelve planned workstreams, in this Report.

In the October Report, I referred to the clearly committed personal engagement in the reform process of Tom Arthur MSP, Minister for Social Care and Mental Welbeing and Sport, that at his invitation I had met him in-person and one-to-one, and that I hoped to be able to share the outcome in the November Report, subject to necessary clearance. I am delighted now to report a change of plan in that the Minister has accepted an invitation to contribute personally, probably to the February Report.

The purpose of the EWG is described in its remit as follows:

> *"This group has been convened to advise and collaborate on the changes required to modernise the Adults with Incapacity system in Scotland, including the future amendment of the Adults with Incapacity (Scotland) Act 2000, with a specific focus on enhancing the rights and protections of people affected by incapacity law."*

I record an interest as a member of the EWG. This article contains my own independent views and comments. Nothing in it is on behalf of the EWG, nor does it purport to represent the views of any other member of the EWG.

Within Scottish Government, the process is led by Amy Stuart, Head of the Mental Health and Incapacity Law Unit, with three teams reporting to her, namely the Adults with Incapacity Improvement Team, led by Gill Scott; the Adults with Incapacity Transformation Team, led by Peter Quigley; and the Mental Health Law Team, led by Aime Jaffeno.

Amy is Chair of the EWG. Her deputies are Gill and Peter. The "substantive members" of the group are:

Jo Savege: Social Work Officer, Mental Welfare Commission

Jennifer Paton: Secretary, Law Society of Scotland Mental Health and Disability Sub-Committee

Professor Colin McKay: Emeritus Professor of Mental Health and Capacity Law, Edinburgh Napier University

Fiona Brown: Public Guardian, Office of the Public Guardian (Scotland)

Ian Waitt: Mental Health Officer, Subgroup Deputy Chair, Social Work Scotland

Adrian Ward: Subject Matter Expert

The Secretary to EWG is Joseph O'Neill. Official support is provided by Sarah Saddiq and Nicola Duncan. Al three are Senior Policy Managers, Mental Health and Incapacity Law Unit, Scottish Government. EWG is an advisory group, with no decision-making powers. Its function is to "make recommendations to be escalated to" the MOG.

The Terms of Reference of the EWG extend in all to nine pages. The first item in its role and remit is to advise and collaborate with Scottish

Government on delivery of the twelve AWI workstreams. With my numbering, the titles and desired outcomes of each of those workstreams are as follows:

1: General Principles: To ensure that the general principles of the Act remain in line with developing thinking and international standards on human rights.

2: Deprivation of Liberty: Develop a Deprivation of Liberty approval system for Scotland, ensuring compliance with ECHR, for adults who lack capacity.

3: Definition of an Adult: Ensure that the Act and any proposed amendments remain compatible with the United Nations Convention on the Rights of the Child.

4: Forced Detention and Covert Medication: To develop any additional safeguards required where force or covert medication may be permitted under Part 5 of the AWI Act.

5: Supported Decision Making: To embed supported decision making as the default approach for adults who lack capacity and to ensure there is effective recognition of the adults will and preferences, in line with the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD).

6: Data Collection: To collate and consider any improvements required to the data collected centrally in relation to AWI.

7: Powers of Attorney: Review and improve Power of Attorney process and practice (legislative and non-legislative) and ensuring that the adults will and preferences are recognised in accordance with UNCRPD.

8: Access to Funds: Review Access to Funds process and practice, identifying opportunities for improvement (legislative and non-legislative) and ensuring that the adults will and preferences are recognised in accordance with UNCRPD.

9: Managing Residents' Finances: Review Managing Residents' Finances process and practice, identifying opportunities for improvement (legislative and non-legislative) and ensuring that the adults will and preferences are recognised in accordance with UNCRPD.

10: Guardianships and Intervention Orders: Review guardianship and intervention order process and practice, identifying opportunities for improvement (legislative and non-legislative) and ensuring that the adult's will and preferences are recognised in accordance with UNCRPD.

11: Medical Treatment: To develop provisions to address a number of discrete issues in relation to medical treatment, examples being; conveying an incapable adult to hospital for non-urgent medical treatment and requiring an incapable adult to remain in hospital for medical treatment; that have been identified in previous consultations on the AWI Act as well as the Scottish Mental Health Law Review.

12: Research: Review and improve the processes for participation in health research and the ethical review of research proposals involving adults with incapacity in Scotland; whilst ensuring the rights, safety, dignity and wellbeing of research participants are prioritised throughout.

The following are my abbreviated preliminary comments, by reference to the above numbering, on the workstreams that are directly relevant to AWI practice. Many of them are achievable by good practice now, but require to be mandatory and explicit in reformed legislation.

1: General Principles:

For much of what is required here, see the Three Jurisdictions Report (Essex Autonomy Project,

6th June 2016). Assistance with communication requires to be widened to cover support for the exercise of legal capacity. The passive language of section 1 needs to be reframed as attributable duties, with remedies for not performing those duties. There should perhaps be an explicit presumption of capacity, and words to exclude any implied presumptions of incapacity when existing orders are renewed. Worldwide, concepts of "incapacity" are being challenged, with emphasis transferring to issues of "vulnerability" and "fragility". The realities of variations and degrees of capacity, and fluctuations over time, need to be better incorporated.

