Essex CHAMBERS

MENTAL CAPACITY REPORT: COMPENDIUM

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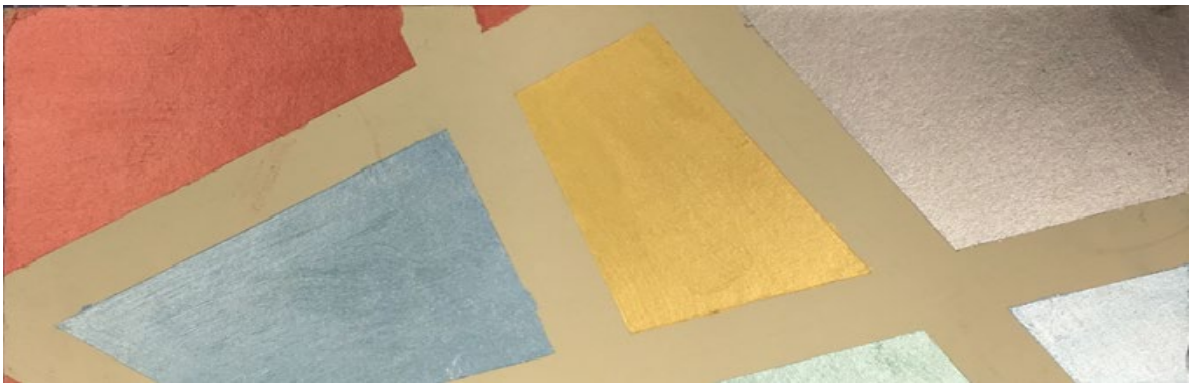

Welcome to the December 2025 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: holding the risk in medical treatment cases; capacity to marry under the spotlight; and mental health conditions, cancer investigation and capacity;

(2) In the Property and Affairs Report: the general costs rule in property and affairs cases under pressure, and a guest post on appointeeship;

(3) In the Practice and Procedure Report: fact-finding in the Court of Protection and recommendations about mediation in medical treatment disputes;

(4) In the Mental Health Matters Report: progress of the Mental Health Bill, community mental health services under pressure and a new website with Nearest Relative resources;

(5) In the Children's Capacity Report: brain stem death testing and procedural fairness, and children in complex situations at risk of deprivation of liberty;

(6) The Wider Context: suicide prevention and assisted dying / assisted suicide;

(7) In the Scotland Report: questionable guardianship.

We have also updated our unofficial update to the MCA / DoLS Codes of Practice, available here.

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.

We will be taking our usual break for the January report, but will be back in February; any urgent things requiring dissemination will be available via Alex's website. In the meantime, for a gentle provocation, you may care to watch this 'in conversation with' between Alex and Professor John Coggon as to whether mental capacity law is, in fact, law.

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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.

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HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

Holding the risk in medical treatment cases

Re RS (Best Interests: Surgery and Intensive Care) [2025] EWCOP 38 (T3) (Poole J)

Best interests – medical treatment

Summary[1]

This is a case which demonstrates the care and thought which – rightly – should go into ensuring that those with cognitive impairments are put forward for appropriate physical procedures, and also contains some very helpful wider observations about the role of the courts in such cases.

The person concerned was RS, a 18 year old man with a complex range of physical and cognitive impairments. The procedure envisaged was surgical correction to curvature of his spine. However, the choice was a stark one:

> *35.* […] *There is no conservative treatment that will help RS's scoliosis. There is no safe way of offering him surgery without the elective post-operative intensive care under heavy sedation, intubation and mechanical ventilation. He either has the corrective surgery and post-operative mechanical ventilation or he has no treatment for his scoliosis at all.*

RS lacked capacity to consent or to refuse consent to the treatment, and, as Poole J noted at paragraph 2:

> *2. Notwithstanding a long and detailed medical decision-making process, concerns remain that the way forward in RS's case is finely balanced. In fact there is a broad measure of agreement between RS's mother, GH, the surgeon who would carry out the operation, independent expert witnesses, the providers of a second opinion to the treating clinicians, and the Official Solicitor, acting as RS's Litigation Friend. No party contends that the proposed treatment is contrary to RS's best interests. However, all involved agree that the decision is finely balanced and the healthcare professionals who would provide the post-operative treatment are particularly anxious for confirmation from the Court that it will be in RS's best interests.*

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

The reference to 'finely balanced' was a reference to the guidance contained in *Applications Relating to Medical Treatment*, [2020] EWCOP 2, which, in turn, drew on the decision of the Supreme Court in *NHS Trust v Y*. That guidance made clear that, where the decision is finely balanced, "*it is highly probable that an application to the Court of Protection is appropriate. In such an event consideration must always be given as to whether an application to the Court of Protection is required*;" if the decision related to life-sustaining treatment, the guidance went on to provide that an application to the Court of Protection *must* be made.

In RS's case, the treatment was not life-sustaining or life-giving (which may explain why the application was not brought by the treating bodies, as would be expected, but rather by RS's mother), but it would have implications for RS's life expectancy.

Poole J gave a very helpful explanation of his approach to the question of (in effect) the legitimacy of a judge making the decision as to whether the surgery should proceed:

> *36. Medical professionals are much more experienced than judges in making decisions about whether a particular treatment or operation is in a patient's best interests but in this case, as Dr Tremlett put it, after months of intense assessment and discussion, he and other professionals of enormous experience have oscillated. They regard this as a finely balanced decision. In accordance with the guidance referred to at the outset of this judgment, the decision has properly been brought to Court of Protection for resolution.*
>
> *37. Whilst NHS Trusts and clinicians have to take into account other matters such as the allocation of resources and the impact on others of providing or not providing the proposed treatment, the Judge in the Court of Protection is required by statute only to consider the subject individual's best interests. The Court cannot require resources to be allocated or force clinicians to provide treatment they are not willing to provide, but when there are choices to be made between available options, then the entire focus is on the individual's interests.*
>
> *38. The assessment of best interests includes, but is not limited to, consideration of the risks and benefits of proceeding with the planned treatment, and of not doing so. Evidence about risks and benefits requires careful consideration. Unavoidably, the evidence before the Court tends to focus on numerical assessments of risk and benefit, such as a 40% chance of a risk occurring, or a 5 year extension of life expectancy. In many cases, including the present case, such evidence has to be treated with caution. Predictions cannot be made with precision when they are based on very limited data. There are no large studies of 18 year olds having elective heavy sedation and mechanical ventilation for two to three weeks after corrective surgery for scoliosis. If not unique, the plan for RS is extremely unusual. The Court relies on expert and professional opinion evidence but in this case much of that evidence is based on personal experience.*
>
> *39. Decision-makers have to look forward and so have to deal with uncertainty. It is a frequent mistake to believe that if something goes wrong after a decision then the decision must have been wrong. If a decision-maker choses option X over option Y because X has a 90% chance of success and Y has only a 50% chance of success, and X fails, it does not mean that they made the wrong choice. There is rarely a risk free option, and there certainly is not one for RS.*

Where there is risk, there is the possibility of a poor or even a fatal outcome, but risk is inevitable, in particular when the decision to be made is finely balanced.

40. When choosing to take a course of action that carries risk over a course of inaction, a decision-maker may feel personally responsible for every risk that then occurs. That may be especially so for clinicians and family members closely connected to the individual concerned. But they would have been equally responsible for the consequences of not acting. A decision-maker may feel a greater sense of responsibility for the consequences of a decision to act as opposed to a decision to do nothing, but for the person who suffers the consequences there is little difference.

41. Judges are not inherently better at assessing risks and benefits than those intimately concerned with a person's care and treatment, including parents and medical professionals, but there are differences:

41.1. Judges have some distance from the person whose treatment is under consideration. Unlike those intimately involved with the individual's care, judges will not have responsibility for carrying out the treatment, dealing with complications, or living with the direct consequences of the decision.

42.2. Judges can hear evidence from key witnesses, including independent experts, scrutinised by experienced Counsel, in a formal court setting to assist them to assess risks and benefits and to assess best interests.

42.3. Judges can take a neutral overview having taken into account the family's perspective and the clinicians' perspective.

43. It might be argued that some of these differences place judges at a disadvantage. Some would say that fundamental decisions about a person's medical treatment should be made by those who know them best and who will be living with the consequences. However, the law requires that when disputed or finely balanced decisions regarding medical treatment of this kind are brought before the Court, it is the Judge who makes the decision as to what is in the person's best interests, applying the principles and provisions of MCA 2005. Court procedures are designed to ensure fairness to all the parties involved. The process requires the judge to be objective. Responsibility for the decision is taken away from the family and the clinicians who may find objectivity difficult to achieve and is placed in the hands of the Judge. Precisely because the Judge is one step removed from the day to day care of the individual, they may find it easier to take a balanced overview than those with a particular, personal perspective.

In RS's case, Poole J found that the benefits of proceeding outweighed the (significant) risks to RS, and that, taking into account all the circumstances, including the views of GH and others concerned with his welfare, it was in his best interests for the surgery to proceed. As he made a point of doing (for different reasons) in the recent case of *KP*, Poole J emphasised that the buck stopped with him:

51. The responsibility for this decision is now the Court's. I was told that GH did not want to bear the weight of responsibility herself. She wanted all the clinicians to agree. That has not quite been achieved but she should know that whilst her evidence is of considerable assistance, the decision is not hers and the responsibility for the decision lies with the Court. Likewise, the treating clinicians,

including those with doubts about the merits of the decision, can focus on giving RS the best possible care without worrying that they made the wrong call.

Conclusion

Reading this judgment was for Alex in some ways mildly surreal, as he did so under 24 hours after having recorded a conversation with Professor John Coggon about whether mental capacity law is law, in which they got quite deep into what judges are doing and why. Poole J's observations almost read like he had been privy to that conversation. They also resonate with a longer-standing debate about whether there is 'overreach' by the law into medical decision-making, as well as a more recent one about whether and when it is sensible to approach the court to assist with clinical unease.

For our part, and whether or not it is conceived as a conventional role for a court, we have always found it to be hugely important, and helpful, for judges to be able to hold risks that - for whatever reasons - are ones that cannot be held by those involved in the person's care. Such can be necessary in a case like RS's, where the desire was to act, but in a situation where there were inherent risks in acting It can also be necessary in a case such as that *Re RC*, where those involved considered that not acting was the ethically right thing to do, but were legitimately concerned at the risk to them of the consequences of doing so). Poole J's judgment provides a clear measure of reassurance that he, at least, is someone who is willing and able to bear the weight of risks on his shoulders.

Short note: communicating the communication limb of the capacity test

Re BV (Medical Treatment - Renal Cancer: Nephrectomy) [2025] EWCOP 41 (T3) is a relatively 'routine' medical treatment case (without, of course, diminishing its huge significance for the man in question). It is a clear and thoughtful example of the relevant statutory bodies and the court working through carefully to ensure that a patient detained under the MHA 1983 received appropriate treatment for an unrelated physical disorder. It is also of note for the clarity of the capacity assessment carried out by BV's treating psychiatrist.

Dr C has formed the view that BV lacks capacity to consent to the proposed treatment for his cancer. He confirmed that BV has a diagnosis of a mild learning spectrum disorder and in his oral evidence he was also able to inform the court that BV's diagnosis of Autistic Spectrum Disorder ("ASD") had recently been formally confirmed. His assessment also makes reference to previous diagnoses of schizoaffective disorder, schizophrenia and anxiety and depression. Having regard to the elements of section 3 of the Act Dr C's evidence was as follows:

(1) BV was unable to understand and weigh up information relevant to the decision in question:

(a) On a basic level BV is aware that he has cancer and can recall the treatment options and the basic consequences.

(b) However, he had difficulty in appreciating the small percentage risk of serious peri/post operative complications and struggled to accept reassurance regarding support.

(c) He was scared and anxious about having the operation, saying he would not be able to mentally or physically recover from it, despite reassurance that this was unlikely. Dr C

considered that BV's fear and anxiety was out of proportion to the relatively low risk of complications. He considered that whilst BV could understand the words used and retain the information, he was unable to apply the information to himself.

(d) BV referred to a previous cancer diagnosis, and was dismissive when told that this was not supported by his medical records. He remained of the view that he has lived with cancer from the age of 28 and due to prayer and healing, it has not affected his life.

(e) Dr C considered that the fact that BV refused to accept this medical fact showed rigidity of thought as part of his autistic presentation. This rigidity of thought similarly affects BV's current view that his likely kidney cancer will once again have minimal impact if he relies on "God's will and religious healing".

(f) Dr C also considered that this demonstrated an inability on BV's behalf to cognitively understand his condition (as it is not currently experienced by him in terms of a contemporaneous bodily experience but is rather a hypothetical future event). He considers that BV's ASD and consequent difficulty with abstract thought restricts him from fully understanding this and renders him unable to make the decision.

(2) BV is able to retain information. He was able to confirm to Dr C that he had been diagnosed with a tumour and that with an operation he would have a 90% chance of being alive after 10 years and without it he would live 2 years.

(3) BV is unable to weigh up information. In individuals with a learning disability, confabulation can often be utilised to mask deficits in memory, executive functioning, and understanding and in BV's case, this has resulted in his somewhat confusing narrative and impacted on his ability to explain his thoughts and decisions regarding the surgery.

(a) Dr C considered that BV's deficits in executive functioning leads to a limitation of his ability to process the information and apply it to his current situation and to appropriately think and plan for the future. This was evidenced by his ongoing belief around a past cancer diagnosis, and the fact that this had had no significant impact on his life due to this being "God's will".

(b) BV's deficits in abstract thinking and theory of mind arising from his ASD lead to an inability to weigh up relevant factors in the balance. Therefore, whilst he understands some of the surgical facts relevant to the decision, he is not processing these to weigh up his situation as only his fixed and overvalued thoughts and feelings are relevant. He has been unable to take on medical opinions and his family's thoughts, concerns and distress caused by his potential refusal of treatment.

(4) Dr C confirmed that BV was able to communicate his wishes and feelings.

Two points stand out. The first is the way in which Dr C worked from the starting point of the clinical phenomenon of executive functioning to the language of the MCA (as to which see further here). The second is the way in which Dr C approached the communication limb. So often, we see that part of the report completed as "P is able to communicate a decision," at a point when the assessor has found that they cannot understand, retain, use or weigh relevant information. At that point, and (as discussed here) there is no 'decision' for the person to communicate, so saying that "P can communicate a decision" is logically meaningless. Dr C framed it correctly – this was a case where BV was able to

communicate his wishes and feelings, wishes and feelings which, in turn, could be considered in the best interests decision-making process.

Mental health conditions, cancer investigation and capacity – the challenges of achieving parity

Powys Teaching Health Board & Anor v NT & Anor [2025] EWCOP 44 (T3) (Theis J)

Best interests – medical treatment

Summary

This case, bluntly, illustrates why those with mental health conditions so often die entirely avoidable deaths. NT, a 41 year old man, had a long-standing mental condition, and was detained under the MHA 1983. In March 2025, it had been recognised that he needed an operation to explore and remove what was thought to be a potentially life-threatening tumour from his bladder through a procedure known as transurethral resection of a bladder tumour ('TURBT'). At that point, an assessment of his capacity to decide upon the TURBT was carried out described by Theis J in these terms:

> *7. The capacity assessment in late March 2025 by Dr J stated 'Today [NT] is capacitated and agreed to have surgical intervention. He needs reassurance from staff he connects with at [Z home]. He might appear lacking capacity sometimes because of extreme anxiety and failure to communicate with staff that he does not know, and then resorts to denial and distortion of reality'. That assessment was superficial, contained no analysis of the history of NT refusing the treatment in the past and did not obviously address the reasonably foreseeable consequences (as required by s3(4) Mental Capacity Act 2005) other than recording 'the procedure and its purpose was explained to him'. It did not accord with the court's expectation that a capacity assessment should be "evidence-based, person-centred, criteria-focussed and non-judgmental" per CT v London Borough of Lambeth & Anor [2025] EWCOP 6 (T3), para. 60(4).*

Pausing there: had NT accepted the TURBT at that point, no one would likely be the wiser as to the quality of the assessment even if, in fact, as it turned out, his 'consent' would have been incapacitous 'assent.' However, NT declined the treatment three times over the next four months. His capacity was, however, not looked at again until August 2025, at which point a further assessment concluded that he lacked the relevant decision-making capacity. The Trust concluded in August 2025 that an application should be made to court to authorise the surgery; it was not, however, filed until October 2025, and was not then determined until December 2025.

