Essex CHAMBERS

MENTAL CAPACITY REPORT: COMPENDIUM

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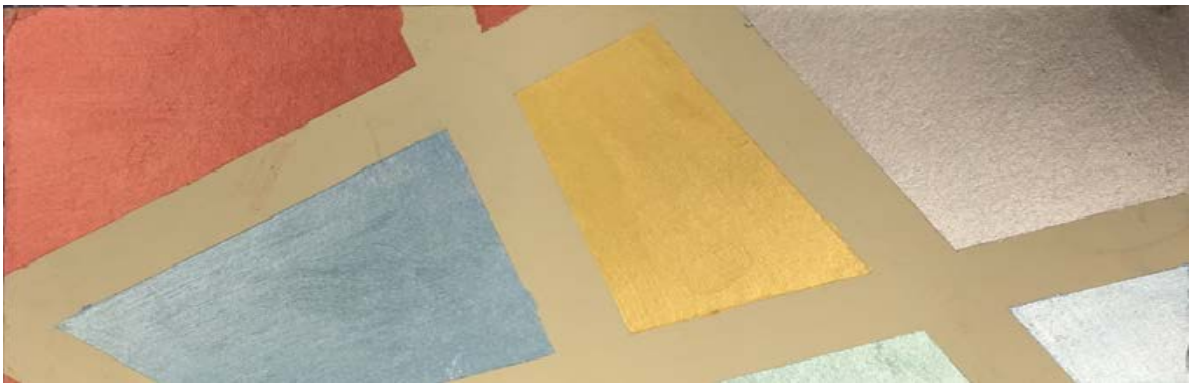

Welcome to the February 2026 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: two tributes following recent deaths of MCA champions, and best interests in the balance;

(2) In the Property and Affairs Report: *ACC* guidance from the OPG and guidance for regulated business on capacity issues;

(3) In the Practice and Procedure Report: personal welfare deputies revisited and facilitating access to pro bono representation;

(4) In the Mental Health Matters Report: the Mental Health Act 2025 and the Supreme Court considers illegality and insanity;

(5) In the Children's Capacity Report: looked after children and serious medical treatment and a consent confusion around DNACPR;

(6) The Wider Context: cannabis, criminality and capacity – a Jersey perspective.

(7) In the Scotland Report: a guest post from the Minister responsible for AWI reform and the Scottish perspective on treatment refusal by children.

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

Chambers have launched a new and zippy version of our website. But don't worry, all the content that you might need – our Reports, our case-law summaries, and our guidance notes – can still be found via here. We know (flatteringly) that many of our materials are embedded on websites; the old links should automatically redirect to the new page, but do please let us know if you encounter difficulties. This is also perhaps a useful opportunity to flag that it is always best to link to the webpage which houses a guidance note, rather than a PDF of the guidance note, as we update them regularly, and linking to the PDF may inadvertently trap you in a time warp.

Editors
Alex Ruck Keene KC (Hon)
Victoria Butler-Cole KC
Neil Allen
Nicola Kohn
Katie Scott
Arianna Kelly
Nyasha Weinberg

Scottish Contributors
Adrian Ward
Jill Stavert

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

Contents

HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

Sir James Munby

The sense of shock amongst lawyers and others concerned with the rights of children and those with impaired decision-making capacity at the announcement of the sudden death on New Year's Day of Sir James Munby is palpable. I share it. I was, the morning I learned of it, writing a book chapter directly inspired by a lecture that he gave, and could hear him with particular vividness (it was an unusual ability to be able to both boom and twinkle at the same time, something he had a particular habit of doing when catching my eye and telling me that I was flat wrong about something about which we both had strongly held but different views). Many others have written tributes (that of Sir Nicholas Mostyn is both particularly illuminating and particularly touching), and others will no doubt be forthcoming. I wanted to record my own gratitude for all that he did to support the Court of Protection (and, alongside that, those working around it, including by writing the foreword to the first edition of the Legal Action Group's Court of Protection Handbook).

Alex Ruck Keene

(The photograph is of Sir James on the outing he took to the Kent countryside to mark his retirement at President of the Family Division)

Rachel Griffiths MBE

We were very saddened to learn of the death of Rachel Griffiths before Christmas. She had been a driving force behind the implementation of the MCA from its outset, including in her roles as MCA lead for Oxfordshire County Council, then as CQC's mental capacity lead. As she said in an interview, rightly, "by appointing me in 2013 to help the organisation embed the MCA into its policies and practice, the CQC did send a clear signal that the MCA matters." She was awarded the MBE in 2017 for her the work, the year she also left CQC. In subsequent years – amongst other roles – she was a consultant for SCIE, and a membership of the National Mental Capacity Forum's leadership group. In part because she was a person who preferred to do, rather than to shout about doing, those who are newer to the world of capacity might not recognise her name. As Lorraine Currie – the former MCA / DoLS lead for Shropshire – put it in an email to me:

> *More recently she had time out due to unexpected illness which frustrated her. I hope she won't mind me quoting her directly, but when she returned to the National Mental Capacity Forum she (like all of us do in this situation felt a little out of things having been away this was her email to me (not in total)*
>
> *"so, I don't mind if I'm now an also-ran - though I prefer to think of myself as the old elephant who still knows where the watering holes and traps full of pointed sticks are…."*
>
> *We all need people with that kind of knowledge; Rachel had it in bucket loads and will be sorely missed.*

Her knowledge and her passion were also singled out by former SCIE colleagues Elaine Cass and Stephen Palmer; as Elaine put it, "she was always happy to explore and debate complex problems and to always stand up for people's rights." Alongside this was her kindness and sense of humour. As Stephen told me: "when she came into the office, it was always with a big smile." That smile was always in evidence, even though I saw it slightly pained on occasion when sitting alongside her in training or meetings where something was said by someone who profoundly did not 'get' the MCA. But Rachel's style was not to shout down, but rather to educate – above all by example.

We send our condolences to her family and friends; professionally, the world of the MCA is just that bit dimmer without Rachel's face beaming in on Zoom from in front of her bookshelves.

Alex Ruck Keene

Best interests in the balance

Royal Free NHS Foundation Trust v EF & Anor [2025] EWCOP 52 (T3) (McKendrick J)

Best interests – medical treatment – residence

Summary

In this case, McKendrick J granted an application by the applicant NHS Trust for EF to be removed from the lifelong care of his father, NN, and placed in a nearby supported living placement for the purposes of ensuring he received a sufficient level of dialysis and regular medication.

EF was a 44-year-old man with Down's Syndrome. He had kidney failure and required thrice weekly dialysis and medication to manage his phosphate levels. He had missed many sessions and had not stayed for the full required time at many more sessions, with the result that his dialysis was chronically inadequate, putting him at risk of sudden death or other complications, including difficulty breathing, heart and peripheral vascular problems, acute confusion, damage to bones and blood vessels, and painful, and/or uncomfortable skin conditions.

The three represented parties (NHS Trust, EF by the Official Solicitor, and the local authority with safeguarding responsibilities), agreed that EF lacked capacity to make decisions about his medical treatment, his residence and care. They all agreed that it was in EF's best interests to be conveyed to supported living for the purposes of receiving sufficient dialysis.

NN, EF's father, was EF's main carer and a litigant in person. He did not file a witness statement or attend the pre-trial review. He attended the final hearing and requested an adjournment, which was opposed by the three represented parties, but a short adjournment to the afternoon and following day was granted.

The court heard evidence that NN remained preoccupied with his bankruptcy and the death of his wife, EF's mother, and continued to believe that EF did not have any kidney damage and did not require dialysis. He had entrenched mistrust of professionals. He did not agree that EF had a kidney problem and insisted that he did not require dialysis. NN had considerable influence over EF's views. It was

unlikely that EF's understanding of his condition and need for treatment would be successful whilst he continued to be subject to his father's influence. EF did not want to undergo dialysis in hospital, or move or live away from his father. There would be risks to EF's mental health if he were to be accommodated away from NN and have his contact with his father limited. NN opposed EF leaving his care or their home.

In weighing up EF's best interests, McKendrick J pointed out that, absent the issue of dialysis and medication, the local authority with safeguarding responsibilities, would not have intervened to separate EF from his father. NN had provided his son with a home and a social life. Given EF's strongly held wishes and feelings, it was unlikely that a court would have separated EF from NN if the issues of treatment for the failed kidneys had not arisen.

However, in the end, McKendrick J accepted that EF's quality of life was seriously impaired because of the symptoms caused by insufficient and infrequent dialysis. He was also likely being negatively psychologically impacted by the ongoing conflict between professionals and his father, and these proceedings. Both the quality and length of EF's life strongly weighed the best interests balance towards separation from his father to ensure he received regular and sufficient dialysis and medication to keep him as healthy as possible.

Comment

This case is a good example of the overlap between the various "domains" when it comes to best interests. The issue of EF's care and residence, and contact with his father, clearly overlapped with the main issue to be determined, namely whether it was in EF's best interests to receive medical treatment. Although the issues presented to court are typically considered under common headings such as care, residence, and medical treatment, it is important not to treat these issues in "silos", and to have regard to the wider picture when considering P's best interests, which will be highly fact sensitive.

We would also take this opportunity to draw attention to the pro bono scheme recently launched by Advocate in conjunction with the Court of Protection Bar Association to assist litigants in the Court of Protection (see further the Practice and Procedure section in this Report). It is not clear from the judgment whether NN sought legal advice or representation at any stage. However, McKendrick J "*wondered whether he does have difficulties and whether he has capacity to conduct the litigation. I do not conclude he lacks litigation capacity but it is clear he is vulnerable and the presentation of his case was impaired by some strange perspectives*."

Jumping the procedural tracks on capacity

Re LM [2025] EWCOP 50 (T2) (HHJ Khan)

Capacity – assessing capacity

Summary

This was a s.21A application issued by the Accredited Legal Representative ('ALR') for a man identified as LM, challenging the standard authorisation in respect of LM's residence at a care home for people with acquired brain injury. A three day hearing was listed to determine the issue of LM's capacity to

make a variety of decisions. The evidence centered around the fact that the brain injury sustained by LM (in the words of HHJ Khan) "*gives rise to a frontal lobe paradox (FLP)*." As explained by HHJ Khan, this was the discrepancy between LM's ability to perform well on assessment and cognitive testing and his struggle to make decisions in every day life. This is often described as a person who can talk the talk but not walk the walk.

By the time the matter came before the court, the parties had agreed that LM lacked the capacity to make decisions about his care and support, and that he had capacity to make decisions about engaging in sexual relations. Following the conclusion of the evidence, the parties agreed that HHJ Khan did not need to decide whether LM had capacity to use the Internet and social media, or have contact with others. They also agreed that the mental capacity requirement in Schedule A1 to the MCA 2005 was met. Thus the only issues for determination were whether LM had capacity to conduct proceedings and to make decisions about his residence.

Oral evidence was heard from a case manager (TW), Dr Radcliffe as the jointly instructed expert and Dr L, a clinical psychologist employed by LM's placement. Both Dr L and Dr Radcliffe had concluded that LM had capacity to make decisions about his residence.

Notwithstanding the fact that the case had been brought under s.21A, HHJ Khan was persuaded that it was appropriate to make a s.15 declaration about LM's capacity to make decisions about his residence. He went on to reject Dr Radcliffe's and Dr L's evidence about LM's capacity and concluded that LM lacked the capacity to make decisions about his residence. He did so on the basis that the issues of care and accommodation could not realistically be separated and LM's inability to "*appreciate his need for intensive support directly affects his ability to make a meaningful decision about accommodation*."

Comment

The case serves as (yet another) reminder that there will be circumstances in which it is simply not possible to disentangle capacity to make decisions about care from capacity to make decisions about residence.

There are two further points of note. First, HHJ Khan expressed both surprise and disquiet regarding the trial timetable provided for one of the witnesses of fact to give evidence in chief – given that the issues that the local authority wished that witness to cover were known to the witness at the time the statement was made and had not arisen since the making of the statement. As HHJ Khan remarked, "*a party who serves an incomplete witness statement runs the risk of the other party being prejudiced by being taken by surprise by additional evidence being given in chief, with a consequence of the inevitable adjournment.*" Court of Protection judges are often prepared to give more latitude to a party wishing to adduce evidence in chief than in other courts, but it is important to bear in mind the risks of this approach as articulated by HHJ Khan.

Secondly, it appears that the parties did not seek a finding in respect of LM's capacity to make decisions about contact and social media and the internet on the basis that the assumption of capacity should remain in place, with staff being able to utilise the provisions of s.5 MCA 2005 if appropriate. It may be that the rationale for taking this approach (despite there being 'no doubt' that LM was vulnerable when

he accessed social media and the internet), was the difficulties that would ensue if steps were taken to restrict or remove LM's access to social media and the internet. This is in line with what may be seen as emerging as a new orthodoxy (or, perhaps, a reversion to what Parliament actually intended), namely that s.5 should be the first line of consideration in relation to acts of care and treatment. That does not mean, however, that judgment calls as to whether decisions about (for instance) contact are 'merely' unwise or incapacitous will necessarily be easy; above all, they will require sound ethical instincts.