2: Deprivation of Liberty:

A clear and workable deprivation of liberty scheme is essential. It is welcome that this is now being addressed, rather than previous indications of possible partial arrangements to attempt to circumvent the fundamental issues. The other UK jurisdictions have significant problems about resource implications. Scotland almost certainly needs to shift to availability in suitable cases of non-court procedures: but these would still require professional input, particularly that currently provided by MHOs. One has to hope for a quicker than usual publication of a decision by the UK Supreme Court upon the current reference by the Attorney General for Northern Ireland "of a devolution issue under paragraph 34 of Schedule 10 to the Northern Ireland Act 1998", framed as follows:

> *"Does the Minister of Health for Northern Ireland have the power to revise the Deprivation of Liberty Safeguards Code of Practice ("the Code") so that persons aged 16 and over who lack capacity to make decisions about their care and treatment can give valid consent to their confinement through the expression of their wishes and feelings?"*

The hearing took place on 20th – 22nd October 2025. Scotland's Lord Advocate participated in the public interest. Waiting in the wings, or rather hovering hierarchically above that case, is the Strasbourg case of *TF and MD v France* (Case 15290/23), in which interveners suggest – in effect – that the *Cheshire West* case went too far, and "invite the court to clarify the meaning of 'valid consent' for purposes of identifying whether a person is subjectively deprived of their liberty".

If decisions in either or both of the UK Supreme Court case and the Strasbourg case become available before a Bill is presented to the Scottish Parliament, they may or may not have significant influence on the content of the Bill. One suspects, on the basis of past patterns, that our reformed legislation could well be in force before the Strasbourg Court issues its decision, though it would still be reasonable to take account of the submission of the interveners in that case.

As a matter of editorial policy across the various components of the Mental Capacity Report, we are likely to avoid the hazards of commenting speculatively on the UK Supreme Court case until a decision has been issued. Readers may however anticipate that they may see comment "from the Scottish angle" (from me) in Scots Law Times before Christmas.

3: Definition of an Adult:

This ought not be a particular problem. We already have the position that under the Hague Conventions our 16 and 17 year-olds are children. It is a matter of practice that proceedings in relation to them must now be conducted so as to respect their CYC rights, as well as complying with the section 1 principles.

5: Supported Decision Making:

The UN Disability Convention quite deliberately does not mention supported decision-making. What it requires is support for the exercise of legal capacity, broadly equating to our "acting and deciding". The narrowing to decision-making is appropriate – if appropriate at all – for the narrower approach of common law systems, exemplified by the differences between Scotland's 2000 Act and the Mental Capacity Act 2005, but extending more broadly as described in the 2023-2024 volume of the Yearbook of Private International Law ("From past to future – the emergence and development of advance choices", Adrian D Ward, page 23). Beyond that, the comments at 1 above are particularly relevant to this item.

7: Powers of Attorney:

The requirements here are largely as listed in responses by the Law Society of Scotland to the 2016 and 2018 Scottish Government consultations, with the addition of the need for clarity as to whether powers of attorney can be integrated into a deprivation of liberty regime; and clear provision to accommodate support arrangements and co-decision-making.

8: Access to Funds ("ATF"):

There have been suggestions that this and the next item could be subsumed into a new guardianship regime. That would increase the load on the courts, when the opposite is needed. The ATF system could be improved, and there needs to be better flexibility both ways between guardianship and ATF, with better guidance emphasising that under the general principles, and also section 58 of the 2000 Act, a guardianship order must not be granted if ATF would suffice. The great majority of deputyship applications in England & Wales relate to financial matters only, because a major proportion of situations which are dealt with by guardianship orders in Scotland can in England & Wales be covered by deprivation of liberty procedures, leaving no need for any welfare powers in addition. One suspects that many of the resulting "financial only" guardianships could be dealt with here by ATF.

9: Managing Residents' Finances:

It would be relevant to have data – if it can be assembled – on the extent to which arrangements under this scheme have "gone wrong", whether from inadequately managed conflicts of interest or otherwise; as well as assessment of whether registration and supervision should remain as at present (for which there must surely be practical advantages).

10: Guardianships and Intervention Orders:

As with powers of attorney, the long-standing lists of needed amendments should at last be implemented. The distinct nature of intervention orders should be emphasised, and there are probably some actions which ought only be available by a section 53(5)(a) order – that is where the court itself acts, rather than authorising an appointee to act. There should be better provision for combinations of intervention orders and guardianships (already used in practice in appropriate situations, but probably benefiting from clear statutory frameworks). A particular topic for both of the above points in combination would be any case where a court authorises a deprivation of liberty, so that the deprivation of liberty can remain potentially "live" before the same sheriff without the cumbersome mechanism of requiring renewal of the whole guardianship order at frequent intervals. Another possible topic for a section 53(5)(a) order might be making or amending a Will (for which England & Wales has had a procedure since section 96 of the Mental Health Act 1983 came into force).