Theis J was understandably concerned about the delay, and made the following observations:

> *9. The Health Boards state that NT's medication was adjusted soon after the best interests meeting and there was understandable concern about the impact on NT's therapeutic relationship with those who cared for him if the procedure was undertaken against his wishes. However, some of the delay was said to be due to what were termed 'structural issues' caused by the need for liaison between the different Health Boards and providers. These structural issues should be addressed without delay to ensure that is not a cause of delay in the future.*
>
> *10. The 'Guidelines for Managing Patients on the Suspected Cancer Pathway' published by the Welsh Government emphasise the need for clinicians to ensure that 'their actions promote the*

> *principle of patients waiting the shortest possible clinically appropriate time for treatment.' (paragraph 27) NT had a condition that required the proposed treatment and the impact of delay risked the condition becoming more serious. Steps should be taken to ensure that such delays are avoided in other cases with a clear timetable agreed at the best interests meeting in the event of decision for proposed treatment as to when (if it is required) an application in the Court of Protection is made.*

Ultimately:

> *11. There is now a large measure of agreement between the parties that the court should make the order for the proposed treatment. In recent discussions with NT he requested a further scan was done through a private hospital, indicating that if that scan still showed the presence of the tumour he would agree to undergo the TURBT. That further scan was arranged, funded by a member of NT's wider family. The results became known on 21 November 2025 and confirmed the existence of the tumour. In discussions with his mother over the weekend before this hearing NT told her that in the light of that scan result he would agree to undergo the procedure.*

Theis J had little hesitation in concluding both that NT lacked capacity, and that it was in his best interests for the TURBT to proceed:

> *60. In undertaking the best interests assessment the court has the recent evidence regarding NT's wishes and feelings as well as the views of his mother. The medical evidence regarding the need for the TURBT procedure is unchallenged although it is recognised that there is a need for clear communication for NT by those around him regarding the procedure and any post operative treatment. Such consistency in communication is likely to reduce NT's anxiety which in turn will support him regarding his wishes and feelings about the procedure and any treatment proposed.*
>
> *61. The court recognises the concern that had been expressed about the impact on NT's therapeutic relationship with those who care for him at Z home if the procedure took place against NT's wishes. That risk has now reduced with the change in NT's views although bearing in mind the history there is a risk NT's views may change. From the evidence the court shares* [the confidence of NT's mother] *that would be managed by the team at Z home in a way that will minimise the risk to those important relationships being adversely impacted*

Comment

In addition to Theis J's observations about delay, it is perhaps also worth recalling those of Cobb J (as he then was) in *Re PG*, another case involving a person with a mental health condition where suspected cancer required investigation:

> *55. It may well be that the delay in the making of the application has arisen from a lack of communication between the two Applicants; this was hinted at by Dr. H. It may be that it flowed from an understandable concern by the Applicants that it would be inappropriate to trouble the court with an inchoate application in the absence of an agreed "fully-worked up" care plan, in respect of the investigations. If so, I would wish to encourage these Applicants and/or any other applicant in such circumstances with such a case, to be less concerned about ensuring that every 'i' is dotted and every 't' crossed before making the application where speed of decision-making may be of the essence: perfect in this instance may well be the enemy of the good. Once it became apparent that NHS Guidance regarding the investigation and/or treatment of PG's condition could*

> *not be complied with timeously, and/or where it was clear that PG's treating/receiving clinicians could not agree upon a care plan to facilitate the investigations and/or treatment, the application could or should have been issued. The Court could then have ensured with the assistance of counsel and solicitors that evidence was filed from the necessary factual and expert witnesses to enable the detail of the care plan to be completed, and a decision to be reached promptly in respect of PG's best interests.*

NT's case was, probably, a case which required a court application – 'probably' because the fact that when NT's desire (it appears) to have confirmation that he really had a tumour had been satisfied, he assented to the operation suggests that it might well have been possible to rely upon the provisions of ss.5 and 6 MCA 2005 to address a situation which, at the end of the medical decision-making process, was not necessarily all that finely balanced. We do not have the postscript that we sometimes have in cases of this kind in which it is explained that the procedure took place; we can just hope no further delay will have occurred in securing for NT the parity in achieving physical health treatment that so often is denied those with mental health conditions.

Capacity to marry under the spotlight

Stockport Metropolitan Borough Council v EKK [2025] EWCOP 42 (T3) (Trowell J)

Mental capacity – capacity to marry

Summary

This case considers the question of whether an assessment of a person's capacity to marry should be carried out on a generic basis or in respect of the particular person it is proposed they marry. Following the decision of the Supreme Court in *A Local Authority v JB* [2021] UKSC 52, the local authority argued that the previous approach of assessing capacity to marry in the abstract was wrong. The local authority argued that the Supreme Court had made clear, in connection with capacity to engage in sexual relations which had also previously been treated as a generic or 'act-specific' assessment, that in fact the Court of Appeal had got it right in *York City Council v PC* when they said in relation to decisions about contact and cohabitation, that the information relevant to a decision had to be assessed within the specific factual context. The Official Solicitor argued that the person-specific approach endorsed by the Court of Appeal only applied to decisions about contact.

Trowell J was clearly concerned that he was determining an issue in the abstract but ultimately decided that he had to be guided by the *York* decision, in which the Court of Appeal had said that some decisions such as marriage are to be assessed on a generic basis, and that to adopt a person-specific approach would 'divert the court into an assessment of the intended spouse, rather than P's capacity', risking making the test for P a higher one than for people whose capacity is not queried. The expert in the case would therefore be instructed to answer the question whether P had capacity to make a decision to marry, not a decision to marry her partner.

Comment[2]

It is not possible to tell from the judgment why this issue was thought to be important on the facts of the case. P had been in a relationship with her partner for 8 or 9 years and the only 'person-specific' factor mentioned is that he was suspected by the local authority of mismanaging her finances. (The judgment does not refer to the Tier 2 decision of *Re DMM (Alzheimer's : power of attorney)* [2017] EWCOP 32 which found that a further item of relevant information is that an existing Will will be revoked on marriage or include any discussion of whether financial implications are relevant to a decision to marry).

An independent capacity report had already been obtained in the proceedings which concluded that P lacked capacity to make decisions about contact and property and financial affairs (among other matters) but had capacity in respect of sex and marriage. It may be that the issue of whether capacity to marry should be addressed on a person-specific basis arose because the local authority considered that if the expert had considered person-specific factors a different conclusion would have been reached.

The question of contact will, one assumes, have been addressed by the expert on a person-specific basis in light of *York*. The approach adopted by Trowell J might result in a conclusion that P has capacity to decide to marry, but does not have capacity to have contact with her partner. Adopting a person-specific approach would avoid that counter-intuitive outcome. It is not at all clear that the *York* decision should be given the weight afforded to it by Trowell J, as the Supreme Court in JB endorsed the context-specific approach of the Court of Appeal in that case and rejected the Official Solicitor's attempts to preserve a generic approach (which had also been rejected in *York*). The same policy arguments that underpin the generic approach to assessing capacity for sex also apply to decisions to marry. No doubt this is an issue which will have to be reviewed by the appellate courts, in a case where the approach taken actually makes a difference to the outcome, to determine whether it is correct that marriage is now the only decision where capacity must be assessed on a generic basis.

Research corner: eating disorder articles

Two articles have recently been published which may be of use / interest for those seeking to think through the approaches to eating disorders in clinical practice and before the courts.

Agnes Ayton et al: Addressing the false dichotomy between autonomy and preservation of life: Clinical, legal, and ethical considerations in severe and longstanding anorexia nervosa (International Journal of Law and Psychiatry)

Jacinta Tan et al: Legal decisions on longstanding severe eating disorders (British Journal of Psychiatry)

[2] For some further thoughts on this, including the relevance of Forced Marriage Protection Orders see also Alex's post about this; for the Irish perspective, see the report on the *AB* case in the Wider Context section.

PROPERTY AND AFFAIRS

Riddle v NA [2025] EWCOP 39 (T3) (Harris J)

CoP jurisdiction and powers – costs

Summary

This case raises questions about the fitness for purpose of a key plank of the costs provisions contained in the Court of Protection Rules.

The case took the form of an appeal against a decision of a District Judge refusing the costs incurred by Andrew Riddle, who had sought to be appointed the professional deputy for a man, NA, but whose application had not been successful because it was ultimately shown that NA had the relevant capacity.

The background facts were crisply summarised by Harris J thus:

> *6. NA is 56 years old. In 2003, he sustained frontal lobe damage as a result of an assault. The injury has a mild impact on his executive functioning, compounded by excessive alcohol use.*
>
> *7. On 6th October 2022, Mr Riddle made a COP1 application seeking his appointment as a professional deputy for NA's property and financial affairs. NA's case was referred to him by CYC which had previously referred the matter to a firm of solicitors who had failed to progress the application. Mr Riddle is not legally qualified but has considerable experience acting as a professional deputy.*
>
> *8. CYC made the referral to Mr Riddle on the basis that they believed NA lacked capacity to manage his affairs and was therefore in need of a Deputy to prevent further escalation into debt and to prevent the potential loss of all his assets. He was living in a state of neglect. CYC did not consider it appropriate for them to make the application because of the complexities of NA's property and affairs and the existence of a potential conflict of interest given the most significant debt NA owed was council tax - a debt CYC were actively seeking to recover. They therefore referred the matter to a professional deputy to progress.*
>
> *9. The COP1 application made by Mr Riddle was supported by a COP 3 capacity assessment completed by NA's social worker, Lesley Stavridis dated 15th August 2022. That assessment concluded NA lacked capacity. NA filed a COP 5 opposing the application. In March 2023, NA entered alcohol rehabilitation treatment which was successful. Supported by Ms James* [from the mental health charity "Mainstay"] *he began addressing the various issues relating to his property and finances. The first hearing on Mr Riddle's application came before District Judge Boorman in August 2023 when directions were made for the filing of further evidence. There followed three further Dispute Resolution Hearings.*
>
> *10. In May 2024, the court ordered a s49 report to address NA's capacity to make decisions about his property and affairs. In his report dated 24th June 2024, Dr Ormrod concluded:*
>
> > *In my opinion, at the time of my assessment, on the balance of probabilities, NA had the capacity to manage his property and affairs. I note that such a conclusion may be at odds with earlier assessments. However, in my opinion it is likely that there have been changes*

> *in NA's levels of functioning as a result of his decision to stop drinking and the support he has received in the last year.*
>
> *Mr Riddle accepted the conclusion of Dr Ormrod. On 13th September 2024, his application to be appointed as Deputy was dismissed.*

Mr Riddle, however, sought the costs he had incurred. At first instance, his application was refused, with District Judge MacCuish holding that there should be no order for costs. Mr Riddle appealed.

His first ground of appeal was, whilst the District Judge had recognised that he had a wide discretion on costs, he failed to apply rule 19.2 (or indeed any of the rules under Part 19 of the Court of Protection Rules 2017) correctly or at all. He was successful on this ground of appeal, but it was a Pyrrhic victory, as Harris J went on to consider the question of costs for herself.

Harris J identified that the application fell within CoPR 19.2:

> *21. The Court is satisfied that an application for deputyship over "P's" property and affairs, includes an application in which "P's" capacity is disputed. "P" is defined within Rule 2.1 as including a person who is alleged to lack capacity. This application therefore falls within the general rule provided for by Rule 19.2.*

That meant, therefore, that the starting point was that the costs of proceedings should be paid for by NA.

Mr Riddle argued that:

> *22.* […] *Rule 19.2 serves a clear public interest in ensuring matters concerning vulnerable adults and the management of their property and affairs are brought before the court. If an application is successful, the order appointing the Deputy will typically provide for the costs of the application to be paid by P, either under the fixed costs regime (£1,204 + VAT) or, particularly if the application is contested, following a detailed assessment of costs. The public interest in ensuring matters of this nature are brought before the court underpins the reasoning of Lindley LJ in Re Cathcart [1892] 1 Ch 549, in which he awarded costs to P's husband, although P was found to have capacity:*
>
> > *An inquiry into a person's state of mind is not like an ordinary litigation, and whilst, on the one hand to obtain and prosecute such an inquiry is to inflict a grievous wrong, if there is no justification for it; yet, on the other hand, it may not only be justifiable but right to institute and prosecute such an inquiry, even though the result should be to establish the sanity of the person whose state of mind has been investigated. This view has long been acted upon by the tribunals of this country, and is sanctioned by Legislature.*
>
> *This approach to costs in matters of property and financial affairs, even if the application is ultimately unsuccessful, ensures people are not deterred from making applications in good faith by being penalised in costs.*

Harris J acknowledged the starting point and the rationale that might underpin it.

> *23.* […] *However, in determining whether the Court should depart from the general rule in Rule 19.2, and in considering all the circumstances of the case, the Court is not persuaded, as argued by Mr*

Riddle, that where an application is made in good faith and accompanied by supportive capacity evidence, the circumstances would have to be "truly exceptional" to justify departure from the general rule. Such a highly restrictive approach to Rule 19.5 and the Court's overarching discretion in matters of costs is to place an unhelpful gloss on the rules.

24. In the Court's judgment, the matters of public interest which underpin Rule 19.2 and give weight to the starting point that the applicant's costs should be met by P, whilst important, should not be regarded as almost determinative. It was urged upon the Court that the COP's jurisdiction is not adversarial; it is about finding the right outcome for P. The same principles apply to welfare applications - where the court very clearly undertakes an inquisitorial, welfare focused enquiry - but the usual rule under Rule 19.3 is for there to be no order as to costs. Mr Riddle has not faced any application by NA for his costs to be met, an order which would arguably penalise Mr Riddle for bringing the application. However, for Mr Riddle to seek an inter partes order against P goes beyond what is deemed as necessary in welfare matters to ensure applications are properly placed before the court.

Another line of argument was put forward by Mr Riddle:

25. It was also urged upon the court that professional deputies such as Mr Riddle play a vital role in ensuring these applications are made, particularly where P has no family to safeguard their financial interests. It was suggested that a failure to award professional deputies such as Mr Riddle their costs will lead to real gaps and difficulties in the system. The court was told that a process has developed whereby local authorities - due to a lack of expertise, resources or a conflict of interest - will refer these applications out to professional deputies who will make the necessary COP1 application. If those deputies are at risk of not recovering their costs, it is suggested they are likely to decline making the applications, placing the burden back on already over-stretched local authorities. The result of that will be delays for P and a risk that P will be left unprotected from exploitation whilst the local authority progresses an application.

This fell on equally stony ground:

26. The Court is again unpersuaded by that argument. The evidence before the Court is that upon such a referral being made by a local authority, the proposed professional Deputy will triage the application, reviewing all the information provided by the local authority or charity, and consider whether they are satisfied the application should be made. The proposed Deputy is under no obligation to make the application. If the proposed Deputy is satisfied on the information provided that the application does have merit, they will make the necessary COP1 application. They will however do so knowing that in accordance with the rules they are taking a calculated risk as to whether the Court will disapply the usual rule in 19.2. The Court does not have the benefit of any system-wide data on this issue. However, although there are a number of reasons why an application for Deputyship may not result in the applicant's appointment, the evidence before the Court is that such an event will be relatively rare.