Care planning in drift

London Borough of Lewisham v SL [2025] EWCOP 51 (T3) (Theis J)

Best interests – residence

Summary

This case concerned SL, a 30-year-old woman with complex needs who lived with her parents. By the time of the hearing, there was broad agreement between the parties that SL should remain living at home with her parents with the current comprehensive package of support. It was also agreed that there should be a pause of at least six months in assessing SL for, and introducing her to, alternative placements, given the level of distress that the process of moving placements had caused her to date.

Theis J heard oral evidence from GF, the allocated social worker, DL and TL, SL's parents, and Mr Caulfield, a jointly instructed independent social worker. The court was therefore presented with both professional and family evidence as to SL's needs, risks, and day-to-day lived experience.

SL developed epilepsy in 2010 and was diagnosed with atypical autism in 2011. She moved to a specialist autism school in 2012. In early 2023 she was diagnosed with sleep apnoea. SL's absconding behaviour began when she was 18 years old. She uses crack cocaine and, when she absconds, is exposed to very serious risks and harm. These risks have been a consistent feature throughout the proceedings and have significantly shaped care planning decisions.

In April 2024, the local authority formed the view that SL should move from her parents' home into a supported living placement, MC, a position that was supported at that time by the Official Solicitor. Between April and July 2024 a transition plan was proposed, involving a period of familiarisation with MC staff followed by respite stays at MC. In July 2024 the local authority applied for urgent authorisation for SL to be discharged from hospital to MC, but the placement did not proceed because MC withdrew its offer.

This level of instability continued for the next year – by the end of August 2025 the local authority had contacted 21 supported living providers, all of whom either declined to offer a placement or had no suitable vacancies.

At the time of the hearing there were no concrete alternative placements for the court to consider. In her evidence, GF acknowledged the need for a tailored respite solution that met SL's needs while providing meaningful relief to her parents. DL expressed concern that, as she and her husband get older, SL might in the longer term need to move to a residential care setting and that it would be beneficial for SL to become familiar with such environments gradually.

The local authority's search had focused on core and cluster supported living and residential placements. SL required ground-floor accommodation or accommodation with lift access because of the risk of falls associated with her seizures. Providers needed experience of supporting individuals with autism, learning disability, challenging behaviour, and epilepsy.

Although the local authority's initial position was that there should be no pause in assessing SL for and introducing her to new placements, following the oral evidence it accepted that a six-month pause was appropriate. GF stated that any future placement exploration would be undertaken in a staged and person-centred manner based on SL's assessed needs.

Theis J observed how the proceedings had been long-running and repeatedly disrupted by significant evidential developments between hearings, with the consequence that carefully constructed plans were repeatedly derailed. The evidence demonstrated the very serious risks SL faced when she absconded and the damaging consequences of those events. Those risks had repeatedly undermined attempts to arrange respite care or any transition away from the family home.

The evidential reality at the time of the hearing was that there was only one viable option: for SL to remain living at home with the existing comprehensive care package. Although the longer-term plan remained to explore alternative placements, the parties agreed – and Theis J endorsed the proposition – that there should be a six-month pause in assessing SL for and introducing her to new placements, allowing SL and her family a period of respite and stability and enabling SL to build on early signs of improved engagement.

Theis J noted an ongoing concern that SL appeared overly dependent on her family and that care planning needed to place greater emphasis on supporting her to develop independence and to engage with people closer to her own age. Despite the broad areas of agreement, Theis J identified an element of drift in the care planning.

While recognising the dynamic and difficult circumstances, Theis J made clear that, with the proceedings coming to an end and the care package relatively stable, there must be renewed and proactive planning by the local authority.

This included solution-focused work to support SL's engagement in community activities, a more creative and flexible approach to respite care, increased direct contact between the allocated social worker and SL and her family, clearer planning around the essential requirements for any future placement, and consideration of a more structured and informed decision-making framework, such as through a multidisciplinary team. The six-month pause was identified as an opportunity to establish this foundation. Theis J expressed concern that, without this foundational work, SL's current placement would remain fragile and vulnerable to emergency breakdown.

Comment

The case illustrates issues that are not uncommon in Court of Protection proceedings, including long-running disputes, changing evidential landscapes, limited placement availability, and unstructured decision-making. The guidance given by the court, particularly in relation to avoiding drift in care planning, provides a valuable framework for practitioners seeking to manage complex cases more

effectively and to ensure that best interests decision-making remains active, focused, and person-centred.

Short note – securing the 'true' wish of the person

In *King's College Hospital NHS Foundation Trust v LE* [2025] EWCOP 46 (T3), Theis J was concerned with LE, a 46 year old woman with a long standing diagnosis of schizophrenia and diabetes.[1] Theis J ultimately endorsed the amputation of "*all four fingers and part of the palm on LE's left hand, and most of her left thumb, the tips of the fingers on her right hand and parts of her toes on both feet due to dry gangrene. Then to carry out reconstruction surgery to both hands to cover exposed bone with tissue from other parts of her body. The plan is for this reconstruction to be done at the same time as the procedure for the amputations*." This draconian step was taken in the face of LE's objections, but in circumstances where LE had made clear that she did not wish to die. Theis J made a particular point of emphasising the fact of her meeting with LE, as "*extremely helpful. Wholly understandably she was scared and worried about what was being proposed. I was struck that she had some understanding of the court, that I would be making a decision and this was her opportunity to tell me what she wanted me to hear. I explained I would listen to what everyone said before I made any decision and she understood that*."

Short note: the end of the *ZX* saga?

Readers will remember the long-running proceedings concerning the very difficult question of whether a young man called ZX had capacity to decide to engage in sexual relations. Having most recently been in the Court of Appeal (*Re ZX (Capacity to Engage in Sexual Relations*) [2024] EWCA Civ 1462), the matter returned to Theis J for rehearing. Following the instruction of an independent clinical psychologist, Theis J made final declarations at hearing in June 2025, agreed by the parties,[2] pursuant to s.15 MCA 2005 that ZX lacked mental capacity to conduct these legal proceedings and to make decisions about (i) where to live; (ii) care and support; (iii) use of the internet and social media; (iv) managing his property and financial affairs; (v) entering/terminating a tenancy; and (vi) sharing personal information about himself, in particular, information about his parents, and details and information about proceedings. In relation to engaging in sexual relations, the court declared that ZX had the capacity to decide to engage in sexual relations.

Directions were made at the hearing on 17 June 2025 for further assessment in relation to ZX's capacity to decide about having contact with others. This was considered necessary due to the lack of clarity on this issue in Dr Williams' reports, ZX taking unusual risks with his own safety to meet people and in circumstances where ZX was due to commence a course later in the year which would provide further evidence regarding ZX's capacity as he interacted with others. The local authority wanted to explore ZX's ability to use and weigh the relevant information about his contact with others.

Unfortunately, ZX was not able to start the course as planned; a further addendum report was obtained from the psychologist, who gave oral evidence which led to agreement that it was open to the court to

[1] Note, Katie having been involved in the case, she has not contributed to this note.
[2] Agreed on behalf of ZK by his litigation friend the Official Solicitor. As ever, we confess to a degree of uneasiness at such agreement for the reasons set out a decade ago now in this article by Alex and Neil.

find that he lacked capacity to make decisions about contact.

In a relatively short judgment, Theis J rehearsed the reasons for endorsing that agreed position that ZX lacked that capacity. Of note, perhaps, is the way in which Theis J (gently but firmly) set out the problems with being too decision-specific in relation to contact in circumstances where the clinical psychologist had (our words) sliced the salami too finely without recognising that his specific deficits preventing him using and weighing the relevant information in the moment affected his decision-making ability in respect of all categories of those with whom he was likely to have contact.

PROPERTY AND AFFAIRS

Property and Affairs webinars

Members of the 39 Essex Chambers Court of Protection property and affairs team are doing a series of webinars on matters spanning the spectrum of issues that arise in this area. Previous and future webinars can be accessed via here.

ACC guidance from the Office of the Public Guardian

On 9 January 2026, Office of the Public Guardian (OPG) published a guidance note to "*set out the Public Guardian's position on the Re ACC judgment and the actions OPG expect deputies to take to ensure compliance*." The guidance note caveats that it is not legal advice, and it is largely a summary of the *ACC* judgment.

It summarises the judgment on the general authority of deputies "*encompassing the common or ordinary day to day tasks that are required to administer P's estate effectively. Deputies must consider when taking property and financial decisions on behalf of P whether the action in question falls within the scope of general authority or whether specific authorisation is required from the court. The deputy acts at their own personal risk if they act outside of their authority*." The guidance note sets out the text of the standard property and affairs deputyship order, and states the position of the OPG that "*the deputy has no authority to perform any of the above activities on behalf of P unless the relevant clause is included in the order*." The deputy "*may undertake ordinary non-contentious legal tasks that are ancillary to the authority conferred by the order including obtaining legal advice*," preparing a tax return, discharging P's responsibilities as a tenant, and applying P's funds to pay for care including employment contracts of directly employed carers.

However, "[s]*pecific authority from the court is required to carry out litigation on behalf of P unless the proposed litigation is in the Court of Protection in respect of a property and affairs issue or to seek direction in respect of a personal welfare issue*." The guidance note sets out the judgment's statement on what constitutes general authority and what requires specific authority. "*Specific authority will also be required to use P's funds to reimburse a third party instructed to act on behalf of P. This includes costs incurred by a member of P's family*."

Where a deputy wishes to instruct a member of their own firm for a work anticipated to cost more than £2,000 plus VAT, the deputy should obtain quotes from appropriate providers (including the deputy's firm) and use the provider whose services are in the best interests of P where reasonable and proportionate, or seek prior authorisation to use the deputy's own firm.

If P has capacity to give instructions around a piece of work and its costs, P may instruct the deputy or deputy's firm without further authorisation.

The guidance note states the following on the OPG's position:

OPG expects any decisions made by deputies in relation to Re ACC to be outlined in the annual report.

1. Existing deputies

The judgment makes clear that there is a continuing expectation that deputies will consider, in detail, the limits of their own authority and address any potential conflicts of interest. Authorisation is required from the court for all on-going and future work which falls outside the authority of the deputyship.

Deputies should obtain three quotes if they wish to instruct a member of their own team to carry out work on behalf of P. They must apply to the court for authorisation in any case where projected costs exceed £2,000 plus VAT. The deputy should make a proportionate decision in instances where obtaining three quotations would cost more than the proposed work. In such cases the deputy must provide details of their decision in the annual report. There may be some instances where it is not possible to obtain three quotations. In these cases, OPG will take a proportionate approach and consider whether to refer the matter to the court.
OPG does not envisage the need for deputies to make applications for retrospective authorisation in any cases completed prior to the release of the judgment, but this will be considered on a case per case basis to ensure P's best interests are being met.

OPG's position is that the positions set out in Re ACC and Others in relation to conflict of interest extend to any instance where a deputy is considering the procurement of services for P which may include provision from the deputy's own firm and hence constitute a potential conflict of interest.

The judgment states that in personal welfare matters, other agencies, such as local authorities and the NHS, who do not need court authorisation to carry out urgent work outside the scope of the deputyship may be better placed to act. OPG expects deputies to consider whether they can ask someone else to handle the personal welfare issue and refer the issue in question to those agencies.

2. Prospective deputies

Prospective deputies should consider whether there is a potential need to instruct someone else to provide advice or carry out legal tasks on behalf of P at the time they apply to be appointed. If their own firm provides the service and they wish to instruct them they should include a request for specific authority to do so, subject to a specified costs limit, with their initial application. The court will decide whether this is in P's best interests, the period of the authorisation, and the level of expenditure.

Where a prospective deputy has been granted authority to instruct someone else, but not specific authority to instruct their own firm, the deputy must obtain three separate quotations from appropriate providers, one of which can be from their own firm. The deputy should then make a best interests decision as to which provider best meets the needs of P, and if they still wish to instruct their own firm, the deputy should make an application to the court for specific authority if anticipated costs are in excess of £2,000 plus VAT.

Supporting customers who may not be able to make their own decisions

This guidance has been published by the Office of the Public Guardian (OPG) and the UK Regulators' Network (UKRN).

Purpose and scope: The guide helps staff in regulated markets (especially in financial services and utilities) understand how to support customers who may lack capacity to make decisions themselves. It covers how to work with legal arrangements such as Lasting Powers of Attorney (LPAs), Enduring

Powers of Attorney (EPAs), deputyship orders, and guardianship court orders, and explains their legal context under the Mental Capacity Act 2005.

