HEALTH, WELFARE AND DEPRIVATION OF LIBERTY
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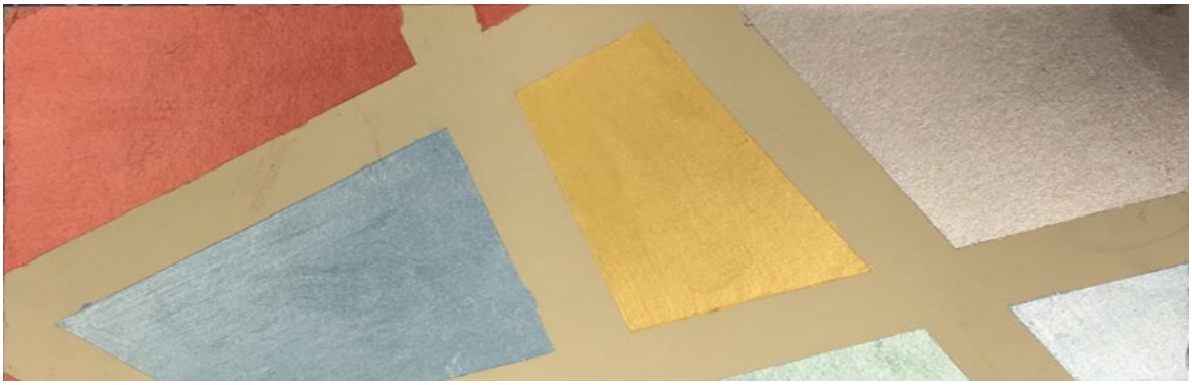

Welcome to the December 2025 Mental Capacity Report. Highlights this month include:

(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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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.*

The reference to 'finely balanced' was a reference to the guidance contained in *Applications Relating to Medical*

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

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.

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)

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.

[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.

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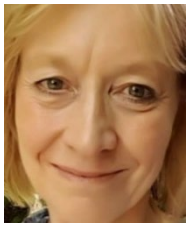

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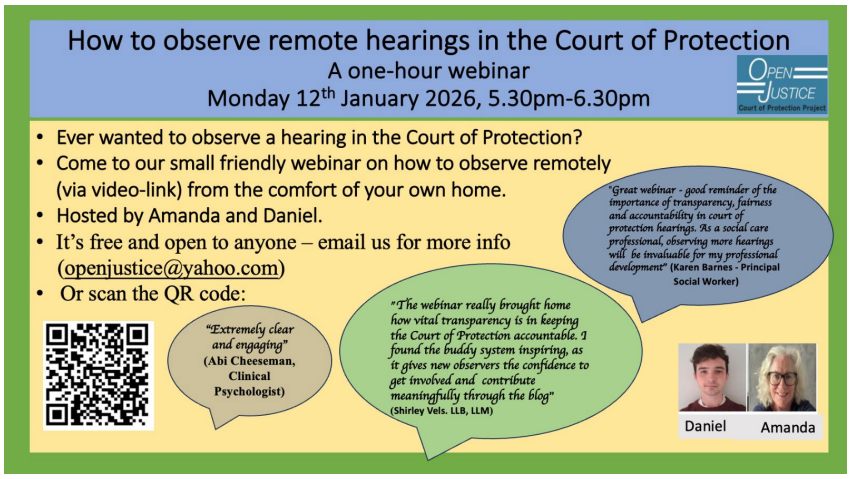
Conferences

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 January. 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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