27. Mr Riddle tells the Court that this is the first time he has found himself in the position that an application for Deputyship has failed and he has not been awarded his costs. CYC similarly tell the court that it is rare for them to make a referral out to a Deputy, and that they have never experienced a case where the application for Deputyship has failed. The risk - whilst it undoubtedly exists - is therefore, on the limited evidence before me, very small, and one which any professional Deputy can perhaps reasonably be expected to mitigate against within the overall structure of their business. The Court is not persuaded that without what would amount, in effect, to a solid

assurance that applicants in the position of Mr Riddle who have acted in good faith will recover their costs of even unsuccessful applications, there is a risk of systemic collapse.

Perhaps most importantly, Harris J identified:

28. In any event, if the risk of failing to recover their costs were to lead to professional Deputies refusing to make such applications, the Court is not persuaded the answer to such a systemic problem is that the vulnerable adult, P, should bear the burden of those costs, as opposed to alternative solutions being found. Local authorities pursuant to their safeguarding duties and responsibilities would need to assume the burden of bringing such applications before the court, ensuring P would not fall through a safeguarding gap. Alternatively, the public authority could choose to enter into contractual arrangements to underwrite the costs of professional deputies such as Mr Riddle to bring the applications on their behalf. That may seem a fairer solution than imposing the costs burden on vulnerable adults such as NA.

This therefore meant that the starting point remained that Mr Riddle should recover the costs of his application. However, that was only the starting point:

29. [….] *in considering all the circumstances of the case and whether it should depart from the general rule in 19.2, the balance should not be unduly and disproportionately weighted against P. In London Borough of Hillingdon v Neary [2011] EWHC 3522, Jackson J held that when considering whether to depart from the general rule on costs, "each application must be considered on its own merit or lack of merit with the clear appreciation that there must be good reason before the court will contemplate departure from the general rule. Beyond that, as MCA s 55(3) makes plain, the court has "full power" to make the appropriate order.*

The first sub-set of considerations provided for in COPR r.19.5 in deciding whether there should be a departure from the general rule concerned conduct:

31. Conduct: The court is satisfied that Mr Riddle acted in good faith in making the application. A number of capacity assessments were carried out by CYC prior to the application being made, which save for one, concluded NA lacked capacity to manage his property and affairs. Although the issue of NA's capacity was not entirely straight forward, the application was supported by a detailed COP 3 assessment conducted by his allocated social worker. It was, on the basis of the evidence available at the time, entirely reasonable for the application to be made. The local authority regarded the application as necessary given their safeguarding concerns for NA - albeit they could have brought the application themselves and it was not necessary for it to be made by Mr Riddle.

32. It is furthermore urged upon the Court that the application was motivated only by NA's best interests and for no personal motive or gain. In this regard, whilst the Court is satisfied the application was made in good faith, Mr Riddle is not carrying out a charitable public service. He acts in the course of his business for profit. Ultimately, he seeks appointment as a professional deputy to further that business. The Court expresses some concern regarding the adversarial tone and hostile nature of some of the comments made by Mr Riddle towards NA in his witness statements of 9th February 2024, 6th March 2024 and 14th May 2024. They do not sit easily with the claim that Mr Riddle acted only in NA's best interests or the fiduciary nature of the Deputy role to which Mr Riddle was seeking appointment. However, the Court is not satisfied that Mr Riddle's

somewhat adversarial approach amounted to conduct that crossed a line, such that it should have a material bearing on costs.

33. Turning to NA's conduct. NA opposed the application throughout. Whilst Mr Riddle makes some criticism of the way in which NA conducted the proceedings and the delay that resulted, it is not suggested it constitutes the kind of litigation misconduct that might sound in costs. NA remains a vulnerable adult who has acted as a litigant in person throughout. That is despite it being the applicant's position that NA lacked capacity to conduct his property and financial affairs. Nevertheless, with the support of Ms James he has engaged fully in these proceedings. The late submission of evidence by NA resulted in two hearings being adjourned and re-listed. Whilst that caused delay it did not result in costs being wasted.

34. Having considered the various orders made over the last two years of litigation, the Court is satisfied the delay and protracted nature of these proceedings resulted from case management decisions intended to gather further information regarding NA's progress, and consequently the late direction to obtain a s 49 report on the question of capacity.

Ultimately, therefore, conduct was not a relevant consideration. Harris J then turned to 'success':

36. Success: Mr Riddle failed in his application to be appointed Deputy. Given the nuances in NA's cognitive presentation and the fact NA made clear from the outset that the application would be opposed, Mr Riddle must always have been aware there was a risk the application would fail. NA was entitled to the presumption of capacity. The burden did not rest on him to prove capacity. No interim declaration that NA lacked capacity was made. Within that context, Mr Riddle chose to take the risk of making and continuing to pursue the application. Mr Riddle carries out his business as a professional deputy for profit. That is not to criticise his business, but he is not in any way obliged to make such applications. He has to take some responsibility for any litigation risks he chooses to assume.

37. Ultimately, NA was successful in defending the application on the basis he had capacity, and the Court therefore had no jurisdiction to appoint a Deputy. The principle embedded in the Civil Procedure Rules 1998 Rule 44.3 that costs follow the event does not apply in the Court of Protection. However, as a matter of natural justice, it may appear perverse that NA should pay the costs of Mr Riddle - who is a complete stranger to him - for an application he did not invite, always opposed, had no choice but to respond to, and ultimately was successful in defending. Unlike Mr Riddle, NA did not choose this litigation. He is not at fault in any way. This has to be a weighty consideration in determining the issue of costs.

The final consideration provided for in COPR r.19.5 was:

38. The role of any public body in the proceedings: The court is grateful to CYC who attended the appeal and made representations to assist the court. They explained how the referral to Mr Riddle came about and their extensive involvement with NA prior to the application being made. It is clear they gave no consideration to the question of how Mr Riddle's costs should be met and whether, as the referring public authority, they should assume any responsibility for those costs should the application fail. In light of the issues raised in the appeal, they confirmed at the close of submissions that moving forwards they would take responsibility for making applications for the appointment of property and financial affairs deputies. The fact an application is made by the local authority does not prevent a professional deputy being appointed by the Court.

Overall, therefore:

> *39. Having considered all the circumstances of the case, the Court is satisfied that it is justified in departing from the general rule in the Court of Protection Rules 2017, Rule 19.2. Whilst it is acknowledged Mr Riddle acted in good faith and spent considerable time and resource trying to progress the application, the Court is satisfied that the application having failed there should be no order as to costs. NA, a vulnerable adult the Court of Protection is designed to protect, has gained little to no benefit or advantage from this application being brought. Any advantage is far outweighed by the costs application he now faces. In stark contrast to Mr Riddle, NA was not in a position whereby he could protect himself against any resulting exposure to costs. Mr Riddle chose to bring the application. He was able to assess the litigation risks. The responsibility to mitigate his exposure to costs should ultimately rest with him.*
>
> *40. The fair and just order is that there be no order for costs.*

Finally, Harris J noted an issue in relation to the assessment of costs in respect of litigants in person:

> *41. The court is told that Mr Riddle's costs are in the region of £10,000. No schedule has been produced to explain how those sums have been incurred. During the course of the appeal hearing, the Court raised with Ms Collinson how Mr Riddle as a non-legally qualified professional deputy, so essentially a litigant in person, could claim such a substantial sum. He is not a Deputy. There is no order authorising him to incur costs in the management of NA's affairs.*
>
> *42. I am grateful to Ms Collinson who following the appeal hearing filed a further note dealing with how legal costs claimed by Mr Riddle as a litigant in person, if an inter partes costs order was made in his favour, could be quantified. There would appear to be no clear authority on the point. Neither s 1 of the Litigants in Person (Costs and Expenses) Act 1975 or rule 46.5 of the Civil Procedure Rules apply. The limited case law on the point is conflicting. In London Borough of Hounslow v a Father [2018] EWCOP 23, District Judge Eldergill found that a LIP is entitled to recover their reasonable expenses but 'is not entitled to a fee or remuneration'. In JMH (by her litigation friend AB) v CFH [2020] EWCOP 63, HHJ Evans-Gordon declined to follow the decision of DJ Eldergill, holding that recoverable costs are those 'that any litigant in person could recover and those are the disbursements/court fees and any time costs recoverable on a detailed assessment'.*

However:

> *43. The Court is mindful that NA is not represented, and it has not therefore had the benefit of full legal argument on this potentially very significant point. The issue no longer arising on this appeal, the Court therefore expresses no view upon it.*

Comment

There has for a long time been a rumbling feeling of dissatisfaction (certainly at this end) about COPR r.19.2, albeit often for another reason, namely that it allows familial disputes to be played out at P's expense. This case highlights another reason why it can be problematic. Had this been a case about whether NA had capacity to make decisions about relevant welfare matters, the starting point would have been no order as to costs, and it is not surprising that Harris J felt that this case was very much in that zone. It is perhaps not entirely surprising that the only authority Mr Riddle could find to support

the proposition that he should be reimbursed from his costs dated from the 19th century, in a very different world. The reality is that in a situation such as this the costs of ensuring that NA's capacity was appropriately investigated and (if he lacked such capacity) appropriate steps taken in his best interests should be (as was) seen as an offshoot of the safeguarding obligations of the local authority, obligations which are not conventionally understood to be deployed at the financial expense of the person. It was unfortunate that the potential for the application to be refused had not been contemplated by either CYC or Mr Riddle, and that this then redounded upon Mr Riddle personally, but it is not surprising that Harris J was unimpressed with the suggestion that the solution should be that NA should pay for the privilege of the unsuccessful application.

Until and unless r.19.2 is amended, Harris J's refusal to place any gloss on the rule in the manner urged upon her by Mr Riddle was undoubtedly helpful in terms of the message that r.19.2 is a starting, but not an end point.

Separately, and whilst it is entirely understandable why Harris J declined to consider the question of costs for litigants in person, it is unfortunate that she was not in a position to do, as it is question which undoubtedly merits definitive resolution.

DWP Appointeeship: Emerging Issues for the Court of Protection

[*This is a guest post from Alex Cisneros, responding to an issue which gives rise to very regular questions for the Court of Protection team. If you have other questions that you'd like answering in a guest post, do please let us know!*]

The Department for Work and Pensions' Appointeeship system is a vital but often overlooked mechanism for supporting adults who cannot manage their state benefits. Unlike deputyship or attorneyship, it operates with minimal safeguards, limited oversight and little interaction with the broader mental capacity framework.

The regulations

A person or body may apply to become an Appointee if the individual in question is "unable for the time being to act" (Reg. 33(1)(b)). DWP guidance expands on this by stating that the person must, "because of mental incapacity (or, exceptionally, severe physical disability), be incapable of managing their affairs." The guidance does not explain "mental incapacity" by reference to the Mental Capacity Act 2005, which is unhelpful. In practice, however, it would be logical to interpret the term consistently with the MCA's test.

DWP guidance explains that an Appointee may be either a suitable individual, typically a family member, friend or carer, or an organisation such as a local authority or care provider.

Once in post, an Appointee can exercise any of the rights and duties that the individual could in relation to their benefits. This would include:

- signing the benefit claim form
- telling the benefit office about any changes which affect how much the individual gets

- spending the benefit (which is paid directly to the Appointee) in the individual's best interests

Crucially, the Appointeeship regime imposes none of the duties that run through the MCA 2005. Appointees are not required to support a person to make their own decisions, to follow the section 1 principles, or to apply a statutory best-interests framework. Their only obligation is to manage the benefit income "on behalf of" the claimant.

In practice, this means there is no legal requirement to explore the person's wishes, involve them in decisions, or consider alternative, less-restrictive ways of meeting their needs.

For individuals with fluctuating or emerging capacity, this lack of statutory safeguards creates a significant gap: the Appointee may be making highly consequential financial decisions without any of the protective duties that would apply to an attorney or deputy under the MCA. This structural mismatch between the two systems is one of the core problems with the current Appointeeship framework.

An Appointee can retire or be removed at any time by the Secretary of State (Reg.33(2)(a)). Internal guidance suggests that reasons do not need to be given for this decision.

The DWP will not normally become aware of an Appointee's wrongdoing unless someone reports it to the benefit office responsible for the claim. Unlike the OPG's supervision of deputies and attorneys, the Appointeeship system has no routine reporting or monitoring requirements.

What can the CoP do?

Concerns about Appointees often emerge indirectly in Court of Protection proceedings, for example, through safeguarding evidence, unexplained shortfalls in a person's personal allowance or signs of coercive control. Although the Court of Protection has no direct jurisdiction over Appointees, it can make orders that scrutinise the situation and prompt the DWP to act.

This may include:

- Making declarations or findings that signal the need for review or removal of an Appointee, prompting the DWP Visiting Team to investigate.
- Authorising disclosure to the DWP, allowing parties to share relevant material from Court of Protection proceedings. Targeted summaries or extracts are often more proportionate and effective than blanket disclosure.
- Appointing a deputy (s.16(1) MCA 2005) to manage a person's property and affairs. DWP guidance states that an Appointee is not appropriate where a "person of equal or higher authority" is already appointed, such as a court-appointed deputy. The making of a deputyship order, even on an interim basis, should therefore provide grounds for the DWP to end the Appointee's authority.
- Directing third-party disclosure from the DWP where information is required. The DWP's processes are not aligned with statutory safeguarding duties, and there is no requirement for the DWP to respond within a set timeframe. A court order may therefore be necessary to obtain timely information.

Motability scheme and Appointeeship

A good example of the misalignment between the Appointee system and the more structured deputyship and LPA frameworks is the way each role is treated under the Motability Scheme.

The Motability Scheme allows disabled people to use their Motability allowance to lease a vehicle. In July 2025, the Court of Protection confirmed that a property and affairs deputy acts only as P's agent for the purposes of Motability agreements; the deputy is not the contracting party.

However, the Motability Scheme website (updated May 2025) states that although an Appointee can also apply on someone's behalf, they, unlike a deputy, become the legally responsible party to the lease agreement. This guidance may not yet reflect the Court of Protection's July 2025 clarification regarding deputies and attorneys, but it does appear to place Appointees at a disadvantage and highlights the ongoing lack of clarity about their role.

The Need for Reform

Appointeeship remains a vital but outdated component of adult financial protection. It lacks oversight, clear standards and integration with the MCA or safeguarding frameworks. The recurring issues seen in CoP proceedings illustrate a system that works well when functioning smoothly, but provides limited protection when things go wrong. Structural reform is long overdue.

The case of *RH v SSWP (DLA)* [2018] UKUT 48 (AAC) illustrates the problem clearly. The case concerned a disability-benefit claimant with significant mental illness whose local authority had been appointed as his Appointee. The Upper Tribunal acknowledged that serious concerns had been raised about the fairness and human-rights compliance of the Appointeeship system. The Appointee had been appointed without any formal capacity assessment or procedural safeguards, yet the FTT treated the mere fact of an Appointee being in place as sufficient protection. It saw no need to explore the claimant's capacity or to consider appointing a litigation friend.

The judgment exposes the structural gap at the heart of the regime: an Appointee may exercise complete control over a person's benefit income without being subject to the MCA's duties to support decision-making, apply a best-interests framework or undergo any routine scrutiny.

As *RH v SSWP* shows, even senior courts have limited tools to address these deficiencies. Without legislative reform, Appointeeship will continue to operate as a low-safeguard, high-impact intervention.

PRACTICE AND PROCEDURE

Short note: fact finding in the Court of Protection

In *Nottinghamshire County Council v SV & Anor* [2025] EWCOP 37 (T3), Lieven J has provided a helpful recap of the approach to the question of when it is necessary to carry out a fact finding hearing in the context of Court of Protection proceedings.