The document offers helpful scenarios and links through to the MCA Code of Practice.

Key principles: Staff are not expected to assess a customer's capacity but should know how to recognise and process valid legal documents that authorise someone else (an attorney, deputy or guardian) to act on behalf of a customer. Organisations should update their records accordingly and treat attorneys or deputies as the customer's authorised representatives once documents are verified. Reports should be made to the OPG if there are concerns about the conduct of an attorney, deputy or guardian.

LPAs: The guide explains how to check whether an LPA is registered and valid, how to interpret its scope (e.g., property/financial or health/welfare decisions), and how attorneys should act within any instructions and conditions set by the donor.

EPAs: Although older than LPAs, EPAs still authorise decision-making for property/financial affairs; staff need to check registration and any restrictions.

Deputyship orders: Court orders appointing a deputy when someone has already lost capacity; the guide explains how to verify validity and what deputies are authorised to do.

Guardianship orders: Newly included in this edition, these are explained similarly with instructions on checking authority and documentation.

How attorneys and deputies must act: Attorneys and deputies must support the person to make their own decisions where possible, act in the person's best interests, consider their wishes and feelings, and act only within the legal powers conferred by the document or court order. The guide explains how staff should interact with these representatives and how to clarify what decisions they are authorised to make.

Practical support: The guide includes FAQs, examples, checklists and procedural advice aimed at making customer interactions smoother and helping organisations build internal policies that reduce confusion and improve outcomes for vulnerable customers. Good examples include how to check if an LPA is registered or what to do in circumstances where a replacement attorney starts to act.

Court of Protection Property and Affairs Users Group

The minutes of the July 2025 P&A users group meeting are now available.

PRACTICE AND PROCEDURE

Personal welfare deputies, principle and pragmatism

Parr v Cheshire East Council & Anor [2026] EWCOP 1 (T3) (Poole J)

Deputies – welfare matters

Summary

This case concerned an application by Alison Parr, the mother of an 18 year old to be appointed as welfare deputy for her daughter, Ruby. Ruby lived with her mother and two siblings, with her mother being her lead carer and the person co-ordinating Ruby's care package. Ruby had a severe learning disability and multiple serious health problems including intractable epilepsy, and was on long term ventilation and was fed by PEG. Her mother's application had been rejected on the papers (as is common) but on reconsideration, Poole J granted the deputyship order and permitted the family to be named. Poole J noted that Ruby's mother was "*highly attuned to her daughter's needs, always acts in in what she considers to be Ruby's best interests, and is extremely well placed to assess what those best interests are, including in medical emergencies and when making decisions about her residence and care.*" Moreover, Poole J accepted that there had been times when it would have been positively advantageous to Ruby for her mother to be welfare deputy, because her status as deputy would mean that her views were not at risk of being sidelined by professionals who did not have the same background knowledge and experience of Ruby, and information about Ruby would not wrongly be withheld from her. Poole J accepted that there would be '*countless*' health and welfare decisions to be made daily for Ruby and that there would be important one-off decisions too, such as whether she should move to a unit run by a specialist care provider. Poole J applied the decision of Hayden in *Lawson, Mottram and Hopton* [2019] EWCOP 22 but, reflecting the reality that best interests decisions would always have to be made for Ruby, noted that "*put bluntly, someone with Ruby's level of cognitive functioning will never have capacity to make any decisions about her personal welfare other than at a very rudimentary level. She might express a dislike of a particular experience or enjoyment of another, but she cannot, and never will be able to, understand consequences of decisions such as where to live, what care package is best for her, or whether she should have a particular medical intervention or an admission to hospital. Appointment of a deputy would not take away autonomy from Ruby because she cannot exercise autonomy in relation to anything except the most basic activities and needs. I would not view the appointment as being restrictive of Ruby's freedom or right to self-determination.*"

Poole J further noted that there was no conflict of views with the family or with professionals about her mother being an appropriate welfare deputy, and that as she was the person '*most in tune with Ruby's wishes and feelings*' and '*most committed to ensuring that Ruby's best interests are met*' it was appropriate to appoint her as deputy: "[n]*aturally, not all adults without capacity and with severe disabilities, who have significant daily care needs, need a PWD. But Ruby's particular history and circumstances, combined with her likely change of residence and therefore carers, mean that a constant voice in decision-making will be to her advantage.*"

Comment[3]

Although Poole J was keen to stress that welfare deputies will not be required "*in most cases,*" the factors relied on in this judgment will be familiar to many other families of disabled young people. Many will be able to point to a series of decisions that need to be made, the sidelining of their input once their son or daughter turns 18, failures to implement the MCA properly, and the value of ensuring that the people with comprehensive background knowledge of P must be involved in decisions about them, particularly where social workers and care staff are frequently replaced. The judgment also helpfully adopts a realistic approach to whether a deputyship order is more restrictive than professionals relying on s.5 MCA to make best interests decisions – both result in the person having decisions made for them, and both require the decision-maker to act in P's best interests and only where they lack capacity.

The court's recognition that third parties often want to see evidence of an LPA or deputyship before sharing information about P with the parent of a disabled adult ties reflects wider experience. For example, the gov.uk guidance page entitled 'Medical disclosure information to attorneys and deputies' does not say anything about being able to disclose such information to a person who is not a deputy or attorney in reliance on s.5 MCA, and says that "*There are no specific statutory provisions enabling a third party to exercise subject access rights on behalf of an individual who does not have the mental capacity to manage their own affairs, but the Information Commissioner's Office advises that "it is reasonable to assume that an attorney with authority to manage the individual's property and affairs, or a person appointed by the Court of Protection to make decisions about such matters, will have the appropriate authority*'."

Fact-finding and capacity

SW v (1) Nottingham City Council (2) JW [2025] EWCOP 53 (T3) (Poole J)

Practice and procedure (Court of Protection) – fact-finding

Summary

In this (complicated) case, Poole J dealt with an application to appeal from findings of fact made by HHJ Rogers (sitting in retirement).

SW and JW had been married for over 29 years. SW was diagnosed with muscular dystrophy, was a long-time wheelchair user and now largely bedbound. JW was diagnosed with OCD and long-standing depression. They lived together in their own home until JW was admitted to hospital in July 2023 with a very serious leg infection. SW could not be left alone and was moved to a care home. On JW's discharge from hospital, she was moved to the same care home. After some time living together in the same care home, the care home raised concerns about SW's conduct, including his conduct towards JW which was thought to be controlling and coercive. The care home gave notice to SW and JW resulting in the local authority making an application to the Court of Protection.

[3] For more commentary on this case, see Alex's post about it on his website here.

The parties instructed a psychologist to report, amongst other things, on JW's capacity in relation to contact. At the first meeting, the psychologist relayed the concerns and allegations to JW but she either did not accept them or she took responsibility herself for matters such as the failure to seek medical attention for her infections. The parties agreed that a fact finding hearing should be listed before further expert evidence on capacity could be sought. However, DJ Buss disagreed and held that a fact-finding hearing would generate excessive delay and was not necessary.

The local authority appealed. HHJ Rogers reversed the decision of DJ Buss not to hold a fact-finding hearing, and directed the local authority to set out a schedule of allegations upon which findings were sought. The schedule produced by the local authority ran to 20 pages. Poole J drew on experience in the family courts and gave the following guidance:

> *24.* […] *In family proceedings, the courts have considered how best to present allegations of fact on which a party seeks findings, in particular where the allegation is of a pattern of behaviour said to constitute controlling or coercive behaviour. In Re H-N [2021] EWCA Civ 448, the Court of Appeal said that when an allegation of controlling and/or coercive behaviour is alleged, that should be the central allegation to be considered and "Any other, more specific, factual allegations should be selected for trial because of their potential probative relevance to the alleged pattern of behaviour, and not otherwise, unless any particular factual allegation is so serious that it justifies determination irrespective of any alleged pattern of coercive and/or controlling behaviour" In Re JK [2021] EWHC 1367 (Fam) and Re B-B [2022] EWHC 108 (Fam) suggestions were made about how to draft allegations of fact in such cases. On the one hand it is unhelpful to have a long Scott Schedule containing multiple allegations about individual events. On the other hand a simple, unparticularised allegation that a person has been guilty of coercive or controlling behaviour is not helpful. It might be helpful to have a narrative statement of the relationship but include some specific examples of abuse and evidence as to when it started and ended, if it has ended. It might assist to group allegations under different headings of control or coercion.*

In his judgment, HHJ Rogers referred to the large bundle of documentary material and witness statements. He gave pen pictures of the evidence of thirteen witnesses who gave oral evidence, including SW. In conclusion, the judge was satisfied on the balance of probabilities that the factual accounts advanced by the local authority were made out, and that the conduct could be properly categorised in part as coercive and controlling.

SW, supported by JW, appealed, which came before Poole J. After recounting the history of the case, Poole J set out the relevant law, emphasising that, *"*[t]*he appellate court should be slow to interfere with findings of fact."* Poole J then dealt with thirteen grounds of appeal one by one, which were summarised as follows:

> *40.* […] *In essence the Appellant contends that the Judge failed to provide any analysis of the evidence and failed to give any or any adequate reasons for his conclusions. The Judge did not identify SW's case, where his evidence differed from that relied upon by the Local Authority, and did not explain how he had resolved those differences. The Judge did not weigh the evidence "warts and all". Any analysis was superficial and the approach taken was confused. There was no specificity about findings made and there was no consideration of the wider context in which SW's behaviour ought to have been analysed. As a consequence any conclusion that he was guilty of coercive and controlling behaviour is unsustainable.*

The appeal was dismissed, but not without a distinct sense of trepidation. For example, Poole J acknowledged that "*this very experienced Judge's analysis of the large bundle of written evidence and oral evidence given by 13 witnesses as well as SW over three days, was at best concise*". Furthermore, Poole J identified that the judge "*did not refer expressly to any specific document within the bundle*", and "[h]i*s analysis of the evidence relied upon by the Local Authority to support the seven findings it sought is found in one paragraph*". Later on, Poole J expressed, "*I am sure that many other Judges would have referred to at least one or two specific alleged events to demonstrate why they preferred the evidence relied upon by the Local Authority over SW's evidence. This Judge did not do so. Nor did the Judge analyse the oral evidence beyond his pen-pictures of the individual oral witnesses including SW*."

In the end, Poole J found that "*the Judge was certainly concise, but he gave adequate reasons. His analysis of the evidence was brief but the dispute on the underlying factual accounts was not nuanced*." After describing this as "*a difficult case*", Poole J held that:

> *61.* […] *There was no discernible error of fact or law. The Judge was entitled to make the findings that he did on the evidence before him. His judgment was coherent and his reasons were adequate. There was no procedural irregularity rendering the proceedings or the judgment unfair.*

Comment

Fact-finding hearings in the Court of Protection are relatively uncommon at Tier 3 level (although they are more prevalent at Tiers 1 and Tier 2), and reported appeals from findings of fact are even more uncommon still. This judgment is a salient reminder that the utmost care should be taken in handling allegations that require findings of fact.

Although there was no appeal against earlier case management directions, it is apparent that this case would have benefited from better preparation in the earlier stages. Poole J found that "[t]*he procedural pathway to the fact finding hearing in this case was problematic and the presentation of the findings sought was not particularly conductive to achieving clarity*". For example, in relation to the allegations presented, Poole J expressed the view:

> *49.* […] *It is regrettable that specific events or examples of SW's conduct were not specified. There was not express allegation that on a certain date at a certain place SW acted in a certain way. However else they may have been presented, the allegations were in fact in the form of general statements about the effects of SW's behavior on JW – affecting her access to health care, to care services, to the community, to her autonomy over finances and so on.*

Poole J made the following suggestion, "[f]*or clarity of understanding it would have been preferable if the specific events had been set out in the schedule rather than referring to them by way of bundle page references.*"

We would stress the need for early, careful, and precise particularisation of specific allegations, especially where it is alleged that a pattern of behaviour amounts to coercive or controlling behaviour, and/or abuse. This would not only be of benefit to the judge making determinations, but to all parties involved.