General on AWI reform process

A matter for disappointment is that it is now understood that the work of the twelve workstreams will not proceed in parallel under the oversight of the EWG, and with participation of members of the EWG as appropriate; but rather that the workstreams will be addressed in sequence, primarily by the EWG, with other participants who are able to make particular contributions joining members of the EWG in dealing with particular workstreams. Coherence is likely to be better, but duration to be extended against a background of unconscionable past delays and resulting urgency, during which fundamental rights of vulnerable people are likely to continue to be violated to their serious disadvantage. One might reasonably estimate that this sequential methodology will add some twelve months to the total duration until reformed legislation is in place, during which additional delay the deficiencies in current practice must continue to be eliminated.

Adrian D Ward

Mental Welfare Commission for Scotland Report on the joint unannounced visit/safe delivery of care inspection: Royal Hospital for Children and Young People, Melville Inpatient Unit

This report was published on 23rd October 2025 following its joint unannounced visit/inspection with Healthcare Improvement Scotland of the Melville Inpatient Unit within the Royal Hospital for Children and Young People in Edinburgh. The unit is a purpose-built Child and Adolescent Mental Health Services unit which twelve beds.

Background

Serious concerns were raised by the BBC Disclosure February 2025 documentary *Kids on the Psychiatric Ward* about the treatment of young people at the Skye House Unit in Glasgow. This was discussed, alongside the relevant rights that were engaged, in the March 2025 issue of the Mental Capacity Report.

As a result of this, the Minister for Social Care, Mental Wellbeing and Sport made a commitment to address these concerns commissioning the Mental Welfare Commission for Scotland and Healthcare Improvement Scotland to conduct visits/inspections across all three young people units in Scotland and the separate children's in-patient psychiatric unit in Glasgow. The unannounced visit/inspection of the NHS Lothian Melville Unit was the first undertaken in this programme of visits/inspections and took place between 12th to 16th May 2025.

Findings

A full reading of this clearly written report is strongly recommended for all the detail. It details both areas of good practice and those where improvement is required. For example:

Areas of good practice included:

1. Positive staff-young people interactions with young people feeling they were listened to.
2. The commitment of staff to working with young people and supporting recovery, and staff feeling they were supported.
3. A positive view of psychology input.
4. Evidence of initiatives seeking to reduce the use of restraint in connection with administering nutrition by artificial means, weekly community meetings for young people and staff and online resources for young people and their families.
5. Daily structured multidisciplinary brief meetings to focus on patient safety issues,

and to identify and anticipate risks (safety huddles).

6. Better assessment and consideration of nursing staffing levels.
7. Relatives and carers being grateful for the care provided and that some staff were approachable but feeling that more dietitian and psychology support was required.

Areas for improvement (requiring enquiry and improvement), and of significant concern, included:

1. The use of restraint, in terms of proportionate use as a last resort and recording of incidents of restraint.
2. Nasogastric tube feeding under restraint.
3. The requirement for adherence to treatment in accordance with the Mental Health (Care and Treatment) (Scotland) Act 2003 and managerial oversight of this.
4. The need to address long-standing issues concerning multidisciplinary team dynamics.
5. The actual availability of activities for the young people, particularly in the evenings and at weekends.
6. The quality of care planning, associated documentation and inclusion of parents and relatives.
7. Communication with young people and their families.
8. The maintenance of the unit to ensure staff and patient safety.

The areas of good practice must be acknowledged. However, importantly, there are areas of significant concern which need addressing, some of which the Commission notes it had previously raised (e.g. adherence to the Mental Health (Care and Treatment) (Scotland) Act 2003, addressing multidisciplinary team dynamics, the qualityof care planning, associated documentation and inclusion of parents and relatives). These are important ethical and human rights issues and must be acted on. The Scottish Mental Health Law Review made it clear that there are many areas of implementation of the Mental Health (Care and Treatment) (Scotland) Act 2003 that can be improved (not least adherence to its human rights-based principles) in advance of any new legislation which incorporates the review's recommendations. Moreover, the incorporation of UNCRC rights into the Scottish legal framework, along with the already incorporated ECHR and influence of the CRPD, add impetus to this and the need for sector wide guidelines on, in particular, the use of restraint for children and young people in psychiatric settings.

Jill Stavert

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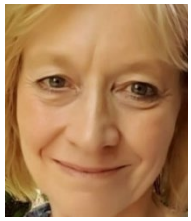

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Conferences

Members of the Court of Protection team regularly present at seminars and webinars arranged both by Chambers and by others.

Alex also does a regular series of 'shedinars,' including capacity fundamentals and 'in conversation with' those who can bring light to bear upon capacity in practice. They can be found on his website.

Advertising conferences and training events

If you would like your conference or training event to be included in this section in a subsequent issue, please contact one of the editors. Save for those conferences or training events that are run by non-profit bodies, we would invite a donation of £200 to be made to the dementia charity My Life Films in return for postings for English and Welsh events. For Scottish events, we are inviting donations to Alzheimer Scotland Action on Dementia.

Our next edition will be out in December. Please email us with any judgments or other news items which you think should be included. If you do not wish to receive this Report in the future please contact: marketing@39essex.com.

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