As she noted:

> *48. Finding of fact hearings are relatively rare in Court of Protection cases. The need for them was considered by Munby P in* ***Re AG [2015] EWCOP 78*** *at [29]-[31] where he confirmed that, unlike in care proceedings in relation to a child, there is no requirement to establish "threshold" in the case of proceedings in relation to an adult in the Court of Protection.*
>
> *49. Given that there is no threshold requirement in the MCA the question arose as to whether and when factual findings would be necessary. The former President expressly endorsed the pre-MCA 2005 decision of Wall J (as he then was) in* ***Re S (Adult's Lack of Capacity: Care and Residence) [2003] EWHC 1909 (Fam)*** *at [18] and [21] (emphasis added):*
>
> > *"18 … I agree that there must be good reason for local authority intervention in a case such as the present. Equally****, if there are disputed issues of fact which go to the question of Mr S's capacity and suitability to care for S, the court may need to resolve them if their resolution is necessary to the decision as to what is in S's best interests.*** *Findings of fact against Mr S on the two issues identified in para [16] would plainly reflect upon his capacity properly to care for S. But it does not follow, in my judgment, that the proceedings must be dismissed simply because the factual basis upon which the local authority instituted them turns out to be mistaken, or because it cannot be established on the balance of probabilities.* ***What matters (assuming always that mental incapacity is made out) is which outcome will be in S's best interests. There will plainly be cases which are very fact specific. There will be others in which the principal concern is the future, and the relative suitability of the plans which each party can put forward for both the short and long-term care of the mentally incapable adult.*** *The instant case, in my judgment, is one of the cases in the latter category.*
> >
> > *21 Whilst I acknowledge that in a relatively untried jurisdiction there are dangers in too relaxed an approach to historical issues, I am unable to accept the proposition that the approach to best interests is fettered in any way beyond that which applies to any judicial decision, namely that it has to be evidence based; that it excludes irrelevant material; and that it includes a consideration of all relevant material. In a field as complex as care for the mentally disabled, a high degree of pragmatism seems to me inevitable.* ***But in each case, it seems to me that the four essential building blocks are the same. First, is mental incapacity established? Secondly, is there a serious, justiciable issue relating to welfare? Thirdly, what is it? Fourthly, with the welfare of the incapable adult as the court's paramount consideration, what are the balance sheet factors which must be drawn up to decide which course of action is in his or her best interests?"***
> >
> > *In* ***An ICB v G & Ors [2024] EWCOP 13*** *Hayden J held at [22]-[23]:*
> >
> > *"Fact-finding hearings at Tier 3 in the Court of Protection are extremely rare. Junior Counsel in this case tell me that they are conducted more frequently at Tier 1 and 2, especially at Tier*

> *2. I have been surprised to hear that. I can see no obvious reason why this should be the case. For my part, I do not think that in this sphere of law, they have quite the same practical utility that they can have in the Family Court. In the Court of Protection, the range of welfare options for P is frequently very limited and unlikely to vary very much in response to a shifting factual matrix. In determining whether a fact-finding hearing should be convened,* ***Judges must consider, rigorously, what real purpose it is likely to serve i.e., from the perspective of informing decisions relating to P's welfare.*** *Such hearings are inevitably adversarial and invariably generate further hostility. This is inherently undesirable. Delay in reaching conclusions is inimical to P's best interests. In a very pressing and literal way, time is often not on P's side. Delay can only be justified if it is identifiably purposeful …* ***However, I am satisfied that the gravity of the allegations here and the nature of the family's responses has made such a hearing unavoidable. It has clear resonance for the central welfare issues i.e., as to where G will live and whether or to what extent it will be in her best interests further to promote her relationship with her family.*** *This disagreeable truth, I very much regret to say, must be confronted.*
>
> *As I have intimated above,* ***fact-finding hearings in the Court of Protection, as in the Family Court, require tight judicial control and an unswerving focus both on their scope and ambit as well as on purpose…" [emphasis added]***

50. Cobb J (as he then was) considered the need for fact finding hearings in CoP in ***LBX v TT [2014] EWCOP 24*** *at [44]-[51]. He referred to the overriding objective in the Court of Protection Rules to deal with cases justly, expeditiously and fairly [44] and the duty in rule 5 to actively manage cases, including considering the proportionality of the costs incurred. Cobb J then went on to apply the caselaw on fact finding in Children Act 1989 cases by analogy, see [46] to [51].*

51. I agree with Cobb J that the issues that a judge in the Court of Protection will have to consider in deciding whether to order a fact-finding hearing are similar, although not precisely the same, as those in the Family Court when deciding the same question.

52. In the context of Children Act 1989 cases there are some well established tests for whether a fact finding hearing should be directed, as set out by the Court of Appeal decision ***Re H-D-H (Children) [2021] 4 WLR 106****, which reiterated the principles espoused in* ***A County Council v DP [2005] 2 FLR 1031****, at [22] Peter Jackson LJ said;*

> *22. The factors identified in Oxfordshire should therefore be approached flexibly in the light of the overriding objective in order to do justice efficiently in the individual case. For example:*
>
> *(i) When considering the welfare of the child, the significance to the individual child of knowing the truth can be considered, as can the effect on the child's welfare of an allegation being investigated or not.*
>
> *(ii) The likely cost to public funds can extend to the expenditure of court resources and their diversion from other cases.*
>
> *(iii) The time that the investigation will take allows the court to take account of the nature of the evidence. For example, an incident that has been recorded electronically may be swifter to prove than one that relies on contested witness evidence or circumstantial argument.*

(iv) The evidential result may relate not only to the case before the court but also to other existing or likely future cases in which a finding one way or the other is likely to be of importance. The public interest in the identification of perpetrators of child abuse can also be considered.

(v) The relevance of the potential result of the investigation to the future care plans for the child should be seen in the light of the s. 31(3B) obligation on the court to consider the impact of harm on the child and the way in which his or her resulting needs are to be met.

(vi) The impact of any fact finding process upon the other parties can also take account of the opportunity costs for the local authority, even if it is the party seeking the investigation, in terms of resources and professional time that might be devoted to other children.

(vii) The prospects of a fair trial may also encompass the advantages of a trial now over a trial at a possibly distant and unpredictable future date.

(viii) The justice of the case gives the court the opportunity to stand back and ensure that all matters relevant to the overriding objective have been taken into account. One such matter is whether the contested allegation may be investigated within criminal proceedings. Another is the extent of any gulf between the factual basis for the court's decision with or without a fact-finding hearing. The level of seriousness of the disputed allegation may inform this assessment. As I have said, the court must ask itself whether its process will do justice to the reality of the case.

23. These are not always easy decisions, and the factors typically do not all point the same way: most decisions will have their downsides. However, the court should be able to make its ruling quite concisely by referring to the main factors that bear on the individual case and identifying where the balance falls and why. The reasoned case management choice of a judge who approaches the law correctly and takes all relevant factors into account will be upheld on appeal unless it has been shown that something has gone badly wrong with the balancing exercise.

*53. It is also relevant to consider the tests set out by the Court of Appeal for holding fact finding hearings in private Family Law cases in **K v K [2022] EWCA Civ 468** at [66]:*

"At the risk of repeating what has been said at [37] in Re H-N and at [41] above, the main things that the court should consider in deciding whether to order a fact-finding hearing are: (a) the nature of the allegations and the extent to which those allegations are likely to be relevant to the making of the child arrangements order, (b) that the purpose of fact-finding is to allow assessment of the risk to the child and the impact of any abuse on the child, (c) whether fact-finding is necessary or whether other evidence suffices, and (d) whether fact-finding is proportionate."

54. In my view the overall approach to whether or not to hold a fact finding hearing is analogous between Children Act cases and Court of Protection cases.

Summarising her conclusions, Lieven J directed herself that:

55. The facts which are sought to be found must have a direct impact on the welfare decisions that need to be made in respect of P. The fact finding must be "necessary" for the determination

of those welfare decisions. The fact finding exercise must be proportionate to the issues that need to be determined. In determining proportionality, the likely cost to public funds, the time taken and the impact of delay on P are all relevant considerations.

Applying that approach to the complex factual matrix before her, in proceedings which had become extremely protracted, Lieven J had little hesitation in concluding that there was no need to hold a fact finding hearing in circumstances where:

56. On the issues in this case, as they now stand, it is neither necessary nor proportionate for a fact finding exercise to take place. There are two matters for determination about SV's best interests under the MCA 2005 – where should SV live, the care and support he receives and what contact should he have with MB [his husband]*. It is also important to have closely in mind that SV and MB are married and, therefore, any order that requires them not to live together or limits/prevents their contact, is an interference in their Article 8 ECHR rights (the right to family life). However, Article 8 is a balanced right, and an interference can be justified under Article 8(2).*

57. Critically here, SV has made it entirely clear that his wish is to remain living at Option 4. In the light of those clearly expressed and consistent wishes it is inconceivable, quite apart from the safeguarding issues, that any Court would order him to leave Option 4 and live with MB. Albeit extremely late in the day, MB now accepts that there is not going to be an order of the Court of Protection that SV live with or be cared for by him. Therefore, no fact finding exercise is necessary for the determination of that issue.

58. In respect of contact, again, the answer lies to a considerable extent in SV's wishes and feelings. In principle, the Court could order that a married couple, where one party lacks capacity, cannot have contact with each other. However, that would be a highly intrusive order where the Court would have to consider justification very carefully. If contact can be managed safely, so that SV's physical, psychological and emotional well-being can be protected, and SV wishes for some contact, then in my view the correct approach is to seek to facilitate such safe contact.

59. Albeit in quite a limited and very cautious way SV appears to want to at least try some contact with MB. He spoke to me about some form of "remote" contact first, and then maybe seeing MB once or twice per month. So long as this can be facilitated in a way that gives SV the time and space to process the experience and then be in a position to express his wishes and feelings, in my view it is in his best interests to test out some limited contact.

60. The parties have now agreed a Contact Plan that leads from some indirect contact, in the form of either cards or letters or voice notes, to trialling supervised contact if it appears that is what SV wishes. If this all goes well and after being given time SV wishes to continue with contact, then there can be a gradual build up of contact. The Contact Plan includes clear expectations upon MB about his behaviour both to SV, but also to the professionals who work with SV and who will supervise contact. There are also a number of topics which MB has agreed not to discuss with SV, such as where SV lives and the ownership of some jewellery which seems to be disputed.

61. It may be that the Contact Plan fails and either SV makes clear that he does not wish to continue, or MB finds it impossible to manage his behaviour during the implementation of the Plan. However, given that SV and MB are married, and SV's apparent wishes, a failure to at least try to re-establish contact would not be justifiable under Article 8(2).

62. In determining that no fact finding hearing was necessary here I have taken into account; (1) SV's recently expressed apparent wish to have some contact with MB; (2) the fact that such contact can be managed safely and in a way that fully protects SV through the Contact Plan; (3) that a fact finding hearing would take two more days of the very limited time available for Court of Protection hearings at Tier 2 level; (4) the disproportionate cost in public funds given the very limited issues that actually needed to be determined and the fact that all the lawyers in the case are paid in some way by public funds.

63. Therefore, I will order that SV continue to live and receive care and support at Option 4 and that contact with MB is progressed in accordance with the Contact Plan.

Comment

This is a characteristically no-nonsense decision from Lieven J, and a helpful summary of the case law. It may be time for a Practice Direction to crystallise the case law into clear guidance which does not require local authority (and other) lawyers to ferret about on Bailii or the Court of Protection Handbook (other textbooks are available) to work out the approach to take. That Practice Direction could also (optimistically) seek to provide guidance about what to do when a fact finding hearing *is* required as regards moving to what is a very different mode of preparation and analysis to that which is required in other types of hearings before the Court of Protection.

In the meantime, and by way of example of a fact-finding hearing (in a s.21A application) see *Denbighshire County Council v P* [2025] EWCOP 43, a case from September 2025 which has only recently appeared on Bailii. It is of note both as a relatively rare example of a reported s.21A application, and also because the 'facts' which needed to be found were predominantly facts about the qualities of P's mother, as opposed to facts about incidents that had (or had not) taken place.

Court User Group meeting minutes and 'Town Hall' webinars

The most recent Court of Protection User Group took place on 22 October 2025. We note the following points of interest regarding court operation and practice:

- 88% of Court of Protection work is administered through the central London hub, and 12% is administered through the regions.
- Digital applications currently have a 13-day acknowledgment of receipt timeframe. Paper applications are being acknowledged within the target of 5 days. Final property and affairs orders are issued on day 8 for paper applications and day 11 for digital.
- Baroness Levitt KC is now the minister with responsibility for the MCA.
- DHSC consultation on LPS due to launch early next year. The DHSC is looking to publish a revised code of practice, including developments in any case law, terminology, organisational structure changes. Responses from the consultation will also be used in the updated code and any updated LPS regulations. There is no firm date for the start of LPS. It has not yet been determined whether the new consultation will be on a new code of practice, or the same code of practice which was previously consulted on.

- COP9s to vacate hearings need to be filed in good time, and in accordance with the specific directions made. The Court does not have the resources to ensure that late applications are dealt with as immediately as applicants may wish if they leave it to the last minute.

- COPDOL11s:

  - There has been a 21% increase in the number of 'Maybe' orders being made in respect of COPDOL11 applications. It was noted by attendees that many of the 'Maybe' orders related to the court's declining to re-appoint a Rule 1.2 representative who had previously been used on the basis that the person was too closely involved in P's care. Senior Judge Hilder noted that listing a hearing would not be the default response to failure to identify a R1.2 representative. The approach of the court is to be mindful of the purpose of Rule 1.2 representation - to monitor implementation and raise concerns with the court. The person tasked with this responsibility needs to have sufficient objectivity, which is difficult if they are themselves responsible for implementing the measures which amount to deprivation of liberty. Where a family member is not appointed on that basis, it is not a criticism of that family member. Rather, it is recognition that they are already doing a difficult job. Sometimes, during the pandemic when outside contacts were severely limited, such family appointment was made as the only possible option but that is not the general approach now we have returned to more open times. Senior Judge Hilder emphasised that the court needs to be satisfied that a person proposed as Rule 1.2 will be able to carry out the functions of the role and referred users to the judgments of Charles J spelling this out. Wherever the applicant proposes an individual as R1.2 representative, it would help the court if explanation is provided as to why it is considered that this individual is suitable for the role.

  - Senior Judge Hilder confirmed that an additional, fourth clause has been included as standard in 'final' orders, requiring the Rule 1.2 rep to notify the court if the local authority does not make the review application in good time. The court does not have the IT ability to monitor and chase when review applications should be made. The express inclusion of the expectation is really intended to alert everyone involved in the case to the need for review. If a matter comes back to court (which may happen for a number of reasons) without a review application having been made as directed, the court will ask why and would be unlikely to re-appoint the same Rule 1.2 representative.

The Court of Protection also held two 'Town Hall' Webinars in September, one relating to welfare and one relating to property and affairs. In the welfare webinar, the court noted the following points of interest:

- At present the only welfare applications which may be filed digitally are s16 urgent/emergency applications, COPDLA and COPDOL11 applications. Non-urgent S16 applications and personal welfare deputyship applications must still be made on paper.

- Applications for welfare deputyship should clearly identify what decisions need to be made, and why a deputyship appointment is needed.

- Applications to vacate a hearing require the filing of a COP 9 application, draft order, and confirmation of consent from all parties. It helps the staff administer these applications if the e-

mails of consent are provided *with* the application and specify which party's consent is being given ('On behalf of the Second Respondent, I consent to …') The application should be made *within* any timescale set by previous directions. Late applications are likely to be ineffective. It should *not* be assumed that a hearing is vacated simply because an application for that has been made. Matters remain listed for hearing unless and until an order vacating the hearing is made. Applications to vacate may be refused.