Separately, athough it did not form part of the appeal, Poole J also observed at (paragraph 20) that:

> *In this appeal I am not concerned with Dr Todd's conclusion that JW's "borderline intellectual functioning" met the diagnostic test, nor the potentially nuanced question of the causal nexus between her inability to make decisions as to care, residence and contact, and her borderline intellectual functioning. However, being a victim of coercion and control is unlikely to be found to be an impairment of or a disturbance in the functioning of the mind or brain. A victim of coercion and/or controlling behaviour may or may not lack mental capacity to make certain decisions including contact with the person who exercised control or coercion. A person who otherwise has mental capacity but is who is so subjugated by abusive behaviour that their will is overborne, may be the subject of an application to the High Court to exercise its inherent jurisdiction to protect the autonomy of such a person.*

As Poole J made clear in remitting the case to HHJ Rogers (having clarified what, in fact, stood as findings of fact), one of the matters that he would have to address as soon as practicable in reaching a conclusion as to capacity was: "(d) [w]*hether the causal nexus is established given the significant role of coercion and control and the need to identify a causal nexus between the inability to make a decision and an impairment or disturbance in the functioning of the mind or brain*." It is to be hoped that there is a judgment forthcoming on this point, as it is one which causes very considerable difficulties, both conceptual and practical (see further this shedinar conversation between Dr Kevin Ariyo and Alex on the former's research on interpersonal influence and capacity)

Short note: compliance with the 'Closed hearings' guidance

In *Bristol City Council v CC* [2026] EWCOP 4 (T3), Theis J followed the guidance issued by her predecessor[4] in giving a short judgment to explain why steps had been taken behind closed doors, and in respect of material kept closed. For reasons which are not material for present purposes, the position of the relevant parties had evolved in relation to the closed material. Theis J concluded by observing that:

> *this case has provided an important reminder of the need to adhere to the Guidance when considering whether an application should be made for a closed hearing/material. Prior to any such application being made there must be careful analysis of the legal and evidential basis upon which the court is being asked to order such a hearing, and for any material to be withheld in accordance with the principles so clearly set out in the Guidance.*

Facilitating access to pro bono representation

A new protocol has been put in place between Advocate and the Court of Protection Bar Association.[5] It sets out the process for sourcing a Court of Protection Bar Association volunteer barrister to help with urgent advice or representation. "Urgent" means that there is a hearing in the next 14 days.

[4] Which she was at pains to note "*is not in and of itself binding upon the court (as is made clear by paragraph 4* [of the Guidance]*) however the principles set out have their foundation in applicable authority*."

[5] Her fellow editors pay particular tribute to Tor for her work in starting the ball rolling on this during her tenure as Chair of the CPBA.

The organisation Advocate helps in two ways: by helping find a barrister and helping with direct public to barrister access. The Protocol can be used by judges, judges' clerks, court staff, lawyers, and people who are a party in the case, or want, or think they need, to be a party in the case.

For non-urgent hearings, the person needing free legal advice or representation can send an application to Advocate.

Requests for a CPBA barrister who can provide free urgent COP advice or representation should be sent to:

courtofprotection@weareadvocate.org.uk

Advocate and the volunteer barrister will be helped by having as much of the following helpful information as possible:

- Case name and number;
- Name of unrepresented party;
- Contact details for the unrepresented person Names of representatives of other parties (solicitors and counsel), and their contact details, where known;
- Date and time of the hearing, hearing time estimate, the judge's name;
- Hearing type (eg, case management or final hearing);
- Whether the volunteer can attend remotely (that will greatly increase the chances of securing very short notice representation);
- An outline of what the case is about and the main issues;
- How those issues relate to the unrepresented party;
- Particular documents to consider.

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MENTAL HEALTH MATTERS

Mental Health Act 2025

The Mental Health Act 2025 received Royal Assent on 18 December 2025. The Act can be found here, and the Explanatory Notes here. The Act is very difficult to read in isolation, as it is an Act amending the Mental Health Act 1983. During the passage of the Bill through Parliament, DHSC produced a version of the Act as it would look as if amended by the Bill as it stood after Report stage in the House of Lords. However, unfortunately, this was not updated to reflect further amendments made later in the Parliamentary process. Alex has therefore produced an entirely unofficial update to that document to show how the MHA 1983 will look in due course. He has also done a walkthrough of the MHA 1983 as amended by the MHA 2025.

Neil has also launched an app (currently for iOS devices, with Android coming soon), explaining the changes.

Sections 30(2), 32, 35, 36(1) and (3)(b), 38 and 39 of the MHA 2025 come into force on 18 February 2026, implementing changes to ss. 42, 48, 71, 73, and 75 MHA 1983 (concerning removal to hospital of a wider range of those under detention, and the provision for deprivation of liberty in the community presence of risk of serious harm to others for those conditionally discharged from hospital). We eagerly anticipate guidance from the Ministry of Justice as to how it anticipates that these provisions should be deployed in practice.

We do not yet have a time-frame for the commencement of other changes.

Alex has a page of resources on the Bill (now Act), available here.

Welsh emergency legislation

A rather faster-tracked mental health reform has come into effect in Wales. The Welsh Government introduced emergency legislation to resolve a technical issue that had sharply reduced the number of available medical members of the Mental Health Review Tribunal for Wales. Under the Mental Health Act 1983, tribunal medical members were understood to require both GMC registration and a licence to practise, leading the Tribunal President to exclude unlicensed—often retired—doctors and leaving only 19 medical members, with serious risks to statutory hearing timescales.

The Emergency Bill removed the requirement for a licence to practise, making GMC registration alone sufficient and retrospectively validating earlier appointments. It was introduced on 13 January 2026, fast-tracked through the Senedd, received Royal Assent on 21 January 2026 as the Mental Health Review Tribunal for Wales (Membership) Act 2026, and came into force on 22 January 2026, immediately restoring tribunal capacity.

Illegality and insanity

Lewis-Ranwell v G4S [2026] UKSC 2 (Supreme Court (Reed, Hodge, Loyd-Jones, Rose and Simler SCJJ))

Mental Health Act 1983

Summary [6]

Mr Lewis-Ranwell, diagnosed with paranoid schizophrenia, was arrested twice on 8–10 February 2019 and displayed clear signs of acute psychosis while in police custody. Despite involvement by G4S, the NHS Trust (L&D service) and Devon CC (AMHP service), no Mental Health Act 1983 assessment or admission was arranged and he was released on bail. On 10 February 2019, during a psychotic episode, he killed three men and later assaulted two others.

At trial, the jury found him not guilty of murder by reason of insanity under the *M'Naghten* rules, and a mandatory s.37/41 MHA 1983 hospital order was imposed. He brought civil proceedings alleging negligence and HRA breaches, claiming losses including detention, loss of liberty, loss of earnings, reputational damage, and an indemnity against victims' claims. In essence he argued that but for the alleged negligence, he would have been admitted to hospital and would not have killed the three men. The issue was whether the illegality defence applied so as to bar the individual's claim against the negligent party in tort.

The Supreme Court unanimously allowed the appeal and held that the claimant was barred by the doctrine of illegality from bringing civil proceedings in negligence. The illegality defence was engaged despite the insanity verdict, because the claimant committed the actus reus of murder with mens rea, albeit without criminal responsibility. Applying *Patel v Mirza* [2016] UKSC 42, the claims for losses flowing directly from the killings and the resulting criminal disposal were barred by illegality as inconsistent with the criminal law and the integrity of the legal system.

Comment

The decision confirmed, for the first time, that the threshold for the doctrine of illegality does not require criminal liability. The availability of the illegality defence in civil law should not be governed by the criminal law's distinctions between the defences of diminished responsibility and insanity. The court said this was because the insanity defence is criticised as being out of date (paragraph 123, in circumstances where the Law Commission is considering insanity as part of its 14th programme of law reform), the criminal law necessarily sets out clear dividing lines between conduct which results in criminal responsibility and conduct which does not, but it is not appropriate for the civil law to rely on the same distinctions (paragraph 124-125). And the difference between those who are criminally responsible for their acts, despite diminished responsibility, and those who are not because they do not know that what they are doing is wrong (as per *M'Naghten*), is a difference between positions on a spectrum of mental illness (paragraphs 126-127).

It is worth noting at paragraph 158 of the judgment that the Chief Constable did not seek a strike out and that the other public bodies may still face a human rights claim under Articles 3 and 8 owing to the decision in *Al Hassan-Daniel v Revenue and Customs Comrs* [2010] EWCA Civ 1443.

[6] Alex having been involved in the case, he has not contributed to this note.

Benefits and hospital orders

The Government has announced its intention to extend the ban on prisoners claiming state benefits to those who are detained under the MHA 1983 under one of the forensic sections of Part 3 on the basis that "*their bed, board and treatment costs are covered*." This proposal has met with considerable concern on the part of mental health charities, Mind, for instance, noting that: "[r]*emoving access to benefits for those who are most unwell undermines court decisions and penalises people for their illness. People need support to recover, understand the harm they've caused, and reintegrate into their communities*."

Short note – recall, conditional discharge and Tribunal jurisdiction

In *Cameron v Secretary of State for Justice & Anor* [2025] EWCA Civ 1574, the Court of Appeal considered whether "*a conditional discharge is extinguished by the recall to hospital of that patient by the Secretary of State for Justice*" (paragraph 1). The patient had pleaded guilty to attempted murder in 2016, and been placed on a ss.37/41 MHA 1983 order. He was conditionally discharged in October 2021, and sent to live in a care home. He applied for an absolute discharge in October 2023, but by March 2024, concerns had been raised about the patient's presentation and he was recalled to hospital by the Secretary of State. His application for absolute discharge had not yet been heard, and was later struck out "*on the basis that the FTT no longer had jurisdiction to consider it in the light of the* [patient's] *recall to hospital.*" However, the FTT did hear the automatic reference which was made upon the patient's being recalled, and did not order his discharge. The FTT considered that the automatic reference "*gave the judicial oversight over the Appellant's detention which the law required*" (paragraph 16). The Upper Tribunal affirmed this decision, finding that "*taking account of the patient's Article 5(4) protection and judicial review, the legislative provisions governing the recall of a conditionally discharged patient provided effective judicial oversight*" in the form of the reference (paragraph 18). The Upper Tribunal's decision was appealed to the Court of Appeal.

The appeal was dismissed, with a unanimous finding that the FTT and UT decisions had been correct. The Appellant argued that there was a 'lacuna' in judicial oversight in the event that a patient who has been recalled to hospital is again conditionally discharged by the Secretary of State before the reference is made, which would bar the patient from being able to apply to the Tribunal for a further 12 months. The Secretary of State argued that the statutory language of the MHA supported the FTT's conclusion, and that "[n]*o problematic lack of access to the Tribunal arises from this interpretation either in the Appellant's case or generally*," and no issues arose under the ECHR (paragraph 25). It was argued that the point raised was academic where the FTT had gone on to consider the reference, an argument accepted by the Court of Appeal. However, the Court of Appeal continued to consider the question to give guidance for future cases. It concluded that the SSJ had a mandatory and unqualified obligation to make a reference on recall, and noted that on the basis of case law, this obligation was likely to require a reference to be made within a few days (it was 4 days in the present case). In these circumstances, "*any outstanding application by the patient under s 75 (2) is subsumed in the recall hearing. It is difficult to see what practical advantage there would have been for Mr Cameron or there would be for any other patient in the same position if it were otherwise*" (paragraph 33). For a patient who was quickly conditionally discharged, "*even in the case of a patient whose status changes repeatedly, the*

legislative provisions governing the recall of a conditionally discharged patient, as interpreted in Rayner, provide effective judicial oversight."

Short note: leave and the role of the Tribunal

In *WM v Bradford District Care NHS Foundation Trust* [2025] UKUT 396 (AAC), the Upper Tribunal confirmed that the First-tier Tribunal can make a statutory recommendation that a patient be granted leave of absence with a view to facilitating discharge under s.72(3) MHA 1983 even if the responsible clinician has already granted leave under s.17. [7] Even if on the face of it, such recommendations might seem pointless, Upper Tribunal Judge Johnston noted that:

> *the discretion given to the tribunal to make a recommendation is designed to identify the best way forward for the patient. If a patient has one form of leave, for example escorted leave, the tribunal when looking at the best way forward must be able to recommend that he is granted unescorted leave. Successful unescorted leave will facilitate discharge on a future date as the patient may show his treating team he is able to manage this successfully without restrictions. That leave is quite different from escorted leave.*

Short note: Schrodinger's cat and mental disorder

The (distinctly complicated) decision of Upper Tribunal Jacobs in *AN v St Andrew's Healthcare and SSJ* [2026] UKUT 32 (AAC) concerned the situation where a First Tier Tribunal was considering a deferred conditional discharge. It had made a provisional determination that patient did not have a mental disorder, but that it was appropriate for him to be liable to recall, subject to specified conditions. Matters then stalled. The assertion was made that the patient was being unlawfully detained thereafter, but Upper Tribunal Jacobs ultimately rejected that conclusion, and also that the Tribunal was entitled to revisit its conclusion in relation to the existence (or otherwise) of mental disorder before making a final decision. As UTJ Jacobs noted, "[]*f the issue arises whether a tribunal should make a different finding at a reconvened hearing, fairness requires that the patient be given notice that the issue arises*" (but, on the facts of the case, that AN had had such notice).

