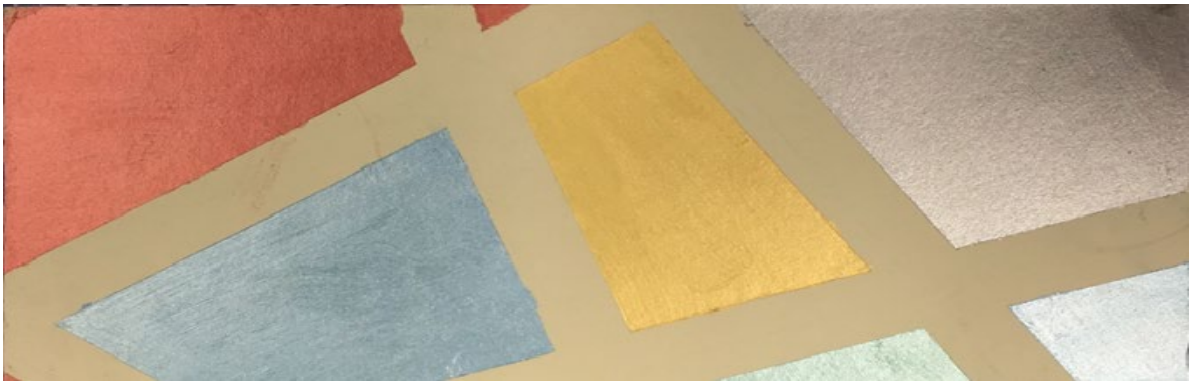

Welcome to the December 2025 Mental Capacity Report. Highlights this month include:

(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.

Contents

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[1] 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*

[1] 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.

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.

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[2] 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

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

Down syndrome (which often favours visual over auditory processing).

- 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).

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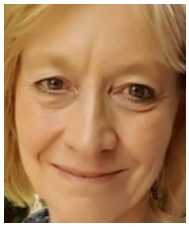
Adrian is a recognised national and international expert in adult incapacity law. He has been continuously involved in law reform processes. His books include the current standard Scottish texts on the subject. His awards include an MBE for services to the mentally handicapped in Scotland; honorary membership of the Law Society of Scotland; national awards for legal journalism, legal charitable work and legal scholarship; and the lifetime achievement award at the 2014 Scottish Legal Awards.



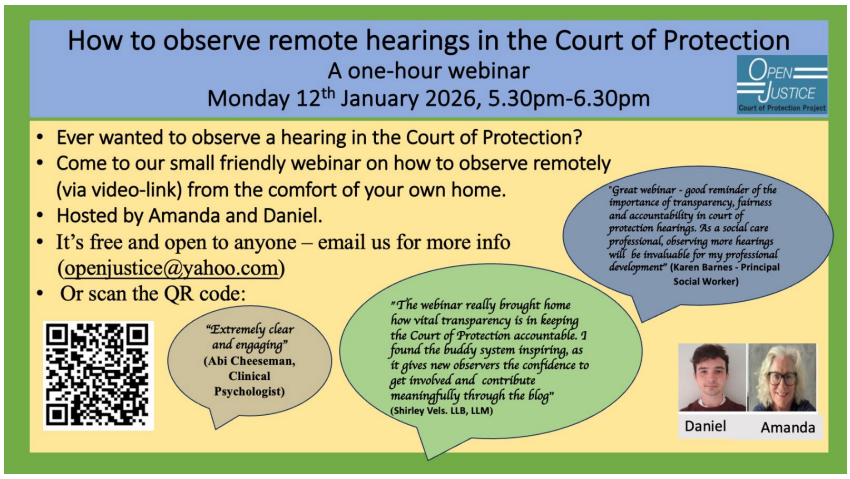
Jill Stavert: j.stavert@napier.ac.uk

Jill Stavert is Professor of Law, Director of the Centre for Mental Health and Capacity Law and Director of Research, The Business School, Edinburgh Napier University. Jill is also a member of the Law Society for Scotland's Mental Health and Disability Sub-Committee. She has undertaken work for the Mental Welfare Commission for Scotland (including its 2015 updated guidance on Deprivation of Liberty). To view full CV click here.

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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