- The attendance of the ALR at hearings is expected, and the appointment is a personal one. If the ALR cannot attend a hearing, they should inform the Court by filing a COP9 application, giving reasons and an explanation of how it is proposed that P will be represented at the hearing.

At the property and affairs webinar, the court noted the following points of interest:

- The court is gradually transitioning to digital processes. Property and affairs deputyship applications – both first appointment and replacement appointments - should be made digitally. At present, all other property and affairs applications should be made on paper. It is intended that new trustees applications will shortly become digital. Local authorities *can* obtain PBA numbers to make digital applications; lay applicants can pay by card.

- Where a local authority applies for the appointment of a panel deputy, as opposed to seeking its own appointment, the application should clearly explain *why*. If the local authority is already appointed as deputy, its authorisations stand until a new order is made. Where the conclusion of the application is that a panel deputy is appointed, a copy of the order should be issued by the court to *both* the appointed deputy and the applicant local authority.

- Terminating tenancies and selling properties:

    - Where the authority to enter into/terminate a tenancy is sought as part of a deputyship application, the application should include an explanation of why this is considered to be in the best interests of P. If the tenancy is currently P's home, the court is unlikely to include authority to terminate that tenancy. The wish to avoid having to make another application in the future does not allay concern to ensure that P's living arrangements are appropriately secured. If the application to enter into/terminate a tenancy is made as a free-standing application, evidence about P's living arrangements will be required – in particular if there is a deprivation of liberty and if so whether it is authorised.

    - Application for authority to sell a property may be included in a deputyship application or made as a free-standing application. Explanation should be given as to whether the property is or was P's primary home. The court will require information on P's current living arrangements - whether they involve deprivation of liberty, and if so whether it is authorised - to avoid shutting down welfare options. Delays in DoLS paperwork need not delay deputyship applications. The court may appoint a deputy but defer the decision as to authority to sell the property pending further evidence. The court is unlikely to grant *conditional* sale authority.

Short note – penal notices and contempt

Buzzard-Quashie v Chief Constable of Northamptonshire Police [2025] EWCA Civ 1397 is a frankly extraordinary case on the facts. It has nothing, per se, to do with capacity matters, but the Court of Appeal did make a number of important observation about the relevance of the presence or absence of a penal notices on an order in the context of contempt proceedings.

In considering whether it is possible to find a person in contempt of an order which does not have a penal notice, the Court of Appeal found that *"there are not two different tiers or classifications of court orders, namely those with a penal notice, and those without. If there were, this would mean that the former must be obeyed because the court would have powers regarding non-compliance, but it would lack those powers for the latter. If that were the case, compliance with the latter could potentially become of the 'nice but not essential' type*" (paragraph 84). Penal notices are standard for some kinds of orders, or may be used "*after a breach, or series of breaches, makes it necessary that such a notice is required*" (paragraph 85). The Court of Appeal agreed with dicta in *Serious Organised Crime Agency v Hymans and others* [2011] EWHC 3599 (QB) at paragraph 12 that "*the lack of penal notice was not fatal to the application to commit, as the respondent in the case clearly knew the consequences of the breach of the order, and it would not be in the interests of justice to allow him to escape those consequences simply because no penal notice had been endorsed on the face of the order*" (paragraph 86). The Court of Appeal was very clear on this point at paragraph 87).

> *'f someone can be committed to prison for contempt of court in respect of breach of an order without a penal notice – and it is clear that the court has a discretion to do this, admittedly used in rare circumstances – then it cannot logically be a bar to a finding of contempt for breach of an order if there were no penal notice attached. There is no such procedural or substantive bar. The penal notice is relevant to sanction, not to any finding of contempt being made.'*

However, the Court of Appeal found that the existence of a penal notice was relevant to committal proceedings, and notice of this will usually be necessary for a court to decide to imprison a person. However, at paragraph 90, the Court of Appeal found that "[i]*t is not a necessary prerequisite or condition precedent to imprisoning someone for contempt that there be a penal notice, and there may be some unusual cases where it is fair and just (**SOCA v Hyman** is an example) to imprison someone for breach of an order even in the absence of a penal notice."*

Specifically in relation to public bodies, the Court of Appeal observed that, given that there was an expectation that orders made against public bodies will be obeyed: "[a] *finding of contempt can be made against a Secretary of State, a minister or a Chief Constable if there has been a failure to obey an order of the court, and it is not necessary for there to have been a penal notice on such an order for such a finding to be made*" (paragraph 94).

Research corner: Mediation of medical treatment disputes: a therapeutic justice model end of project report

Jaime Lindsey, Gillian Francis and Margaret Doyle have published Mediation of medical treatment disputes: a therapeutic justice model end of project report. The project starts with the premise that one of the difficulties in studying mediation is its confidential nature, leading to difficulties in accessing mediations, and participants understanding its potential. The project considered medical

treatment disputes relating to both children and adults, and typically in cases where the person at the centre of the dispute was very unwell and not able to directly participate in the mediation. The work considered 'reported case law, theoretical analysis of therapeutic justice and best interests, and empirical research with mediation participants.' Borrowing from the summary:

The research found:

1) that mediation could be a therapeutic process where it was designed to be flexible, participatory, less adversarial, voluntary, collaborative and enhance participant communication and understanding and we suggest that mediation's use in health and care disputes should ensure these features are protected and promoted through mediation design;

2) that some participants were closed to mediation and resolution, cynical about mediation and mediators (sometimes family members who distrusted the mediator's independence of the HCPs), and felt process coercion to participate (usually paediatric HCPs who saw it as a requirement from the court), attitudes which could be seen as anti-therapeutic;

3) that mediation can cause delay in resolution, but that there was no evidence that mediation led to agreements that undermined the patient's best interests;

4) that religious views of the parties were not a barrier to mediation and that, rather, religious support in mediation can be beneficial for parties.

The report made a number of recommendations regarding health and care disputes:

- Increased Transparency Surrounding Mediated Disputes: The report recommends including a question on court applications as to whether mediation has been attempted, and the data be collated and published in Family Court Statistics. The report also recommends that judges record in published judgments when a case has been mediated.
- Publication of Anonymised Details of Mediated Cases: The report recommends that public bodies (specifically NHS Trusts, primary care organisations and local authorities) and mediation providers should consider publishing anonymised details of mediated cases they are involved in.
- Representation of the Child or Adult Subject: The report recommends that the adult or child who is the subject of the mediation should have their views represented at the mediation either through direct or indirect participation, with an obligation on the mediation ensure that the patient's wishes are represented at the mediation.
- Educational Materials and Information Sessions: The report recommends the development of educational materials regarding mediation which can be shared with potential participants in advance of mediation's use, and the MOJ implements a scheme for Mediation Information and Assessment Meetings (MIAM) for health and care disputes, similar to those provided in other areas of the family courts. However, this ought not be mandatory as it would undermine the benefits of the voluntariness of mediation.

- Guidance published about mediation's use in health and care disputes: The report recommends the development of best practice guidance on mediation for health and care disputes for adults and children.

Jaime and Gillian have also published an article in the Medical Law Review entitled Compromise, coercion, and delay: best interests decision-making in mediation of paediatric medical treatment disputes, available here.

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MENTAL HEALTH MATTERS

Mental Health Bill progress

The Mental Health Bill moves ever closer to passage, although we understand that it is likely that Royal Assent will not be until the start of next year. At the first stage of 'ping pong' (and drawing on Tim Spencer-Lane's extremely helpful summary), the Lords agreed to the removal of the following amendments: (1) the extension of police detentions powers to health and care professionals, (2) limits on renewing community treatment orders (CTOs), and (3) debriefing meetings with discharged patients by IMHAs.

On each of those issues, the Government agreed the following concessions:

(1) Police powers – the Government agreed to launch a consultation into emergency police powers. This will look at the powers available to different professionals in different situations and settings, in particular but not limited to sections 135 and 136 of the MHA 1983.[3]

(2) CTOs – the Government agreed to review the statutory CTO forms, make regulations to require that statutory Care and Treatment Plans specify any CTO conditions and their justifications and issue guidance on how responsible clinicians should respond to tribunal recommendations on CTO conditions

(3) Debriefing – the Government said it will use the Code to explain that the processes of care planning and supporting someone to make an Advance Choice Document should include the opportunity for the individual to reflect on past experiences.

The House of Lords also agreed to the Commons amendments on the following:

(1) Extending the remit of the Human Rights Act to cover private care providers delivering section 117 services and to informal psychiatric hospital patients.

(2) Further clarifying the duties on NHS bodies to make arrangements regarding Advance Choice Documents.

At the second stage of 'ping pong,' the Commons agreed to the Government's amendment, tabled in the Lords, to the nominated person appointment process for patients under 16 where the AMHP is tasked with selecting the nominated person. In effect, the amendment gives priority to those with parental responsibility.

Nearest Relative resources

[3] Note, as we have previously flagged, the HSSIB are also conducting an investigation into *Mental Health Crisis: Care of patients in emergency departments*, which we anticipate is very likely to flag up problems with the law as well as practice.

A very helpful new website has been launched providing resources for Nearest Relatives on their role and rights under the MHA 1983. The website launch took place online on Carers Rights Day 2025 (20th Nov) and was supported by the Carers Trust. The resources have been co-created with, and for, Nearest Relatives and the project has been funded by the UKRI. There is a blog on the website about the launch event, which includes a link to the launch recording on You Tube.

The resources include information about NR rights, how it fits with other roles they might have, the NR journey through the MHA 1983, and sources of further information, advice and support, including short films, downloadable tools and info leaflets.

The project team (lead by Professor Judy Laing) would welcome any feedback / comments (via here) to help them to refine it and also to prepare for the new Nominated Person role in the Mental Health Bill.

Community Mental Health Services

The House of Commons Health and Social Care Committee have published a report on Community Mental Health Services, highlighting how:

> *Too many people with severe and enduring mental illness are continuing to fall through the gaps of our Community Mental Health Services. Many experience unacceptably long waits to access care, are discharged without ongoing support while they are still in recovery, and are denied care because they do not meet arbitrary thresholds. Too often, support is only available when people reach crisis point.*

Of no little interest is the following:

> *In June 2025, we visited Trieste, Northern Italy, to explore its internationally recognised model of community mental health care, which, as noted above, helped inspire the 24/7 Neighbourhood Mental Health Centre pilots. Trieste's system is built on principles of deinstitutionalisation, social inclusion, and integrated support across housing, employment, and health. The visit aimed to understand the structural, cultural, and political conditions that underpin the model, and to assess what lessons could inform the development of similar services in England.*
>
> *78. We heard that the Trieste model was not something that could be "bought and sold easily." It is deeply rooted in local culture, values, and history, particularly the legacy of the Basaglia reforms which closed psychiatric asylums and prioritised social inclusion. The model is built on principles of minimal coercion, and co-production, with services designed around individual life plans rather than clinical pathways, where services are designed around the needs of the whole community rather than segmented by specialism. As Dr Roberto Mezzina explained, "[I]t means going beyond the medical approach," working with "the person, their stories, their lives, their networks" to develop "their life plans."*[4]

[4] As an editorial point, and based on Alex's comparative law excursions, it is perhaps important to note that the model also exists in a legal system which appears to take a very different attitude towards deprivation of liberty to that in England & Wales. There may well therefore be many people who are in living in the community in Trieste who would be identified in England & Wales as confined, with the consequent necessity for legal authorisation. Whether this is a 'good' or 'bad' thing is an interesting question.

> *79. While the system offers impressive integration of health, housing, employment, and social support, it faces challenges including workforce shortages, data fragmentation, and political pressures that threaten its sustainability—challenges which have been experienced by CMHS in England. We noted that data infrastructure was limited: service-level data was not routinely published or shared, and outcome measurement relied heavily on individualised health budgets rather than system-wide indicators.*

The Committee strongly endorsed the model of 24/7 Mental Health Centres being piloted in East London, noting that:

> *Delivering real change and achieving parity of esteem in mental health care requires dismantling the current fragmented system and reimagining service design and delivery. The 24/7 Neighbourhood Mental Health Centre pilots seem to be genuinely transformative. The experience from Trieste, and early evidence from Barnsley Street, show that radically different, individualised, community-based care gets results. We also heard that the model shows possible cost savings for the wider system. Realising large-scale reform will depend on sustained and ringfenced investment to enable stretched Integrated Care Boards to take the action needed. This must be matched by a profound cultural shift across the system from clinicians to commissioners to government.*

This meant, in turn, that the Committee recommended that:

> *the 24/7 Neighbourhood Mental Health Centre pilot programme must be extended by at least 12 months beyond April 2026, with additional service development funding to allow all sites to become fully operational and generate sufficient data for analysis. This will require NHS England to finalise the outcome measures and evaluation metrics for the pilots without further delay.*

Independent review into mental health conditions, ADHD and autism

The terms of reference have been published for the Independent review into mental health conditions, ADHD and autism commissioned by the DHSC. As the relevant page notes, the review will seek to understand:

- the factors behind trends in prevalence
- the impact of clinical practice, including social and cultural factors and the risks and benefits of medicalisation
- ways to promote the prevention of mental ill health
- ways to create resilience and improve early intervention

Professor Peter Fonagy will chair the review, supported by Professor Sir Simon Wessely and Professor Gillian Baird as vice-chairs. There will also be a multidisciplinary advisory working group to directly shape the recommendations and scrutinise the evidence.

CHILDREN'S CAPACITY

Brain stem death testing and the courts: procedural fairness, and the definitive diagnosis of death

Re A (A Child) [2025] EWCA Civ 1504 (Court of Appeal (King, Moylan and Phillips LJJ) and *Barts Health NHS Trust v MC & Anr* [2025] EWHC 3140 (Fam) (Family Division (Hayden J))

Other proceedings – family (public law)

Summary[5]

The issue of brain stem death testing (or, more formally, diagnosing death by neurological criteria) is one that has been before the courts no less than three times in the last month. The first case, *Re DT*, concerning an adult, focused on the question of where such testing should take place, as opposed to whether. The second two cases arose out of the awful situation facing a family whose 12 year old daughter, LS, suffered an irreversible hypoxic ischaemic brain injury in consequence of asphyxiation. As Hayden J described it in the most recent judgment, *Barts Health NHS Trust v MC & Anr* [2025] EWHC 3140 (Fam):

> *5. On her admission to Hospital A, LS was "neuroprotected" for 72 hours, to prevent secondary brain injury. She was reviewed by the neurosurgeons at Hospital A and the Paediatric Neurosurgeons at Great Ormond Street Hospital. Both neurosurgical teams concluded that LS had suffered a profound brain injury for which surgery was not an option. On clinical examination, LS's pupils remained fixed and dilated, she displayed no cough or gag reflex, and there were no signs of spontaneous breathing. An aEEG (amplitude integrated Electroencephalogram) was performed on 30th October 2025, which revealed an absence of any electrical activity. An EEG performed on 31st October 2025 was reported to be featureless and "does not show any discernible cortical rhythm consistent with diffuse cerebral dysfunction as seen in HIE".*
>
> *6. In the light of LS's flat clinical presentation, the clinical team considered that brain stem testing was indicated to determine whether LS had died. This, I am satisfied, was explained to LS's parents both by Dr. H, Paediatric Intensive Care Consultant, and Dr. G, Adult Intensive Care Consultant, on 30th October 2025. The plan was to perform the tests on Monday, 3rd November 2025. To ensure that the brain stem testing could be optimally performed, this was delayed to 4th November 2025 to enable LS to recover sufficiently from a chest infection she had developed following her admission to Hospital A.*
>
> *7. In Guy's and St Thomas' NHS Foundation Trust v A & Ors [2022] EWHC 2250 (Fam), I encountered circumstances which raised real and important questions concerning the conditions necessary for the confirmation of death, most particularly in the context of babies under six months of age and those with open fontanelles. The Trust applied to the High Court for a declaration that A, who was two months of age, was dead. They also sought authorisation to withdraw his ventilation, ancillary care, and treatment. He had sustained a profound hypoxic ischaemic brain injury after a cardiac arrest that happened shortly after he was found limp in his cot with abnormal breathing. Brain stem tests had been conducted on four different dates, the last of which been performed by two doctors from a different Trust. Without exception,*

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

every test confirmed brain stem death. Over a week later, an experienced nurse on night duty discovered that the baby was beginning to breathe spontaneously.