CQC Monitoring the Mental Health Act in 2024-2025

The CQC has published its annual report on its activities monitoring the Mental Health Act 1983 in England. Its themes of overstretch, poor quality environments, and unlawful practices (especially around unlawful deprivation of liberty) are familiar, but no less depressing, In respect of unlawful deprivation of liberty, this passage in particular stood out:

> *De facto detention*
>
> *Our MHA reviewers expressed their concerns that too many people, especially those on wards for older people, were deprived of their liberty without clear legal authorisation. They explained that this can happen when a person is kept in hospital while not being formally detained under the Mental Health Act or having a Deprivation of Liberty Safeguards authorisation in place to provide*

[7] Note, Arianna having been involved in the case, she has not contributed to this note.

an alternative authority to keep them detained. As discussed in our State of Care report, applications to authorise the deprivation of a person's liberty have increased significantly over the last decade, often resulting in lengthy delays. MHA reviewers said that this practice has become so common it is "almost normalised". Where patients are deprived of their liberty without a legal authorisation in place, they have no legal framework to use to appeal the deprivation of their liberty or de-facto detention. They also have no right to support from an Independent Mental Health Advocate to help them understand their rights, or to support them in raising concerns about their situation.

Learning disability and discharge from mental health hospitals – progress in Wales

The Welsh Government has published an update on its progress securing better support for those with learning disabilities, alongside a report from the Learning Disability Ministerial Advisory Group's Stolen Lives Task and Finish Group. The report makes very powerful reading – and sounds the alarm both in relation to the extent to which discharge from hospital into 'social care detention' can replicate precisely the same problems as experienced in hospital, and also in relation to the direction of travel in terms of the Mental Health Act 2025. As the report notes:

The Mental Health Act (1983) (MHA) is the primary law governing the assessment and treatment of people with mental health conditions in the UK, especially when they are detained in hospital. The term 'mental disorder' in the MHA (1983) is currently defined to include learning disability and autism, even though they are not mental health conditions. This means people can be detained under the MHA (1983) when they do not have a mental health condition, which is a significant point of discrimination. Mental health reform aims to change this by linking Community Section 3 to 'psychiatric disorders' only. However, without investment in community housing and support many people could remain in hospital under the Deprivation of Liberty Safeguards (DoLS) system, with no right to s117 aftercare. This is a system already under pressure. There might also be an increase in forensic detentions with individuals held under criminal law for behaviours that could be better addressed in a community-based setting. It is important that Welsh Government plans for mental health reform and any unintended consequences of the proposed Mental Health Bill.

CHILDREN'S CAPACITY

Looked after children and serious medical treatment

VW (Looked After Child: SMT: Need for Application) [2025] EWHC 3928 (Fam) (High Court Family Division (Poole J))

Other proceedings – family (public law)

Summary

This case was brought by Liverpool City Council for a declaration that it would be lawful for a three year old child (VW, a looked after child in long term foster care) to undergo cranio-facial surgery. The case was listed for a preliminary issue, namely whether it was necessary for the application to have been brought and whether the application should be permitted to proceed in circumstances where the treatment was unanimously recommended by the treating team and was agreed by VW's parents and the local authority as being in VW's best interests.

The local authority's justification for bringing the application was that they were sufficiently concerned about the risks of the treatment that it was anxious to have the Court's declaration that the treatment was in VW's best interests. In making this submission, the local authority relied on the well-known Court of Appeal decisions *Re C (Children)* [2016] EWCA Civ 374 ("*Re C*"), *Re H (A Child) (Parental Responsibility: Vaccination)* [2020] EWCA Civ 664 ("*Re H*"), which establish the proposition that some decisions are of such magnitude that it would be wrong for a local authority to use its power under s.33(3)(b) of the Children Act 1989 to override the wishes or views of a parent.

In his consideration of the issue to be determined, Mr Justice Poole examined *J v Bath and North East Somerset Council* [2025] EWCA Civ 478 in which Lady Justice King made the important point that *Re C* and *Re H* were *cases "about the profound impact upon the Article 8 rights of a parent who continues to share parental responsibility with a local authority which has no Article 8 rights."* As Mr Justice Poole noted on the case before him

> *the parents' views are known and the Local Authority is not seeking to limit or restrict the exercise of the parents' parental responsibility. There is no need to do so in order to safeguard or promote the child's welfare. The parents have been engaged in the decision-making process. They have capacity to exercise their parental responsibility in respect to serious medical treatment for their son. They fully understand the risks and benefits involved and they support the proposed surgery. The Local Authority also supports the proposed surgery. There is no debate amongst the treating clinicians – they agree that it is in VW's best interests to undergo the surgery. The treatment, whilst serious, is not experimental or unusually risky.*

In such circumstances Mr Justice Poole held that the application was not required, and that the clinicians could "*proceed on the basis that they have the necessary consent to perform the surgery, and the Local Authority can have confidence that it can exercise its parental responsibility to consent to the surgery, that being in accordance with the views of the child's parents and all treating clinicians*."

Comment

This is an important case for those concerned with the medical treatment of children who have been subject to public law proceedings, because it makes the undoubtedly correct point that 'unnecessary applications' cause delay for the child who are likely to required the proposed medical treatment as soon as possible. Such application also of course take up resources which could be usefully deployed elsewhere.

It is interesting to note that Mr Justice Poole at paragraph 19 stated that he did "*not wish to imply that the position would be different were the treatment decision about withholding or withdrawing life sustaining treatment*." While he is clear that the treatment decision that he was concerned with was of a different kind, he must be correct that the logic of his judgment would apply equally in case concerned with the withdrawal or withholding of life sustaining treatments.

Consenting confusion and DNACPR recommendations

Bradford Children and Families Trust v Doncaster and Bassetlaw Hospitals NHS Foundation Trust & Ors [2025] EWHC 3311(Fam) (High Court Family Division (McKendrick J))

Other proceedings – family (public law)

Summary[8]

The local authority in this case applied under the inherent jurisdiction for relief for a declaration of lawfulness in respect of a DNACPR form which had been placed in the medical records of a young boy in foster care who had a life-limiting medical condition. The boy's parents and doctors had agreed that the DNACPR was appropriate, but the local authority did not consider it was able to consent to it, even though they did in fact agree that it was in the child's best interests, as part of a wider palliative care plan for the child.

At the hearing, the Trust confirmed that it was not offering chest compressions, defibrillation or admission to intensive care to the child, and so there was no best interests issue for the court to determine. The only possible treatment where there was a choice to made was the use of non invasive ventilation and intraosseous access, which the Trust did not consider in the child's best interests but which the doctors were not refusing to offer. The Trust also pointed out that the DNACPR (in this case, the RESPECT form) is not legally binding and there was nothing stopping the Trust forming a different view in the future should the child's circumstances change.

The local authority submitted that a court order was required since even though the local authority had the power to give or refuse consent to medical interventions through the care order, cases where the exercise of that power had very serious consequences for the child or its parents should be brought before the court.

The court decided to make a declaration that "*It is not lawful, being unethical, for [the child] to be provided with*" the treatments the Trust had said it was not offering. McKendrick J noted that the medical

[8] Note, Katie having been involved in the case, she has not contributed to this note.

records showed discussion of whether the RESPECT form was in the child's best interests, which implied that there had not been a decision not to offer resuscitation, and the ReSPECT form itself did not make clear which treatments were being withheld because the medical professionals were not willing to offer them, and which were judged not to be in the child's best interests. The judge also took the view that a local authority could not consent to a DNACPR decision as it was a matter of life and death and since the medical records had not made clear that certain treatments were not on offer, the local authority had been right to issue the application. If the Trust's position had been clear, the local authority would have understood that their only option was to issue proceedings for judicial review if they disputed the medical decision.

The judge therefore suggested that NICE may wish to consider whether its NG61 guidance, the CYCAP and ReSPECT should be revised.

Comment

The ReSPECT form includes what is described by the Resuscitation Council as "*a recommendation on whether or not CPR should be attempted if the person's heart and breathing stop*." It is a clinical judgment, based on consultation with the patient or their family – the requirement of consultation or involvement of the patient and family having been confirmed in *R (Tracey) v Cambridge University Hospital NHS Foundation Trust* [2014] EWCA Civ 822 [2015] QB 543 and *Winspear v City Hospitals Sunderland NHS Foundation Trust* [2015] EWHC 3250 (QB)). It is not a best interests decision, because a person can never, themselves, make the decision as to what the doctors should recommend.

The ReSPECT form itself does not characterise the decision to put in place a DNACPR recommendation as a best interests decision (and, in relation to adults, makes clear that the 'capacity' question is not capacity to make decisions about CPR, but capacity to participate in the making of recommendations). It also – deliberately – does not include a place for the person themselves or for someone on their behalf to sign the form, because logically it is not a question of 'consenting' to the making of recommendations by medical professionals. [9]

However, this case makes clear that there is further work to be done to get this message across. What does not help in this regard is the confusion caused by the analysis in the *Winspear* case, in which the court:

(1) endorsed established caselaw which confirms that the first stage in the decision-making process is for the doctor to decide what options to offer in the exercise of their clinical judgment; but

(2) framed the requirement to consult with the relatives of a person without capacity as deriving from s.4 MCA rather than Article 8 ECHR. This leads to confusion as it implies that the process the doctor

[9] And also, in relation to adults, because a signature would turn the form into a Frankenstein advance decision to refuse treatment, both purporting to refuse CPR, but at the same time not complying with the requirements for validity under the MCA 2005. In relation to an adult, clinicians must be careful – if the person really wishes not to have CPR – to guide them towards creating an advance decision to refuse it, which will stand as their own decision.

is involved in is one of making a best interests decision, not deciding how to exercise their clinical judgment.

This confusion relates to adults with impaired decision-making capacity; it applies equally to children.

This sentence from R (Burke) v General Medical Council [2006] QB 273 correctly summarises the position*: "If, after discussion with the patient, the doctor decides that the form of treatment requested is not clinically indicated he is not required to provide it although he should offer to arrange a second opinion.""* The doctor decides whether to offer CPR, following consultation with the patient or their family. If they decide not to offer it, they cannot be compelled to change their minds, and so there could not be any best interests challenge in the court, as it is procedurally improper to use the court to pressure a doctor to change their clinical opinion (*AVS v A NHS Foundation Trust* [2011] EWCA Civ 7).

This clarity in *Burke* is not reflected elsewhere – in addition to the confusion in Winspear, the joint statement by the Resuscitation Council, the BMA and the RCN throughout refers to the need to take decisions in the patient's best interests. And it is common for doctors to use the phrase "best interests" even when what doctors are referring to are their clinical decisions, not a best interests choice, as appears to have occurred in this case.

Finally, it is of interest in this case that the declaration made was not a best interests declaration, but a declaration of lawfulness, the Trust have clarified the situation by the time of the hearing. If clarity about the nature of the clinical decision is given at an earlier stage, further such applications should be avoided.

Human rights of children in care settings

The Joint Committee on Human Rights, as part of its inquiry into the human rights of children in care settings, held an evidence session which (coincidentally) was on the 77th anniversary of the Universal Declaration of Human Rights. Alex hopes that it is not too cheesy to note that this gave him the opportunity in giving evidence to read into the record Eleanor Roosevelt's timeless observation that human rights start in the small places close to home.

THE WIDER CONTEXT

Capacity key elements videos

Alex has updated and added to his 'key elements' videos on his website on such matters as capacity and best interests: see here.

Terminally Ill Adults (End of Life) Bill

The increasingly complex progress of the Bill can be followed on Alex's website here.

The UK National Preventive Mechanism 2024-25 Annual Report

The UK National Preventive Mechanism is made up of 21 organisations, which independently monitor different settings of detention across the UK, and a central team, which supports and leads NPM bodies in delivering their responsibilities under the Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). The NPM undertakes collective work to prevent ill treatment of detained people in the UK, promotes awareness and understanding of OPCAT principles, and works with international mechanisms and organisations with a mandate to prevent ill treatment of detained people.

The NPM published its 2024-25 Annual Report on 11 December 2025, highlighting risks of inhuman and degrading treatment of people in UK detention settings. This includes children and adults deprived of liberty under mental health and mental capacity laws, as well as individuals detained in immigration detention, prisons, and police and court custody.

The report warns that systemic failures continue to undermine efforts of many dedicated staff to uphold people's dignity, raising concerns about potential breaches of the UK's obligations under the Torture Convention.

The report identifies a wide range of issues, including:

> *Institutionalisation and closed cultures in care settings*
>
> *People with a learning disability, and autistic people, continue to be detained in hospitals, even when their deprivation of liberty offers no therapeutic benefit. Long stays in institutional settings can erode connections with family and friends, and restrict basic freedoms to make everyday choices and decisions about treatment. Closed cultures (cultures where it is unlikely that many outsiders go in, CQC 2022) in health and social care risk normalising poor practice and perpetuating harm.*

The Autism Act

No-one in our experience has heard of this 2009 Act. In this context, the House of Lords Autism Act 2009 published a report in November 2025 entitled Time to deliver: The Autism Act 2009 and the new autism strategy. The Government's response was published in January 2026. It is of some use as an overview of measures taken across Government in relation to addressing the needs of autistic people, although concrete additional commitments do not leap off the page. The response addresses the December 2025 launch of the independent review into mental health conditions, ADHD and autism, a

review which is likely to have very significant weight in determining the scope of future commitments which cost money.

LeDER revisited

Somewhat embarrassingly, the (very delayed) 2023 LeDER report had to be withdrawn very shortly after publication when it became clear that it contained a significant number of data errors – leading, inter alia, to an underestimation of the proportion of deaths classed as avoidable particularly in 2023 (40.2% vs 38.8%). However, as the Government made clear to the House of Commons when the report was republished on 27 January 2026

> *The headline findings of the updated 2023 LeDeR report remain consistent with those previously published. The updated analysis reaffirms that people with a learning disability continue to experience significant health inequalities: on average, they die 19.5 years younger than the general population and are almost twice as likely to die from an avoidable cause of death. This remains unacceptable, and tackling these disparities continues to be a priority for this Government.*

Cannabis, criminality and capacity – a Jersey perspective

Re E [2026]JRC002 (Jersey Royal Court (A. R. Binnington, Esq., Commissioner, and Jurats Ronge and Berry))

Deputies – property and affairs

Summary[10]

In the Capacity and Self-Determination Law 2016, Jersey has a framework which looks a great deal like the Mental Capacity Act 2005; the Jersey courts look to the caselaw in England & Wales to help them navigate some of the dilemmas that they are encountering in considering capacity and best interests. The decision in *Re E* [2026]JRC002 provides an example – we suggest – where the English courts might well wish to look south.

The case was brought by the Delegate (the equivalent of a Deputy) for a young man, E, seeking

> *the Court's blessing of her decision to continue to pay pocket money to E should she deem it appropriate to do so. Described in that way the application would appear to be straightforward. However, the circumstances of the application are highly unusual, in that there is a distinct likelihood that E will use the pocket money given to him to purchase cannabis for his personal consumption, which is both illegal and adverse to E's health.*

As the Royal Court described it:

> *14. The Delegate is, understandably, concerned that funds advanced to E may be spent on cannabis, alcohol, or, potentially, other illegal drugs. The Delegate is similarly concerned that depriving E of funds could lead to a deterioration in his condition due to the loss of the small*

[10] Tor having given advice cited in the judgment, she has not contributed to this note.

amount of independence it affords him and/or cause him to take detrimental steps, such as getting into debt, in order to procure cannabis and maintain his social life.

15. The issue was usefully summarised by Dr Stoffels in her report for the Court, dated 31 October 2025, in which she stated:

> *"Professionals are therefore faced with a profound ethical dilemma. On one hand, continued access to substances directly contributes to physical and psychological harm, psychotic relapse, and financial exploitation. On the other hand, strict prohibition or withdrawal of all funds has historically precipitated aggression, non- engagement, escalation of risk-taking behaviours, and covert substance seeking through unsafe channels.*
>
> *From a clinical and safeguarding standpoint, the MDT and financial deputy are therefore required to balance two competing imperatives:*
>
> *i) Protection from harm - minimising the risks of intoxication, psychosis, and exploitation; and*
>
> *ii) reduction of immediate crisis behaviours - preventing escalation, aggression, or absconding when access is restricted too abruptly.*
>
> *The current approach, maintaining a limited weekly allowance (£50) under close deputy and staff supervision, does not imply endorsement of substance use but is instead a harm-reduction measure. It allows a degree of autonomy while containing the scale of potential damage and preserving engagement with care. This is a pragmatic, ethically proportionate response in an individual who lacks capacity to make safe decisions about drug use and finances, yet whose behavioural volatility and disinhibition make absolute restriction unsafe in practice."*

In the absence of Jersey precedent, the Delegate obtained advice from English Leading Counsel, Gideon Cammerman KC and Victoria Butler-Cole KC on criminal law and the English Court of Protection approach respectively. Having considered both the arguments put forward by the delegate and the Attorney General acting (in rough English analogy) as Advocate to the Court, the Royal Court concluded as follows:

> *70. As we have already noted, the Delegate was faced with having to make a difficult, and somewhat unusual, decision. She had to balance the risks of continuing to pay an, albeit modest, sum in pocket money in the knowledge that E might use it to purchase illicit cannabis, against the risk that stopping the pocket money would negatively impact his relationship with his carers and potentially lead to further acts of criminality by him.*
>
> *71. We took into account, in particular, E's wishes to continue receiving pocket money and thus to have some degree of independence and the steps being taken by his carers to seek to reduce the likelihood of him purchasing cannabis.*
>
> *72. In the circumstances, having considered the evidence placed before us, we were satisfied that the decision taken by the Delegate was in E's best interests. Had we been applying the Re S test* [a test under Jersey law which had been applied previously when determining whether to 'bless' the decision of a delegate] *we would also have approved the decision.*

> *73. For the avoidance of doubt, our decision is not to be regarded as the Court determining that it is in E's best interests to commit a criminal offence or declaring that illegal conduct is lawful.*
>
> *74. We accordingly made the order requested, namely that:*
>
> > *"The Court approves the decision of the Delegate to advance funds to ("E") in the form of pocket money, currently £50 per week, in circumstances where, in the exercise of the Delegate's discretion, she considers it in E's best interests to do so notwithstanding the risk that E may spend the funds advanced on illegal cannabis (or other illegal substances) and/or alcohol. The discretion of the Delegate shall continue to be guided by the advice of the Multi-Disciplinary Team responsible for E's welfare, particularly Dr Martine Stoffels and Mrs Verity Boak (or such other professionals as may from time to time act in a similar capacity)."*

Comment

As noted at the outset, this is a decision which we suspect – and hope – will be placed before the English courts in relatively short order, representing as it does a detailed analysis of a not uncommon dilemma, and an analysis which was properly tested through the role of the Attorney General. It also relied heavily upon, and commented upon, English case-law. Of particular relevance, we would suggest, is approach taken to the decision in *EG & Anor v P* [2024] EWCOP 80 (T3), a case about which we have previously expressed some concerns as regards its approach to the Proceeds of Crime Act. In a passage which clearly satisfied the Royal Court, Gideon Kammerman KC identified that the approach taken in *EG* had been

> *simplistic. The payer of the drugs debt in EG is unlikely to attract choate criminal liability under section 328 POCA. As set out above, the delegate's funds (or for that matter the funds of the payer in the case of EG) are not criminal property in their hands. Those funds may well become criminal property in the hands of the drugs dealer, and an agreement furnishing him with funds that are later rendered criminal by his possession of them would lead to an offence by him, and therefore potential inchoate liability by their donor. As with the payer of a ransom, English law has long recognised a distinction between (1) doing an act for good reason, knowing that the outcome may be the commission of an offence by another, and (2) attracting liability by either agreeing with that other person to commit an offence or doing something that perhaps you don't want to but is virtually certain to result in the commission of an offence.*

SCOTLAND

IAWI reform: Ministerial guest contribution

We are delighted to introduce the following guest contribution to this Report by Tom Arthur MSP. He is the Minister for Social Care and Mental Wellbeing, and as such has the ministerial responsibility for carrying forward the process of AWI reform. While we have in the past quoted from public statements by Ministers and press releases by their officials, this is the first occasion upon which any Minister has opted to communicate direct with our readership, in his own words, as a guest contributor.

In our last issue (December 2025) we were able to report that we had been advised that following the scheduled December meeting of the Ministerial Oversight Group ("MOG"), which took place after the December Report went to press, and which as usual was personally chaired by him, he intended to offer a guest contribution for publication in the next issue of the Report after that. He has done so.

Over an extended period, in more issues of the Report than not, I have sought to keep readers advised of the progress of AWI reform. Until quite recently I have had no option but generally to comment critically upon lack of progress, broken promises to make progress, and other disappointments. I then sought to convey the clear and positive change, as much a change in atmosphere as in specifics, though the specifics have been notable, with the establishment of the MOG chaired personally by the Minister, the Expert Working Group ("EWG") making its recommendations to the MOG, and a series of working groups overseen by the EWG, each with direct involvement of appropriate members of the EWG. Disappointment at the longer timescale necessitated by this more thorough process had to be balanced against the clear intention to do the work thoroughly and to address all issues, rather than only some of the most prominent in isolation from their essential roles across the breadth of our adult capacity law.

What will happen during the forthcoming election period, and following it? The Minister will require to step back from his involvement, but it is notable that – at least as yet – there appears to have been no intimation of any intention to halt the monthly meetings of the EWG. The future after the election will be in the hands of whatever government is then formed, and thus ultimately in the hands of the electorate. Those with interest in this whole subject would be well advised to read party manifestos, ask appropriate questions at election meetings, and generally exercise their right and privilege to participate in the democratic process.

In the meantime, I can step back from the responsibility of seeking to interpret and describe the process of AWI reform, and allow all readers to read and consider the Minister's own words, as set out in his following contribution.

Adrian D Ward

The contribution to this Report by the Minister for Social Care and Mental Wellbeing

Adults with Incapacity Reform: Progress and Next Steps

I welcome the opportunity to contribute to the Mental Capacity Report Scotland and to reflect on developments in Adults with Incapacity (AWI) reform since my appointment as Minister for Social Care

and Mental Wellbeing in June 2025. At that juncture, Ministers had recently taken the considered decision to defer introduction of an AWI Amendment Bill. This was to allow for further detailed policy development and, critically, to ensure that reform is advanced in close collaboration with those directly affected and with stakeholders across the system.

The Importance of the AWI Act

The Adults with Incapacity (Scotland) Act 2000 remains a cornerstone of our legal framework in Scotland, safeguarding individuals who lack capacity. Where an adult is unable to make decisions, it is incumbent upon the State to ensure that robust mechanisms exist to protect both financial interests and, importantly, personal welfare.

Such protections require a coherent and credible statutory framework, supported by effective partnership across public authorities, private practice, and the third sector. Our collective responsibility extends beyond facilitating decision-making; it rightly demands that the dignity, autonomy, and rights of the individual remain central to every intervention.

Progress to Date

Momentum is beginning to build as we advance our programme of AWI reform. We have established two key governance structures: the Adults with incapacity reform: Expert Working Group , which has met five times, and the Adults with incapacity reform: Ministerial Oversight Group, which I have chaired on two occasions.

Through these groups, we have agreed a range of workstreams that are essential to preparing for legislative reform. In addition to reviewing the existing Act through a continuous improvement lens, we are committed to broader developments, and the workstreams include exploring how best to introduce a deprivation of liberty approval system for Scotland and the role that Supported Decision Making should play moving forward.

A significant milestone has been the completion of the discovery phase for deprivation of liberty. Looking ahead to the next quarter, our focus will shift to the discovery phase for supported decision-making and to formulating recommendations on general principles, powers of attorney, and guardianships. These steps are critical to ensuring that reform is comprehensive, practical, and aligned with human rights standards.

Collaboration and Engagement

What government does not possess—and it is important to acknowledge this—is the depth of practical experience accumulated over 25 years of implementation of the existing Act. That expertise lies with practitioners and those delivering services on the ground. It is this insight that will enable us to move from identifying what must change to determining how best to achieve meaningful, workable reform.

Engagement with those with lived experience remains a central priority. Meetings have taken place with a number of representative organisations to explore how best we can involve individuals and families directly affected by the legislation in a meaningful and sustainable way. Work is now underway to develop a comprehensive engagement plan early in 2026, thereby ensuring that reform is informed by

practical experience and firmly grounded in human rights principles.

Next Steps

Looking ahead, the intention is to bring forward a legislative package in the next parliamentary term, informed by the workstreams now underway and by the voices of those with lived experience. I am clear that this cannot be a superficial update but a substantive modernisation of Scotland's incapacity law - one that reflects contemporary human rights standards and delivers practical, workable solutions for practitioners and families alike.

I would like to put on record my thanks to those who are already engaged with and supporting our programme of AWI reform. My officials will be happy to update further as this important work progresses.