8. I was told in that case that the Code of Practice for the diagnosis and confirmation of death was being considered and reviewed at a national and an international level. This has now resulted in the Code of Practice 2025, which has been rigorously complied with in this case. The first set of clinical tests were carried out by Dr. D, Locum Consultant in Paediatric Intensive Care and Dr. E, Paediatric Specialty Registrar (ST6), and the second set of tests were performed by Dr. D and Dr. F, Clinical Fellow in Paediatric Intensive Care, with Dr. B, Consultant in Paediatric Intensive Care observing the testing and updating the assessment documentation. Both sets of clinical tests confirmed the absence of brain stem function and death by neurological criteria was diagnosed and confirmed at 4.45pm on 4th November 2025. LS's parents were informed of the outcome of the tests and were informed of the conclusions.

Breaking off the narrative from Hayden J's judgment there, the parents did not agree to intensive care being withdrawn. Proceedings were brought by the Trust, on the basis that the case needed to be dealt with urgently. It was dealt by Judd J, in circumstances which gave rise to an appeal to the Court of Appeal on the basis that the proceedings had been so compressed as (in effect) to disable the parents from participating effectively in them. The Court of Appeal allowed the appeal,[6] agreeing that the proceedings had been procedurally unfair. It did not, however, accept that it had been necessary to join the child (identified at that point as 'R') as a party. Moylan LJ identified that:

38. […] *it is agreed that, in respect of the current proceedings which are made pursuant to the High Court's inherent jurisdiction, there is no rule which requires R to be joined as a party and that the court has a discretion whether to do so. The Family Procedure Rules 2010 apply to "family proceedings" which include "all causes and matters … relating to … (ii) the exercise of the inherent jurisdiction of the High Court in respect of minors": s. 61 of and para. 3(b)(ii) of Schedule 1 to the Senior Courts Act 1981 and s. 75(3)(b) of the Courts Act 2003. The provisions in Part 16 of the FPR 2010 deal with the representation of children. They set out "when the court will make a child a party in family proceedings". Rule 16.2(1) provides: "(1) The court may make a child a party to proceedings if it considers it is in the best interests of the child to do so." If the court does make a child a party then, pursuant to rule 16.4, the court "must appoint a children's guardian for a child who is the subject of proceedings". There are a number of other provisions in Part 16 and PD 16A which deal with when a child should be joined as a party, the appointment of a guardian and the powers and duties of guardians.*

39. In my view, the judge was entitled to decide that it was not necessary to join R as a party. As submitted by Ms Butler-Cole, the court was not engaged in a bests interest decision and there was no justification for joining R.

40. I do not accept Ms Dolan's submission that, as a matter of policy, a child should always be joined as a party and represented by a guardian when an application seeks a declaration of death. I agree with Ms Butler-Cole that it is difficult to see why, in accordance with the rules and more generally, it would be appropriate to join a child as a party and to appoint a guardian when the court is not engaged in a best interests decision as in the present case. Contrary to Ms Dolan's

[6] For some odd reason the judgment is available on the Judiciary website, but does not appear to be on Bailii / the National Archives.

submissions, it is not necessary for a child to be joined and for a guardian to be appointed for the court to be able properly and fairly to determine the application and for the relevant rights and interests to be fairly and properly addressed. If the court requires additional assistance then the right route would be to seek such assistance from Cafcass as an advocate to the court although now that parents are entitled to non-merits and non-means tested legal aid, the need for this would seem to be significantly diminished.

The case was then listed before Hayden J for directions. At that point, he endorsed the instruction of a further expert to comment on the following:

"1. The validity of brain stem testing which has already taken place. and in particular whether the requirements in paediatric cases were satisfied that two clinicians be nominated to review the evidence of brain death prior to testing, that these same clinicians satisfied the requirements for expertise laid out by the Code.

2. The potential for recovery if ventilation was to continue for a further 2-3 weeks (or longer period).

3. The likelihood that the administration of steroids to [LS] could have impacted on the result of the brain stem tests.

4. Whether [LS]'s CRP markers are likely to have impacted on the results of the brain stem testing.

5. Provide an explanation for the movements [LS] has been making, i.e. What is the reason for the movements, and are they inconsistent with the death by the neurological criteria? Why are the movements happening now, but were not happening prior to the brain stem tests? [ML] and [MC] have videos of this movement, which you may find helpful to view.

6. Provide an explanation for the activity [ML] and [MC] observed on the scans, as outlined above, and the possibility that this was evidence of brain stem activity.

7. Whether there has been any improvement in [LS]'s condition and whether there has been increasing somatic homeostatic stability, including the ability to thermoregulate. If so, does this show that the brain stem is functioning at least in part?"

As Hayden J continued:

25. The instructed expert was Dr. Simon Nadel, a Consultant in Paediatric Intensive Care and Visiting Professor in Paediatric Intensive Care Medicine at St. Mary's Hospital, London and Imperial College London. He arrived at the clear opinion that the brain stem testing carried out on 4th November 2025 was valid and demonstrated lack of brain stem reflexes, confirming brain stem death. Dr. Nadel had also been asked to consider movements in LS's fingers and limbs, observed by both the family and the treating clinicians. Dr. Nadel agreed with the view articulated by Dr. C, Consultant in Paediatric Neurology at the treating hospital, that the observed movements are non-purposeful, or "reflexive", as they have been called, and likely to be neuromuscular in origin. In his report dated 25th November 2025, Dr. Nadel stated the following, "a further full clinical evaluation of brain stem function may prove beneficial to reassure [LS]'s parents". He also went on to say that "if there continues to be doubt, I suggest to repeat the CT brain angiogram or carry out an MRI / MRA of the brain". It is necessary to state that extensive efforts have been made, with no fruition, to reassure LS's parents.

Ultimately, for reasons that I will turn to below, their objection is predicated on their religious beliefs, which in MC's case, are uncompromising. I hope she will not take that phrase as a criticism, in her evidence she expressed her faith as requiring strict compliance.

26. The medical opinion as to brain stem death is, therefore, unanimous. Dr. Nadel was clear that the further clinical evaluation he discussed was not necessary to diagnose brain stem death but only required for the purpose of providing some reassurance for the parents. LS died on 4th November 2025. It is now 27th November 2025, she has been dead for over three weeks. In that period, her organs have been artificially maintained by invasive intubation, ventilation and other medications. There cannot be further protraction of this parlous situation. To do so would be to fail to respect the young girl LS was. A girl whom, her mother told me, "brought energy in to the room". It also fails to recognise the continuing distress this has caused, in particular, to the nursing team.

27. Mr Lawson, on behalf of the parents, has invited me to encourage Hospital A to repeat the CT brain angiogram. I do not take up that invitation. I have concluded that LS died. I am, therefore, not exercising a "best interests" jurisdiction. Nonetheless, as Dr. B emphasised, "this is about dignity". Undertaking a CT angiogram where the 'patient' is intubated and ventilated is, for obvious reasons, not a straightforward matter. Though there are not the same attendant risks here, given that brain stem death has occurred, it is inconceivable, to my mind, that an angiogram could be undertaken, the sole purpose of which would be to reassure the parents. That would compromise LS's dignity in death. In any event, having heard MC in evidence, I do not consider the scan would reassure her at all. Moreover, it is, again, inconceivable that the treating clinicians should be required to undertake a process which both they and I would regard as unethical.

28. The parents explained their perspective in their statement in these terms:

> *"From our Islamic faith, even if someone is declared clinically dead, we believe that as long as the heart continues to beat, the soul remains attached to the body. In Islam, the soul is understood to be connected to the heart, not the brain, and therefore the heart and mind are regarded as separate matters. Accordingly, because [LS]'s heart was still beating, we firmly believed that her soul was still present and that she remained alive."*

29. In the witness box, MC reiterated this position. She also told me that she converted to Islam as a young woman. She had been brought up as a Protestant but told me that she had been very close to her Catholic grandmother, whose religion appears to have been a stronger influence upon her. MC told me that when she was younger, she considered other religions. She investigated Judaism, but felt it to be inaccessible to her, given the importance of the maternal line to Jewish identity. She also considered Buddhism, but that did not attract her. She discovered Islam, through colleagues at work, and told me of a point in her life when she was extremely low and how she was "rescued" by the Muslim faith. It was an experience that she described in transcendent, numinous and revelatory terms. Though she had been very controlled and measured in her evidence, it was only at this point that she became emotional and tearful. Her faith is manifestly important to her. She has studied the Quran and endeavoured to learn Arabic. She told me how important it was to her and to LS to have time to pray together. Her understanding of the medical evidence collides with the stronger pull of her faith.

30. MC told me that she had made enquiries with a hospital in another European country which might be able to accept and treat LS. She believed that their criteria for brain stem death were different from those in the UK. Ultimately, MC recognised that she had not been able to structure this into a choate plan to be considered by the Court.

Hayden J set out a crisp summary of the law:

31. As I have discussed above, death is a process, culminating in a diagnosis, thus, there is no statutory definition. The House of Lords in Airedale NHS Trust v Bland [1993] 1 AC 789 accepted the concept of brainstem death as legal death:

> *"In the eyes of the medical world and of the law a person is not clinically dead so long as the brain stem retains function." (per Lord Keith at para. 856C)*

32. Lord Goff expanded the point, at para. 863F-G:

> *"…as a result of developments in modern medical technology, doctors no longer associate death exclusively with breathing and heartbeat, and it has come to be accepted that death occurs when the brain, and in particular the brain stem, has been destroyed…"*

33. The legal position was confirmed by the Court of Appeal in Re M (Declaration of Death of Child) [2020] EWCA Civ 164 at para. 91:

> *"Firstly, as a matter of law, it is the case that brain stem death is established as the legal criteria in the United Kingdom by the House of Lords's decision in Bland. It is not, therefore, open to this court to contemplate a different test." (per Sir Andrew McFarlane (P))*

34. The President also emphasised, at para. 96, that once brain stem death has been diagnosed, the issue of best interests does not arise:

> *"Once a court is satisfied on the balance of probabilities that on the proper application of the 2008 Code (and where appropriate the 2015 Guidance), there has been brain stem death, there is no basis for a best interests analysis, nor is one appropriate. The court is not saying that it is in the best interest for the child to die but, rather that the child is already dead. The appropriate declaration is that the patient died at a particular time and on a particular date, without more."*

Ultimately, therefore, the answer was clear:

35. From the early stage of her admission to hospital, LS has shown no responses. The brain stem death tests have been thoroughly conducted and rigorously reviewed. I am left with no doubt, on this compelling evidence, that LS died on 4th November 2025 at 4.45pm and make Declarations to that effect.

36. As a postscript, I would wish the clinical team and the nurses to know that I am very much aware of the reality of what has been asked of them since 4th November 2025. I have been told and understand how ethically challenging this period has been. It is also clear to me, having listened to Dr. B, that they have provided sensitive, gentle care and with real compassion. They have

> *maintained LS's dignity, in death, in circumstances where it could easily have been lost. This requires to be recognised as a very considerable professional achievement.*

Comment

Hayden J took the opportunity to set out in some detail the new (2025) iteration of the AOMRC Code of Practice for the diagnosis and confirmation of death. He made a specific point of highlighting the Lay Summary, noting that:

> *12.* [it] *is, to my mind, an accessible document expressed in plain and sensitive language which does not compromise its intellectual rigour. It strikes me that, if it is not already the practice, parents or family members in these and similarly challenging circumstances should be made aware of it and directed to it by a member of the clinical team* […]. *It is perhaps the ubiquitous experience of lay people meeting with doctors that the questions they most want to ask occur to them only after the meetings have concluded when they have had a chance to absorb what they have been told. This lay summary of the Code of Practice anticipates many of the questions likely to be asked.*

More generally, it was helpful of the Court of Appeal to confirm that, in cases where a declaration of death is sought, since the issue before the court is not one of best interests, the child does not need to be joined. The same logic must also apply to adults; it is to be hoped that the Official Solicitor would accept an invitation to act as advocate to the court in the circumstances envisaged by the Court of Appeal at paragraph 40 of the judgment. The Court of Appeal focused, however, very narrowly on the procedural requirements **if** the application is brought. It was notably reticent, however, as to **why** cases need to come to court where the tests have been carried out according to the AOMRC guidelines. That is an issue which may need to be addressed in due course.

Secure Children's Homes – guidance for young children

The Department of Education has published guidance entitled *Secure children's homes: how to place a child aged under 13*. This sets out the criteria for placing a child in a secure children's home (SCH) on welfare grounds, as well as the process that needs to be followed. In short, a local authority needs to get approval from the Secretary of State for Education to be able to place a child aged under 13 in a SCH. The guidance provides a step by step guide for seeking the Secretary of State's approval, including out of hours. Importantly, this Guidance specifies that a young person cannot be placed in secure accommodation without a court order for more than an aggregate of 72 hours in any period of 28 consecutive days. A local authority can however circumvent the need to go through the process of obtaining the Secretary of State's approval and then going to court, by simply making an application to the High Court.

Deprivation of liberty and complex situations

In a recent 'in conversation with,' Alex talks to Dr Susannah Bowyer, Deputy Director at Research in Practice, about the recent research paper published by Research in Practice and the National Children's Bureau (commissioned by DfE) entitled (snappily) *Improving the outcomes of looked-after children and young people in complex situations with multiple needs, at risk or subject to a Deprivation of Liberty*. Spoiler alert, they do not spend a great deal of time on the technicalities of deprivation of liberty,

but instead think about the 'upstream' issues (they do, though, flag chapter 5 of the paper – the case-law briefing) written by Camilla Parker KC (Hon)).

THE WIDER CONTEXT

Safeguarding adults data

The Safeguarding Adults Collection ("SAC"), a data collection from local authorities across England, was published on 27 November 2025, showing a five year high in reported concerns and s.42[7] enquiries.

The data is collected directly from councils' adult social services departments which, under the Care Act 2014, have a duty to safeguard vulnerable adults from abuse or neglect.

Data collected from 2024 to 2025 records 640,240 concerns of abuse raised – a 4% rise from last year albeit at a lower growth rate from 2023 to 2024.

This included 185,270 s.42 enquiries, most commonly involving risks of neglect and omission, 51.9% of which were focused on risk in the vulnerable person's own home.

Suicide prevention and assisted dying

The International Association of Suicide Prevention published on 1 December a position statement on assisted dying / assisted suicide and euthanasia. It is available here; we reproduce below the accompanying statement on its website.