Tom Arthur MSP

Minister for Social Care and Mental Wellbeing

AWI impact of Legal Aid reform

On 28th January 2026 the Minister for Victims and Community Safety, Siobhian Brown, announced a 13% increase in Legal Aid fees, to apply from September 2026. She said:

> *"Access to justice is a fundamental right and we want to ensure people get the help they need and that there are solicitors available to provide it. These reforms mark the biggest change to Scotland's legal aid system in a generation. This 13 per cent uplift, combined with our doubling of traineeship places and expanded digital support, demonstrates our commitment to a legal aid system that works for everyone.*
>
> *"This builds on other important legal aid reforms we have already made and are already making a real difference, including clearer income eligibility rules, non means tested legal aid for families in Fatal Accident Inquiries where there has been a death in custody, and the removal of eligibility checks for children in the hearings system. By cutting complexity, widening access, and ensuring fair pay, we are creating a legal aid system that delivers justice for all.*
>
> *"As part of this wider support package, we anticipate the support of solicitors to continue with the constructive engagement on the development of planning and roll out of improvements that would enhance the early stages of justice system reform."*

This follows a series of mixed messages to practitioners. As recently as 16th January 2026 the Law Society of Scotland roundly condemned the refusal by Scottish Government, in its Budget that week, to implement cross-party calls for an increase in Legal Aid funding. The Society President Patricia Thom was reported as calling that refusal "a bitter blow". However, less than a fortnight later, in Scottish Legal News of 29th January 2026 she was quoted as saying, of the ministerial announcement that day, that: "*This is a significant fee increase and a lifeline for access to justice in Scotland that will help stabilise the Legal Aid system while work on long-term reform continues.*" It is understood that discussions are ongoing about the fundamental issues of whether solicitors will be able to charge on an itemised basis, and at adequate rates, as an alternative in each case to opting for a block fee; and whether SLAB will

limit any future observations to those which are relevant and competent, not infringing upon the professional skills and judgement of solicitors, nor threatening to put them in breach of the standards of service and other obligations under their code of conduct.

One must await developments in order to evaluate the effect of this change, and the delay in implementing it, upon the existential threat to necessary legal services for persons to whom AWI law is applicable, and upon the ability of Scottish Government to deliver on the promised reforms following the process described in the preceding article. These issues have been repeatedly addressed in successive editions of this Report. For an example, see the item "AWI reform: progressing, but imperilled by SLAB" in the September 2025 Report, and my two-part article "Adults with incapacity improvement and reform" in the first two issues of Scots Law Times in 2026 (at 2026 SLT (News) 1 and 9, particularly at page 2. It is perhaps significant that I was able to write, in the second column on page 2, that: "*It is understood that there is communication between SLAB and Scottish Government's AWI reform team*".

One will have to await "the proof of the pudding", against tests such as whether by September 2026 the number of solicitors forced out of legally aided AWI work has dwindled even further, and the absurd consequences of that, including (firstly) whether the lack of skilled representation results in even further appointments by courts of safeguarders, generally at greater cost to the public purse than if adequately-remunerated skilled solicitor services were available to parties, and (secondly) whether the same lack of skilled practitioners continues to result in continuing avoidable delays in discharging patients inappropriately held in hospital when they have been assessed as suitable for discharge, also at much greater cost to the public purse than if appropriate legal services were available to ensure prompt discharge. Many other measures of success would be appropriate.

Adrian D Ward

Capacitous refusal of treatment by a 14 year-old

On 4th December 2025 Lady Tait issued an intriguing decision in the case of *A Scottish Health Board, Petitioner*, [2025] CSOH 121, reported last week at 2026 SLT 71. A 14 year-old refused consent to treatment. The medical evidence was that she had full understanding of the issues and that her refusal of treatment was capacitous. The doctors sought permission of the court to overrule that refusal if it were to become critical in a life-saving situation. By reference to relevant child law, Lady Tait granted permission, concluding that in a life-or-death situation it would be in the best interests of the girl for such treatment to be administered notwithstanding her capacitous refusal of consent to it.

The decision seems to have gone to the heart of the conflict between the deemed incapacitation of children, and situations where they in fact have capacity. That was of course formerly the position in relation to adults diagnosed as having a mental disorder, rejected in developments up to and including the Adults with Incapacity (Scotland) Act 2000, that rejection being reinforced by the UN Convention on the Rights of Persons with Disabilities. However, what was not addressed in Lady Tait's decision is whether the outcome would have been different in relation to a 17 year-old or a 19 year-old, and if so what is the evidenced basis for those differences in treatment.

Moreover, the decision makes reference to the United Nations Convention on the Rights of the Child

(Incorporation) (Scotland) Act 2024, but not the UN Convention on the Rights of Persons with Disabilities, the protections of which are not limited to adults. The circumstances seem to raise a "which Convention?" issue. It is doubtful whether the effective incapacitation of the 14 year-old girl could be justified in relation to the protections in the Disability Convention. Although the Disability Convention has not yet been incorporated in Scots law, it is the declared intention of the current Scottish Government to incorporate it, and in the meantime a complaint by a citizen (of any age) of discrimination on grounds of disability can be taken to the UN Committee on the Rights of Persons with Disabilities under the First Protocol to the Disability Convention, ratified in respect of the whole UK.

Those of us concerned editorially, as well as contributors, with the Scotland section considered that it would be best for an appropriate specialist to be invited to contribute an item on this case. Hilary Steele, now of Starling Lawyers, has well-recognised leading expertise in this relevant area of law. We are delighted that she accepted our invitation.

Remarkably, accordingly, this Report is unique not only in carrying a ministerial contribution, but in carrying two guest contributions in the same issue. Hilary's contribution follows.

Adrian D Ward

A Scottish Health Board, Petition (Outer House, Court of Session) [2025] CSOH 121 Opinion of Lady Tait, 4 December 2025.

The facts

The Court of Session ordinary petition involved a 14-year-old, referred to as Child A, who needed an elective medical procedure. As a Jehovah's Witness, Child A told her doctors she would not agree to receive blood or blood products, even in a life-threatening situation. The treating clinicians had assessed that Child A had capacity to make this decision.

Although blood loss was an inevitable feature of the procedure, the need for transfusion was described as a recognised but very rare complication. If a complication arose, the consequences of the clinical team not administering blood could be catastrophic, resulting in brain damage or death.

The Court appointed a curator ad litem to establish Child A's views. The curator described Child A as "a mature, confident and articulate young person" who had "thoroughly researched material relevant to her refusal to consent to receive the transfusion and the other processes to which she had consented." Nevertheless, applying a best interests perspective, the curator concluded that the risks of death or serious harm outweighed Child A's "clearly expressed and considered views".

The remedy sought

The petitioner (a Scottish Health Board) sought the Court of Session's exercise of its *parens patriae* jurisdiction to authorise the administration of a blood transfusion or blood products, if clinically necessary, at any time from the procedure until 14 days afterwards, to avoid serious harm, including but not limited to death.

The "novel" legal issue for the court was how it should exercise its parens patriae jurisdiction in circumstances where the patient is a child under 16, and assessed as having statutory legal capacity to consent to treatment under section 2(4) of the Age of Legal Capacity (Scotland) Act 1991, yet was refusing a specific treatment that may be life-preserving.

The parens patriae jurisdiction in Scotland

In Scotland, the Court of Session has *parens patriae* jurisdiction (as "parent of the nation"), authorising it to act in the best interests of persons (including children) unable to protect their own interests. In medical cases, this may include authorising specific treatments or, in certain circumstances, authorising non-treatment or the withdrawal of treatment when consent is unavailable, contested, or legally uncertain. [*Law Hospital NHS Trust v Lord Advocate* 1996 SC 301].

Parens patriae v Declarator

Scots law distinguishes between authorisation under (i) *parens patriae* where the court provides authority, with the same legal effect as if consent had been given by the person (or, in the case of a child, by a person able to consent on the child's behalf), and (ii)Declarator: a declaration that a proposed course of action would be lawful. This distinction remains important in medical cases where clinicians seek the court's authority to provide specific treatments, rather than a declaration of legality.

Circumstances where a *parens patriae* petition may be appropriate

1. Absence of any person able to provide consent, for example, no holder of parental rights and responsibilities ("PRRs") available.

2. Dispute or legal uncertainty about who can consent. Even when there is "care and control" reliance under section 5 of the Children (Scotland) Act 1995, the 1995 Act is not suited to non-emergency care or elective procedures - see the opinion of Lady Carmichael in a *Petition by a Health Board in respect of KL* [2024] CSOH 108, who observed that section 5 appears "more obviously apt" for emergency situations requiring treatment to which the child cannot consent.

3. Conflict about welfare, including disagreement between clinicians and parents/PRR holders, or where a child (including a child assessed as having capacity) opposes treatment and a judicial determination is sought to safeguard the welfare of the child.

The capacity of a young person in Scotland

1. Scotland has a distinctive approach to legal capacity when compared to the rest of the UK. Under the Age of Legal Capacity (Scotland) Act 1991 ("the 1991 Act"), a person aged 16 or over has full legal capacity to consent to or refuse medical treatment, provided they have decision-making capacity in the clinical sense (the ability to understand, retain, weigh and balance the relevant information necessary to make an informed decision).

2. Section 2(4) of the 1991 Act also provides that *"A person under the age of 16 shall have legal capacity to consent on his own behalf to any surgical, medical or dental procedure or treatment*

where, in the opinion of a qualified medical practitioner attending him, he is capable of understanding the nature and possible consequences of the procedure or treatment."

3. Regarding a person under the age of 16, regardless of their capacity to give or withhold consent to medical treatment, the Court of Session may exercise its *parens patriae* jurisdiction in the child's best interests. [*Law Hospital*].

For a young person aged 16-17 who has capacity, a clinician cannot provide treatment in the patient's best interests if it is contrary to the patient's views. *As* Lady Tait noted, "A patient who has legal capacity can decline treatment for reasons which others consider irrational or for no reason at all; it is the patient's decision [para 7] *R (Burke) v General Medical Council* [2006] QB at paragraph 30.

This autonomy can sit uncomfortably in welfare situations where a young person can be both an adult and a child under Scottish law.

Adult or child?

When a person becomes an "adult" in Scotland depends on the legal context. Under the Age of Legal Capacity (Scotland) Act 1991, a person aged 16 or over has full legal capacity to enter into transactions, including the instruction of a solicitor, subject to limited statutory qualifications. This is why many Scottish statutes, including the Adults with Incapacity (Scotland) Act 2000, treat an "adult" as someone aged 16 or over, despite the age of majority remaining 18 [Age of Majority (Scotland) Act 1969].

This approach is at odds with up-to-date child welfare and protection guidance. These include the National Guidance for Child Protection in Scotland (2023), which provides child protection processes for under-18s, The Children and Young People (Scotland) Act 2014 (children's services planning and wellbeing). Importantly, the UNCRC, incorporated into Scottish domestic law on 16 January 2024 (The UNCRC (Incorporation) (Scotland) Act 2024), applies to anyone under 18.

When (if at all) can such a refusal be overridden?

Adults with Incapacity (Scotland) Act 2000. The 2000 Act provides a framework for "adults" (16+) who lack capacity (as evidenced by a section 47 certificate). It does not, and should not, however, be used as a means of overriding a refusal by a person with legal capacity.

Mental Health (Care and Treatment) (Scotland) Act 2003. The 2003 Act can authorise treatment without consent for a mental disorder under statutory safeguards. However, it should not be used as a blunt tool to authorise physical healthcare or override a refusal of treatment simply because the outcome is undesirable.

Emergency / necessity: In emergency circumstances, clinicians may be able to provide immediately necessary treatment to save life or prevent serious deterioration, provided the legal tests for emergency intervention are met.

When legal capacity and clinical decision making diverge

Legal capacity and clinical decision-making capacity can diverge in cases where refusal of treatment has potentially grave consequences. The ability for conflict is greater in healthcare situations where a

patient is neuro-developmentally immature; there is acute distress (pain, fear, shock) and a fluctuating mental state. Young people, are often reliant on family (socially and financially), which may lead to coercion. Meanwhile, family intimidation can lead to defensive medicine by clinicians concerned about potential litigation and regulatory investigations.

In 'all or nothing' cases where treatment is effective and has a low burden (such as administering antibiotics or a blood transfusion), the temptation for clinicians and health boards may be to frame a refusal of treatment as one of child protection or welfare under *parens patriae*. However, if the young person aged 16-17 is truly capable, the case is not obviously a situation where consent cannot be obtained; instead, it is a conflict between autonomy and welfare.

Using *parens patriae* or attempting to shoehorn the dispute into an AWI case risks circumventing statutory frameworks or providing an override that lacks a clear legal basis. In short, neither approach provides a clear remedy to safeguard a young person's rights or future.

The situation seems out of step with more recent practice when considering the approach taken by the Scottish Sentencing Council, an independent statutory advisory body with responsibility for preparing sentencing guidelines for the Scottish courts. The Sentencing Council accepted evidence that "maturity" continues into the mid-20s. The rationale being that many people under 25 have not yet attained full intellectual and emotional maturity. The guideline proceeds on the evidential premise that, compared with older adults, young people are more likely to:

- exercise poorer judgment and impulse control;
- be susceptible to peer pressure, coercion and exploitation,
- take risks and fail to foresee consequences.

This is considered relevant to culpability (blameworthiness) and may lead to a reduced sentence.