> *The International Association for Suicide Prevention (IASP) has released a Position Statement on Assisted Suicide and Euthanasia, reflecting growing global developments in legislation, policy, and public debate related to medically assisted dying. The statement provides an evidence-informed perspective on how assisted suicide and euthanasia intersect with suicide, suicidal behaviour, and broader suicide prevention efforts. It outlines the organisation's key concerns, expectations, and recommendations for jurisdictions considering, expanding, or regulating these practices.*
>
> *IASP notes that an increasing number of countries and jurisdictions are introducing or revising laws related to assisted suicide and euthanasia, sometimes referred to as "medical assistance in dying" or similar terms. As these practices evolve, the association highlights the significant potential for overlap between assisted dying and what is traditionally understood as suicide, especially when these practices are offered to individuals with chronic conditions who are not at the end of life. Evidence shows that situations that appear irremediable can often change, and that premature deaths can be prevented through effective support, treatment and follow-up.*
>
> *The position statement sets out several core expectations. IASP calls on jurisdictions to engage suicide prevention expertise when considering legislation or policy expansion in this area. It emphasises that adequate psychosocial, mental health, material, and palliative supports must be in place and should always be offered systematically. The statement reinforces that death must not be positioned as a substitute for insufficient care or a lack of accessible services.*

[7] S.42 Care Act 2014 places a duty on local authorities to make enquiries to investigate any risk of abuse or neglect of adults in its area with care and support needs.

> *The Statement also outlines expectations for professionals and systems across suicide prevention, end-of-life care, and health services. This includes the need for training in suicide risk assessment and intervention for those involved in assisted dying decision-making, and reciprocal training for suicide prevention professionals working with individuals with severe, chronic, or terminal illnesses.*
>
> *Finally, IASP calls for further research on the relationship between suicide and assisted dying, and raises concern about the lack of reliable evidence to determine long-term prognosis for individuals whose suffering is solely related to mental illness. Based on current evidence, the association concludes that access to assisted dying should not be extended to this group.*

Of particular relevance for Parliamentary bodies in England / Wales and Scotland considering private members' Bills at present might be thought to be these two parts from the IASP's full position statement:

> *Jurisdictions considering legalising and/or expanding the availability of assisted suicide and euthanasia should engage meaningfully with suicide prevention experts and/or organisations to carefully weigh concerns about overlap between what is being contemplated and what we usually consider to be suicide. Any such concerns should have a prominent impact on decision-making.*
>
> *Jurisdictions that legalise and regulate assisted suicide and euthanasia must ensure that other means to alleviate a person's physical and emotional suffering, including provision of better psychosocial and material supports, mental health services and palliative care, are systematically offered and provided. Death should never be a substitute for adequate care and support.*

(Alex has sought to give some thoughts about the interaction between suicide prevention and assisted dying / assisted suicide with a particular focus on the capacity question here).

Evaluation of Palliative care in England

The Health and Social Care Committee has published the evaluation of a panel of experts of the progress the Government made against its own commitments in relation to (1) commissioning of palliative and end of life care ('PEoLC'); (2) delivery of palliative and end of life care; (3) shifting to community; (4) workforce, education and skills; (5) inequalities and inequities. The Committee noted that "we felt this was an essential topic both in light of, and in spite of, the passage of the Terminally Ill Adults (Assisted Dying) Bill through Parliament."

The table of contents rather gives away that progress has been problematic.

> *Commissioning of palliative and end of life care*
>
> *1. Commissioning priorities amongst ICBs are variable, creating a 'postcode lottery' in the provision of palliative and end of life care services*
>
> *2. Most ICBs are not equipped to understand the PEoLC needs of their populations well enough to commission the right services*
>
> *3. Competing financial pressures for ICBs result in insufficient funds being allocated to palliative care*

4. There is a lack of a commissioning framework for social care

Delivery of palliative and end of life care

1. Palliative and end of life care services are under strain, across all settings

2. People struggle to navigate a complex and fragmented PEoLC system

3. PEoLC patients, service users and their families are too rarely given the opportunity to plan effectively for the future

4. Bereavement support is valuable, but frequently inaccessible

Shifting to community

1. Shifting PEoLC to community is challenging because of current funding approaches

2. The transition to community care is hindered by inadequate provision of social care and widespread workforce and skill shortages

3. Integrated care services contribute to the transition to community-based care.

Workforce, education and skills

1. The health and social care workforce is ill-equipped to meet the needs of people at the end of life because of the insufficient provision of education and training

2. The specialist palliative care workforce is in a "critical situation" and there are additional workforce shortages across the generalist workforce
3. Children and young people's palliative care services are negatively impacted by workforce shortage, including social care shortages

Inequalities and inequities

1. There are persisting structural and systemic drivers of inequity and inequality in palliative and end of life care

2. There are geographic inequalities in access and outcomes for PEoLC

3. Underserved and marginalised communities have significant unmet needs in PEoLC

Exploring capacity in cases of suspected exploitation of people with cognitive impairment

Drawing upon research into the intersection between cognitive impairment and exploitation funded by the Nuffield Foundation and undertaken by the University of Nottingham and the University of Birmingham between 2022 and 2025 (for the study, see here), a toolkit for practitioners has been produced. It both explores issues such as how cognitive impairment may connect with other factors to increase exploitation risks, and sets out a series of case study examples for use in reflection and training.

Facilitated communication – don't do it

Facilitated Communication is a technique that aims to help a person to communicate, through a 'facilitator' giving them physical support to point to letters, pictures, or objects on a keyboard or other device. It may be referred to by other names, such as 'Assisted Typing' or 'Supported Typing'.

Two key UK clinical guidelines[8] include recommendations that Facilitated Communication should **not** be used for supporting autistic people. The Royal College of Speech and Language Therapists has published a statement that:

> *Having considered the evidence, it is the position of the RCSLT that Facilitated Communication is a discredited technique that should not be used in any circumstance.*

Down Syndrome Act 2022 draft statutory guidance – consultation

This consultation seeks public feedback on the draft statutory guidance for the Down Syndrome Act 2022. Its primary purpose is to ensure that "relevant authorities" (such as NHS bodies, local authorities, and housing/education providers) clearly understand their legal duties and best practices for supporting people with Down syndrome. Its objective is to improve life outcomes for people with Down syndrome by consolidating existing requirements and setting out specific steps authorities should take to meet their needs.

The draft has been issued under Section 1 of the Down Syndrome Act 2022, and the consultation closes on **28 January 2026**. Once finalised, the relevant authorities will have a statutory duty to have "due regard" to it. The draft also states it should be used to support people with other genetic conditions or learning disabilities who have similar needs (e.g., Williams syndrome), effectively broadening the cohort for whom these standards are best practice. Below we focus on those aspects of the guidance most relevant to the Mental Capacity Act 2005.

A. Practicable Steps

The draft mandates that capacity assessments must be underpinned by specific communication support.

- Effective communication: Practitioners must identify and record a person's communication needs (referencing the Accessible Information Standard).
- Validity of Assessment: An assessment concluding a person lacks capacity may be deemed invalid if the practitioner cannot demonstrate they used appropriate tools (e.g., Easy Read, Makaton, visual aids) relevant to the specific learning profile of Down syndrome (which often favours visual over auditory processing).

[8] NICE Clinical Guideline CG142 Autism spectrum disorder in adults: diagnosis and management and SIGN Guideline 145 Assessment, diagnosis and interventions for autism spectrum disorders.

- Flagging: Requirements include clearly "flagging" communication needs in clinical notes to ensure locum or agency staff are aware of the support required for decision-making.

B. Best Interests

The draft guidance emphasises the statutory requirement to consult with those "interested in the person's welfare" (family/carers). It warns against making assumptions based on a general diagnosis rather than individual need. It also explicitly targets diagnostic overshadowing, so that when weighing medical treatments or care options, the diagnosis of Down syndrome (or learning disability) must not be used as a proxy for "poor quality of life" in best interests analyses.

C. Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)

The guidance makes clear that "Down syndrome" or "learning disability" must never be listed as a reason for a DNACPR decision. Every person has individual needs and preferences that must be taken account of, and everyone should always receive a good standard and quality of care.

D. Advocacy and Representation

The guidance reiterates the duty to refer for independent advocacy (IMCA/Care Act Advocate) where the person lacks capacity or has "substantial difficulty" involving themselves in the process, and lacks an appropriate family member to support them. It highlights the necessity of advocacy during safeguarding enquiries, serious medical treatment decisions, and long-term accommodation moves.

E. Transition (16-25 Years)

The "Preparation for Adulthood" section requires practitioners to actively manage the legal shift at age 16. Practitioners must transition from "parental consent" models to supporting the young person's own decision-making authority, ensuring families understand the changing legal framework while remaining key consultees.

To respond to the consultation, click here.

Fine for care home company after failures resulted in resident's death

Care home operator HC-One Limited was fined £1.8 million after pleading guilty to health and safety breaches following the death of 96-year-old resident Elizabeth "Peggy" Campbell at Cradlehall Care Home in Inverness. The incident occurred on June 11, 2022, when she choked on her evening meal while eating alone in her room.

Key Failures

- Lack of Supervision: Ms Campbell was on a specialist diet (soft, bite-sized food) and her care plan explicitly stated she required close supervision while eating. However, she was left unattended for up to 20 minutes while eating macaroni and chips.

- Staffing Issues: The unit was staffed by two agency carers who were responsible for 12 residents. The investigation found that the company failed to ensure these agency workers had access to or were familiar with the residents' care plans.
- Delayed Response: One carer left to get a drink but was diverted by urgent issues with other residents, leaving Ms. Campbell alone when she choked.

Following the HSE investigation, the company introduced a skills mix policy to ensure agency staff are always paired with regular employees who are familiar with the residents' specific needs.

Research corner: capacity training in care homes

As part of an NIHR-funded project seeking to improve capacity assessment in care homes, the project team have published an initial scoping review in BMC Geriatrics: Nina Jacob et al, *What is known about the design, delivery and implementation of mental capacity training in care homes?*. The results highlighted two key factors:

Firstly, a standardised one-size-fits-all approach to mental capacity legislation training fails to take account of the diverse needs of both care home residents and staff. Secondly, understanding the relationships between these domains can help overcome barriers and enhance facilitators, leading to more effective training outcomes. The review highlights a knowledge gap, with limited research considering the design and delivery of mental capacity related training. This limits the development of consistent and effective training across the sector. Future research should consider issues of diversity among care home staff or residents, to ensure the appropriateness and applicability of training for all those who receive it.

Capacity and marriage - the changes brought about in Ireland by the Assisted Decision-Making (Capacity) Act 2015

In the Matter of AB [2025] IECC 7 is an extremely interesting decision from the Circuit Court in Ireland. It concerns the capacity of the man in question (the 'relevant person' using the language of the Assisted Decision-Making (Capacity) Act 2015) to marry. AB was in his forties and had an an intellectual disability. He had resided in a residential centre for a number of years, following the death of his parents. Upon discharge from wardship under the 2015 Act, he had been determined by the High Court to lack capacity (even with a co-decision-maker) to make decisions about welfare, or about a number of specific areas in relation to the management of his property and affairs; a solicitor had been appointed as Decision-Making Representative (crudely, in English terms, a deputy) for those property and affairs matters.

AB's intended spouse, CD, (the 'notice party' using the language of the 2015 Act), also an adult with an intellectual disability, was his long-term partner. AB and CD had been in a committed relationship for approximately 20 years. Their relationship was described by all who know them as one of genuine love, mutual support, and enduring commitment. They had participated in a celebration of their relationship and had consistently expressed a wish to marry. CD lived independently with support, while the AD lived in a supported living environment.

Perhaps slightly surprising (from an English perspective) the application was not brought by the relevant statutory authorities (in Ireland, the Health Services Executive), but rather by the residential centre itself. The application was for a declaration that the man lacked capacity to consent to marry (even with a suitable person as a co-decision-maker), which would serve as an impediment to marriage under the relevant Irish legislation.

Also slightly surprisingly (again from an English perspective), the application was heard by the Circuit Court, rather than the High Court, but that was a function of the 2015 Act, which reserved applications of this kind to the Circuit Court. Undeterred by the novelty and significance of the case, HHJ Geoffrey Shannon SC rolled up his sleeves and got (in technical terms) entirely stuck into both what test he should apply, and whether the relevant experts before him had appropriately assessed the person's capacity.

As to the test, HHJ Geoffrey Shannon SC drew on a range of English cases, as well as pre-existing Irish case-law, and came to the following conclusions:

> *20.5 In light of the constitutional significance of marriage and the statutory framework under the 2015 Act, the Court proposes the following four-pronged test for assessing capacity to marry:*
>
> *1. Understand the Nature of Marriage*
>
> *The individual must grasp that marriage is a legally binding union that alters their civil status and creates a lifelong commitment between two people.*
>
> *2. Appreciate the Duties and Responsibilities*
>
> *The person must have a basic understanding that marriage entails mutual obligations, such as emotional support, companionship, and shared decision-making, even if they cannot articulate these in legal or financial terms.*
>
> *3. Recognise the Potential Consequences*
>
> *The individual must be aware, in general terms, that marriage may have legal and financial implications, including rights and responsibilities that arise upon separation or death. A rudimentary appreciation suffices.*
>
> *4. Give Full, Free, and Informed Consent*
>
> *The decision to marry must be made voluntarily, without coercion or undue influence, and with sufficient understanding of what the commitment entails.*
>
> *20.6 This test reflects a low threshold and is designed to safeguard autonomy while ensuring informed consent. It is functional, decision-specific, and time-specific, and must be applied with all practicable supports tailored to the individual's communication needs.*
>
> *20.7 This test does not require a sophisticated understanding of matrimonial law, nor does it permit exclusion based on intellectual disability alone. The threshold is intentionally low,*

> *reflecting the principle that the right to marry is a fundamental constitutional right and must not be restricted unless clearly justified.*

HHJ Geoffrey Shannon SC then set out in detail the provisions in relation to support within the 2015 Act:

> *21.1 The 2015 Act places a statutory obligation on all interveners to take all practicable steps to support a relevant person in making a decision before concluding that they lack capacity. Section 8(3) of the 2015 Act provides:*
>
> > *"A relevant person … shall not be considered as unable to make a decision in respect of the matter concerned unless all practicable steps have been taken, without success, to help him or her to do so."*
>
> *21.2 This principle is central to the rights-based framework introduced by the 2015 Act. It reflects a shift away from status-based incapacity and towards a functional, time-specific approach that prioritises autonomy and participation. The obligation to provide support is not discretionary; it is a precondition to any lawful finding of incapacity.*
>
> *21.3 Counsel for the Notice Party, Ms. Emma Slattery BL, referred the Court to the Decision Support Service Code of Practice for Supporting Decision-Making and Assessing Capacity (March 2023) (hereinafter "the Code"), which elaborates on the nature and scope of the supports required. Section 6.1.1 of the Code states:*
>
> > *"All information relevant to the decision must be provided to the relevant person at the beginning or prior to the assessment. The relevant person must be given all the relevant information and options so that their capacity to understand this information can be accurately assessed."*
>
> *21.4 This provision underscores the importance of timing and transparency in the assessment process. Information must be provided in advance or at the outset, not incrementally or reactively, so that the person has a fair opportunity to engage with the decision in a meaningful way.*
>
> *21.5 Section 3.1.1 of the Code further requires assessors to identify and respond to the specific challenges faced by the relevant person. It provides:*
>
> > *"Understanding the specific challenges for a relevant person will help you to provide them with more targeted support. You should consider what can be done to reduce or address challenges, for example, using memory prompts such as visual aids may help the relevant person to retain information."*
>
> *21.6 This guidance reflects the principle that supports must be tailored to the individual's communication needs and cognitive profile. Generic assessments are insufficient. The process must be iterative, educative, and responsive to the person's evolving understanding.*
>
> *21.7 Section 3.2.1 of the Code sets out the minimum standards for information provision during the assessment. It requires that assessors:*
>
> a) *Use examples relevant to the decision or tell a story to explain the decision;*
> b) *Present options and choices in a balanced way;*

c) *Set out the risks and benefits of each option;*
d) *Describe foreseeable consequences, including the consequence of making no decision.*

21.8 The Code also mandates neutrality in the presentation of information, ensuring that the relevant person is not unduly influenced or pressured in the decision-making process.