Given that age in Scotland is accepted as a mitigating factor and culpability modifier, is it reasonable that a capacitous 16 or 17-year-old child's decision to refuse treatment should be determinative in all circumstances?

A north-south divide?

Sir James Munby provided a helpful summary of the legal principles to be applied to the court when concerning the medical treatment of children in the case of *Re X (a child) (No 2) An NHS Trust v X* [2021] EWHC 65 (Fam)

X involved a 15-year-old Jehovah's Witness who challenged the 'conventional wisdom' that no child has an absolute right to refuse medical treatment, even if the child is Gillick competent or, having reached the age of 16, is presumed to be Gillick competent under section 8 of the Family Law Reform Act 1969 (FLRA 1969), and whether the court, in the exercise of its inherent *parens patriae* jurisdiction, can overrule that decision in an appropriate case.

The "conventional wisdom" is founded *In re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11 and *In re W (A Minor) (Medical Treatment: Courts Jurisdiction)* [1993] Fam 64 ("Re R/Re W")

The challenge here to the "conventional wisdom" was on the grounds that, whatever was or was not decided in those two cases, society and the law had changed with the Human Rights Act 1998 (HRA) and Mental Capacity Act 2005 (MCA); the principles established in those cases no longer reflect the law, or indeed society.

The court was invited to look to the decision of the Supreme Court of Canada in *AC and Others v Manitoba (Director of Child and Family Services)* 2009 SCC 30, [2009] 2 SCR 181, [2009] 5 LRC 557, where the majority held that if a young person under the age of 16 is able to establish that he or she has the requisite capacity, then regardless of the possible medical consequences, that persons' decision is determinative.

X, herself, was Gillick competent and described as "mature and wise beyond her years". She suffers from sickle cell syndrome and would intermittently go into crisis, requiring urgent admission to hospital and, in the opinion of her treating clinicians, life-saving treatment with blood transfusions. In accordance with her religious beliefs, X refused to consent to blood transfusions.

Sir James Munby, sitting as a High Court judge, held that it is settled law that in relation to medical treatment, neither the decision of a Gillick competent child under the age of 16 nor the decision of a child aged 16 or 17 is determinative in all circumstances. The starting point is the general premise that the protection of the child's welfare requires, at least, the protection of the child's life, and it is the duty of the court to ensure, as far as it can, that children survive until adulthood.

Sir James found there is nothing in MCA 2005 invalidating *Re R/ Re W*, and nothing in MCA 2005 to suggest any need for judicial re-evaluation of the legal principles established by those cases.

Regarding Re R/Re W being incompatible with the ECHR, Sir James disagreed and held that the common law principles established in *Re R/ Re W* did not involve any breach of Articles 3, 8, 9 or 14 of the ECHR, and preserving the lives of children until adulthood is a legitimate aim.

Finally, Sir James concluded that the decision in the Canadian Supreme Court in *AC "is not authority for the proposition that the decision of either a Gillick competent child or a child aged 16 or more is always, and without exception, determinative in relation to medical treatment. In the final analysis, as I read* [Abella J's] *judgment, the court always has the last word."* [99]

The Scottish approach

In the present case, Lady Tait agreed with the petitioner's submission that there is no principled reason why the Scottish approach should differ from that of the Court of Appeal in *E v Northern Care Alliance NHS Trust* [2022], which followed *Re X*, and adopted the three-stage approach, in which the court must:

1. establish the facts: the risk of the event occurring (its probability) or the risk to the person of that event (its consequences);

2. consider whether an immediate decision is necessary (assessment of how realistic it is to expect a fair and timely decision if a future crisis does arise; and

3. assess the child's welfare – an objective assessment of what is in the child's best interests – balancing the preservation of life and personal autonomy.

While a level of consistency with our English counterparts may have been reached in relation to the under-16, it is far less certain that a consistent approach would be taken in respect of a child of 16, where there is considerable diversion in Scotland in addressing capacity.

Lady Tait did not comment on the suitability of Scotland's ordinary petition procedure for dealing with complex refusal cases as it is already established in Scots Law [11]. Neither did she address any perceived societal changes suggesting a need for parliamentary scrutiny.

The process for such cases remains the Court of Session's ordinary petition.

Court of Session's ordinary petition procedure

Challenges: Court timeline versus clinical timeline

Even urgent petitions require the instruction of counsel, careful drafting of fact-specific craves, lodging productions [evidence], obtaining interim orders, and arranging a hearing. In refusal cases, the clinical window may be hours or days, and the ordinary petition procedure will struggle to keep pace with evolving clinical developments.

Where the patient's condition is fluctuating, evidence can rapidly become outdated, requiring repeated affidavits and supplementary expert opinions and productions.

Procedural complexity (intimation/representation)

Refusal cases often require the intimation of proceedings to multiple parties (parents/PRR-holders, the local authority, Mental Welfare Commission)

The court will likely require independent representation for the patient/child (e.g., a curator ad litem). There can be delays in identifying and instructing a suitable curator quickly, in arranging legal aid funding, and in the curator's ability to obtain instructions and to test the evidence.

Evidential burden

Clinicians must produce evidence specific to an uncertain legal criteria (capacity/voluntariness; best interests; proportionality; alternatives). It is not simply a matter of clinical preference.

The need to lodge sensitive medical records can raise confidentiality issues, increasing the risk of disputes regarding disclosure.

[11] Law Hospital NHS Trust v Lord Advocate 1996 SC 301.

Uncertainty where the person has capacity

For adults (and, in Scotland, 16–17-year-olds with legal capacity), the most challenging cases are those in which a person's refusal may be clinically catastrophic. Petition procedure does not by itself solve the underlying uncertainty of what legal principle permits override (if any), and on what threshold?

Expense and inconsistent access to justice

Court of Session litigation is expensive, where legal aid funding is not available. It can also be practically inaccessible to families wishing to attend an in-person hearing, as hearings are held in Edinburgh on short notice.

There may be uneven access across Health Boards, for example, for patients living in remote areas such as the Highlands and Islands.

Litigation can entrench parties' views and damage therapeutic relationships. In mental health contexts, it can exacerbate disengagement.

Even with the anonymisation of parties involved in the dispute, refusal disputes can attract publicity. The "jigsaw identification" risk is higher in rare-condition or high profile treatment disputes.

A time for legislative reform?

Disagreements about refusal of serious medical treatment by 16 and 17-year-olds raise complex questions about self-determination and legal certainty. Where the consequences might be fatal or irreversible, the current framework risks leaving clinicians, families, and young people without a clear, rapid, and rights-compliant route to independent decision-making.

Scientific evidence on neurodevelopment has led to reconsideration of how young people's capacity should be assessed. There is no evidence that the average Scottish 16-year-old has greater capacity than their English counterpart. Yet case law indicates that the welfare of a 16- or 17-year-old is significantly better protected south of the border in matters involving medical decision-making.

Is such inconsistency reasonable or justifiable in the face of scientific developments and legal approaches to criminal responsibility for young people in Scotland?

While societal attitudes may have evolved, it is far from clear that society supports granting children complete autonomy to refuse medical treatment with potential life-threatening consequences.

A statutory scheme, limited to high-risk cases, could preserve autonomy while ensuring that interventions in the care of young people are lawful and consistent. UNCRC alignment would support meaningful participation by the child, along with transparency on how the child's views were treated and, if departed from, why.

Potential benefits of legislative reform

Statutory criteria setting out when escalation to a court or tribunal is necessary.

1. Requirement for meaningful participation from children (including access to independent advocacy and the appointment of a curator ad litem).
2. Application of the least restrictive principle (along with clear interaction with the AWI 2000 and MHA 2003).
3. Fast-track dispute resolution through a specialist court or tribunal
4. Meaningful consideration of advance planning: access to advance statements and welfare powers of attorney.

Scientific evidence on adolescent neurodevelopment undermines the current position that 16 and 17-year-olds in Scotland should have an unequivocal right to self-determination regarding their medical decision making - a position that is out of step with the rest of the UK.

It is harder to justify such divergence when considering (i) modern understanding of evolving capacity and vulnerability during late adolescence, and (ii) the gravity of outcomes that may flow from a single time-critical decision.

In these circumstances, Scotland may benefit from a clear, narrowly framed statutory framework for such high-risk cases. A framework that preserves autonomy as the default position, but ensures that any departure from it is lawful, necessary, and proportionate.

A legal framework aligned with the UNCRC and ECHR would ensure procedural fairness, encourage meaningful participation (through access to independent advocacy and, if necessary, a curator ad litem), and transparency in assessing the child's views and capacity to consent to treatment.

Conclusion

Safeguarding young people during a critical neurodevelopmental period requires more than broad "protective" discretion provided by the court as the parent of the nation. Legislative reform has the opportunity to ensure that Scotland's approach to child welfare is consistent and child-centred in its application of both UNCRC principles and ECHR standards.

Editors and contributors

Alex Ruck Keene KC (Hon): alex.ruckkeene@39essex.com

Alex has been in cases involving the MCA 2005 at all levels up to and including the Supreme Court and the European Court of Human Rights. He also writes extensively, has numerous academic affiliations, including as Visiting Professor at King's College London, and created the website www.mentalcapacitylawandpolicy.org.uk. To view full CV click here.

Victoria Butler-Cole KC: vb@39essex.com

Victoria regularly appears in the Court of Protection, instructed by the Official Solicitor, family members, and statutory bodies, in welfare, financial and medical cases. She is Vice-Chair of the Court of Protection Bar Association and a member of the Nuffield Council on Bioethics. To view full CV click here.

Neil Allen: neil.allen@39essex.com

Neil has particular interests in ECHR/CRPD human rights, mental health and incapacity law and mainly practises in the Court of Protection and Upper Tribunal. He trains health, social care and legal professionals through his training company, LPS Law Ltd. When time permits, Neil publishes in academic books and journals and created the website www.lpslaw.co.uk. To view full CV click here.

Arianna Kelly: Arianna.kelly@39essex.com

Arianna practices in mental capacity, community care, mental health law and inquests. Arianna acts in a range of Court of Protection matters including welfare, property and affairs, serious medical treatment and in inherent jurisdiction matters. Arianna works extensively in the field of community care. She is a contributor to Court of Protection Practice (LexisNexis). To view a full CV, click here.

Nicola Kohn: nicola.kohn@39essex.com

Nicola appears regularly in the Court of Protection in health and welfare matters. She is frequently instructed by the Official Solicitor as well as by local authorities, ICBs and care homes. She is a contributor to the 5th edition of the *Assessment of Mental Capacity: A Practical Guide for Doctors and Lawyers* (BMA/Law Society 2019). To view full CV click here.

Annabel Lee: annabel.lee@39essex.com

Annabel has a well-established practice in the Court of Protection covering all areas of health and welfare, property and affairs and cross-border matters. She is ranked as a leading junior for Court of Protection work in the main legal directories, and was shortlisted for Court of Protection and Community Care Junior of the Year in 2023. She is a contributor to the leading practitioners' text, the Court of Protection Practice (LexisNexis). To view full CV click here.

Katie Scott: katie.scott@39essex.com

Katie advises and represents clients in all things health related, from personal injury and clinical negligence, to community care, mental health and healthcare regulation. The main focus of her practice however is in the Court of Protection where she has a particular interest in the health and welfare of incapacitated adults. She is also a qualified mediator, mediating legal and community disputes. To view full CV click here.

Nyasha Weinberg: Nyasha.Weinberg@39essex.com

Nyasha has a practice across public and private law, has appeared in the Court of Protection and has a particular interest in health and human rights issues. To view a full CV, click here

Scotland editors

Adrian Ward: adrian@adward.co.uk

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 is speaking at a conference organised by St Christopher's Hospice on Mental Capacity in Palliative Care on 9 March. The conference is in person (in London) and online; for details and to book, see here.

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 March. 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.

Sheraton Doyle
Director of Clerking
sheraton.doyle@39essex.com

Peter Campbell
Director of Clerking
peter.campbell@39essex.com

Chambers UK Bar
Court of Protection: Health & Welfare
Leading Set

The Legal 500 UK
Court of Protection and Community Care
Top Tier Set

clerks@39essex.com • DX: London/Chancery Lane 298 • 39essex.com

LONDON
81 Chancery Lane,
London WC2A 1DD
Tel: +44 (0)20 7832 1111
Fax: +44 (0)20 7353 3978

MANCHESTER
82 King Street,
Manchester M2 4WQ
Tel: +44 (0)16 1870 0333
Fax: +44 (0)20 7353 3978

SINGAPORE
Maxwell Chambers,
#02-16 32, Maxwell Road
Singapore 069115
Tel: +(65) 6634 1336

KUALA LUMPUR
#02-9, Bangunan Sulaiman,
Jalan Sultan Hishamuddin
50000 Kuala Lumpur,
Malaysia: +(60)32 271 1085