21.9 Taken together, these provisions establish a clear legal and procedural framework for supporting decision-making. The Court must be satisfied that these supports were not only considered but actively implemented before any finding of incapacity can be made. In the present case, the adequacy of the supports provided to the Relevant Person is a matter of central importance and is addressed further in the Court's findings.

Many might find what he then said of particular interest:

21.10 Role-play was a support which received scrutiny during the course of the evidence in this case. While not explicitly referenced in the Code, role-play is implied as a suitable support under several provisions. Section 3.1.1 of the Code encourages the use of targeted supports tailored to the relevant person's specific challenges in the decision-making process, such as a difficulty understanding or retaining information. Moreover, section 3.2.1 recommends the use of examples or storytelling to explain decisions, which aligns with the principles of role-play as an experiential learning tool. These provisions collectively support the use of role-play as a method to scaffold understanding, particularly where abstract concepts such as the legal implications of marriage may be difficult to grasp.

21.11 In the present case, Dr. EF acknowledged in her oral evidence that role-play could have been an appropriate form of educational scaffolding to support the Relevant Person's understanding of marriage. While not employed during the assessments, the Court notes that role-play remains a recognised and practicable support within the framework of the Code and should be considered where appropriate, particularly in cases involving complex or abstract decisions.

After making some observations about the weight to be placed on expert reports, chiming with the approach taken in the Court of Protection, HHJ Geoffrey Shannon SC turned to the evidence received. Of particular interest was the systemic challenge by Counsel for CD to the approach taken by the two experts before the court, one of whom (GH), had been instructed on behalf of AB, and had agreed with the other expert, EF, that AB lacked capacity to marry.

Drawing the threads together, HHJ Geoffrey Shannon SC concluded that:

32.14 The Court finds that these provisions [relating to support, set out above] *are not discretionary. They are essential to the lawful conduct of a capacity assessment and must be adhered to. An assessor may exercise professional discretion in conducting the assessment. That said, the assessor should have regard to the Code in the exercise of his/her discretion.*

32.15 The Court has considered the expert evidence with care. Both Dr. EF and Dr. GH concluded that the Relevant Person lacks capacity. The Court wishes to acknowledge the professionalism, diligence, and evident care with which both experts approached their assessments. The Court is particularly mindful that these assessments were undertaken under a new statutory framework, in the absence of judicial precedent or settled guidance on the threshold for the capacity to marry.

The task placed upon the experts was very onerous, and the Court recognises the complexity and sensitivity of the issues involved.

32.16 Notwithstanding the commendable efforts of both experts, the Court is not satisfied that the assessments complied with the statutory requirements under the 2015 Act and the Code. In particular, the Court was not satisfied that the assessments clearly identified the relevant information for the decision to marry at the beginning or prior to the assessment, nor did they demonstrate that all practicable steps were taken to support the Relevant Person in understanding that information. The assessments were static in nature and did not reflect an iterative or educative process. There is no indication that the Relevant Person was given repeated opportunities to learn about marriage, to receive information in varied formats, or to have his understanding tested over time.

32.17 Section 8(7) of the 2015 Act provides that the intervenor, in making an intervention in respect of a Relevant Person, shall:

> *"(a) permit, encourage and facilitate, in so far as is practicable, the relevant person to participate, or to improve his or her ability to participate, as fully as possible, in the intervention,*
>
> *(b) give effect, in so far as is practicable, to the past and present will and preferences of the relevant person, in so far as that will and those preferences are reasonably ascertainable."*

The Court finds that section 8(7) fundamentally underpins the essence of the 2015 Act.

32.18 Both Dr. EF and Dr. GH acknowledged the Relevant Person's longstanding relationship with the Notice Party and his clearly expressed wish to marry her. However, the Court notes a lack of evidence that any structured or sustained educational effort was undertaken prior to the assessments to support the Relevant Person in understanding the nature and implications of marriage. The assessments appear to have interpreted the Relevant Person's repeated expressions of love and desire to marry as indicative of limited comprehension, rather than as genuine manifestations of his will and preference.

32.19 In the absence of a preparatory process designed to scaffold understanding, such as iterative engagement, tailored communication supports, or contextualised explanations, the Court is not satisfied that the assessments adequately explored whether the Relevant Person's preference to marry was both authentic and enduring, or whether his understanding could have been enhanced through appropriate educational interventions.

32.20 The Court is mindful that the 2015 Act was enacted to give meaningful effect to the principles of autonomy, dignity, and equality for persons whose decision-making capacity may be in question. The 2015 Act is not merely procedural; it is purposive. It seeks to ensure that individuals are supported to make decisions for themselves wherever possible, and that their rights are respected even where support is required. To set the threshold for capacity to marry too high would be to render the spirit of the 2015 Act redundant. It would risk transforming a protective framework into a restrictive one, contrary to the legislative intent and the values underpinning the UNCRPD, to which Ireland is a party.

32.21 The Court finds that there is no direct or reliable evidence of coercion, manipulation, or undue influence. The Relevant Person's wish to marry the Notice Party appears to be genuine, enduring, and freely expressed.

32.22 The Court is satisfied that the presumption of capacity as set out in section 8(2) of the 2015 Act has not been rebutted. The making of a declaration to the contrary would constitute a disproportionate and unnecessary interference with the constitutional and human rights of both the Relevant Person and the Notice Party. The Court therefore declines to make the declaration sought under section 37(1)(b) of the 2015 Act.

33.Court Decision

33.1 This was a particularly difficult application. It is important to state that the Court was in no doubt that the motivation for the Applicant seeking the declaration under section 37(1)(b) of the 2015 Act was the best interests of Mr. AB. It is clear from the submissions and the evidence tendered to the Court that Mr. AB has received high quality care and support from the Applicant.

33.2 This application has required the Court to navigate the intersection of law, autonomy, and human dignity. The 2015 Act is not merely a procedural reform. It is a statement of values which affirms that individuals with cognitive impairments are entitled to support, respect and the presumption of capacity. Moreover, the 2015 Act requires that individuals with cognitive impairments have their voices heard and their rights upheld.

33.3 In matters as intimate and constitutionally protected as the right to marry, the Court must apply the law in a manner that safeguards against exclusion and affirms personal agency. The statutory framework is clear: capacity must be assessed functionally, supportively, and with fidelity to the individual's will and preferences. The law must protect, but it must also empower.

33.4 Having considered the evidence and the statutory provisions of the 2015 Act, the Court refuses to grant the declaration sought under section 37(1)(b) of the 2015 Act.

The concluding paragraph of the judgment was of note in terms of hinting that this might not be the end of the story:

The Court finds that the presumption of capacity under section 8(2) of the 2015 Act has not been rebutted. That presumption is a cornerstone of the statutory framework and cannot be displaced unless the evidence adduced demonstrates full compliance with section 8(3) of the 2015 Act, including that all practicable steps have been taken to support the Relevant Person in making the decision. The assessments relied upon in this application did not meet that threshold. The Court's determination is confined to the specific issue and time at which the application was made, and does not preclude the possibility of a future application. Accordingly, the Applicant has liberty to re-apply, should they wish to do so, on the basis of fresh evidence that satisfies the statutory obligations and procedural safeguards set out in the 2015 Act and the associated Code.

Comment

The body of caselaw under the 2015 Act is still relatively small (and, on one view depressingly, being matched by a body of caselaw being decided under the inherent jurisdiction which is picking up all the gaps in the 2015 Act now that wardship has been abolished – for a good example, see here). This is a

very interesting decision emphasising the extent to which the 2015 Act is intended to be more than a procedural reform but a statement of values. The observations in relation to support are particularly clear and strong.

We might offer three small observations. The first is that it was interesting that the English cases the court took into account did not include *Re DMM*, in which the Court of Protection (at Tier 2 level) fleshed out the issue of foreseeable financial consequences. As we noted in the comment on the case at the time, this is an issue which remains (in England) in need of appellate level consideration.

The second is that it is not entirely clear whether or not the court proceeded on the basis that the test was person-specific (i.e. capacity to marry this person, not capacity to marry in general). Counsel for CD submitted that it was person-specific (see paragraph 9.7); the summary of English law proceeded on the basis it was status-specific. The test proposed by the court appears to be status-specific; it makes interesting reading by comparison with the *EKK* case discussed in the Health, Welfare and Deprivation of Liberty section of this Report.

The third observation is in relation to the fourth limb of the test for capacity proposed by the court – i.e. that the person can give full, free and informed consent. Arguably, this is not part of the test for capacity, but rather what the test is intended to determine: i.e. that the person is able to give full, free and informed consent (and, parenthetically, it might be thought, understandably, also to require more than 'mere' capacity by requiring that the consent be free).

SCOTLAND

Inappropriate use of guardianship proceedings, but order questionable for other reasons

ABG applied to Perth Sheriff Court for appointment of herself as guardian to her husband AAG ("the adult"), with both welfare and financial powers, and appointment of the adult's second son EFG as substitute welfare and financial guardian. CDG, the adult's elder son, by Minute opposed the appointment of the applicant to be financial guardian, and sought appointment of himself. He did not oppose the appointment of the applicant as welfare guardian. The case was heard and decided by Sheriff Donald W Ferguson, whose judgment dated 13th August 2025 now appears on the scotcourts website as *ABG, Applicant v CDG, Minuter*, [2025] SC PER 83 (Court Reference PER-AW163-24).

The background to the Minuter's opposition emerged at proof. The judgment narrates that the applicant is the adult's third wife, who had been married to him for 28 years by the time of the hearing, when she was aged 75 and he was aged 90. Each had three children by previous marriages. The matrimonial home had been in their joint names. By Will in 2015 the adult left his one-half share in liferent to the applicant, and thereafter to his three sons (the judgment refers to the applicant having executed such a Will, but it is clear that it was the adult who did so). However, in 2020 he disponed his one-half share in the matrimonial home to the applicant. The sheriff appears to have penetrated to the heart of the matter at [9] of his judgment:

> *"Whilst understanding the minuter's frustration and annoyance (and this was to some extent echoed by EFG in evidence) at what had transpired with the disposition of the one half share of the matrimonial home, that is not really the issue. The primary issue is whether the applicant is a suitable person to be financial guardian as well as the welfare one."*

The sheriff then identified the contradiction in the Minuter's position:

> *"In evidence he said that 'we' (not clear) offered that there should be a codicil to reverse matters- 'and then the world is perfect'. It struck me that the minuter wanted things his way, ie, that a share of the house be left to him and his brothers and if that was done he would not have opposition to the applicant being the financial guardian. If one analyses that, it is a somewhat contradictory position because either a person is to be considered suitable or not within their own merits and that suitability should not be dependent on them doing something that you want them to do." [10]*

The sheriff granted the guardianship order as craved. One might quibble with the sheriff's apparent application of the same tests for suitability for both welfare and financial matters:

> *"If the applicant was thought to have probity, the ability, the competence and the trust of others to be a suitable welfare guardian, it seems somewhat strange that no longer applies when financial arrangements are considered." [3]*

That would appear to be a *non sequitur*: a satisfactory welfare guardian might lack suitable financial management skills, depending in part upon the nature of an adult's assets and affairs.

In other ways, however, apparent deficiencies in the judgment potentially give rise to significant concerns. Disappointingly, these are concerns that still seem to arise, and to merit comment, despite

the extent to which such concerns have been identified, analysed and discussed in other cases recently. There is nothing in the judgment to suggest that the sheriff proceeded in accordance with the mandatory provisions of section 1 of the Adults with Incapacity (Scotland) Act 2000. There are indications that he did not. For the purposes of the jurisdiction under the 2000 Act, a "best interests" approach, suitable for children but not for adults, was rejected in favour of the section 1 principles. Nevertheless, the sheriff wrote in his judgment that:

> *"I am satisfied that it is in the best interests of the adult that the applicant should be appointed both as welfare and financial guardian …" [12]*

Moreover, the first three welfare powers granted were in the following terms:

> *"(a) [to] decide what care and accommodation may be appropriate for the adult;*
>
> *"(b) [to] require the adult to reside in a particular residential establishment including a locked unit if necessary;*
>
> *"(c) [to] return the adult to such an establishment should the adult leave and to prevent removal without prior consent of the guardian;*
>
> *…"*

The adult was not present, nor represented, nor was a safeguarder appointed. The only consideration of the adult's "past and present wishes and feelings" appears to have been that when interviewed by the mental health officer:

> *"In broad terms he confirmed that he wished the adult to be his guardian"*.

The powers narrated above clearly amounted to blanket authorisation to deprive the adult of his liberty, but there appears to be nothing in the order to ensure compliance with Article 5 of the European Convention on Human Rights in relation to any deprivation of liberty in fact authorised by the guardian. On the contrary, the order was granted for 10 years without any provision for mandatory review of those powers (among other failures to comply with Article 5). There is no narration of "cause shown", in terms of section 58(4) of the Adults with Incapacity (Scotland) Act 2000, for exceeding three years in terms of that section. It is doubtful whether even as much as three years in any case of deprivation of liberty would comply with Article 5.

Adrian D Ward

(In brief) Grant of guardianship order appealed

In the October Report we expressed concerns, not entirely dissimilar to those in the immediately preceding item of this Report, regarding the decision at Edinburgh Sheriff Court in a contested application for a guardianship order by City of Edinburgh Council in respect of the adult "B", contested

by the adult's son "M". We understand that the decision in that case has been appealed. We shall endeavour to report the outcome of that appeal in due course.

Adrian D Ward

(In brief) AWI reform

The work of the Expert Working Group and of the Ministerial Oversight Group, established by Scottish Government towards submitting necessary legislative reforms to the Parliament, continues as outlined in recent Reports. The Expert Working Group is currently addressing the priority workstreams in relation to deprivation of liberty, and updating of the principles of the 2000 Act. We are pleased to report that we have been advised that following the scheduled December meeting of the Ministerial Oversight Group (due to take place after this December Report went to press), Tom Arthur MSP, the Minister for Social Care, Mental Well-Being and Sport, who personally chairs all meetings of the Ministerial Oversight Group, intends to offer a guest contribution for publication in the next future issue of the Report (likely to be in February 2026).

Adrian D Ward

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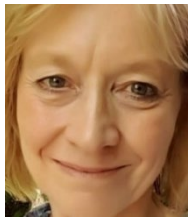

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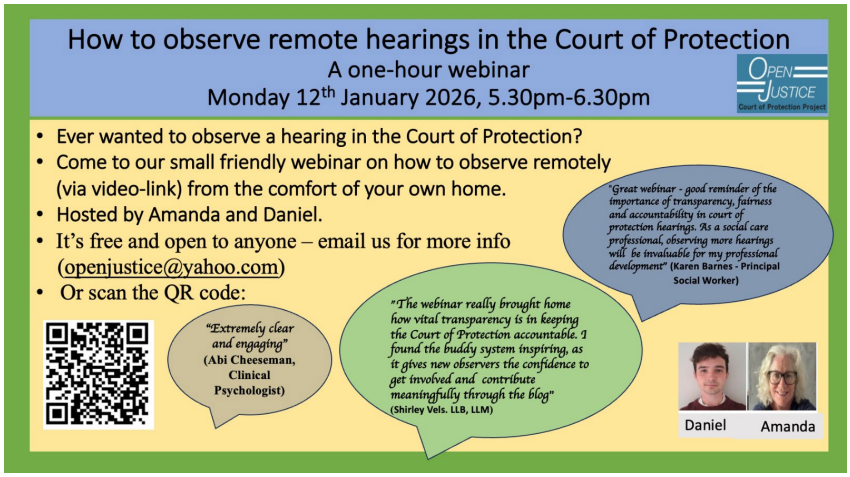
Conferences

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 February. 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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