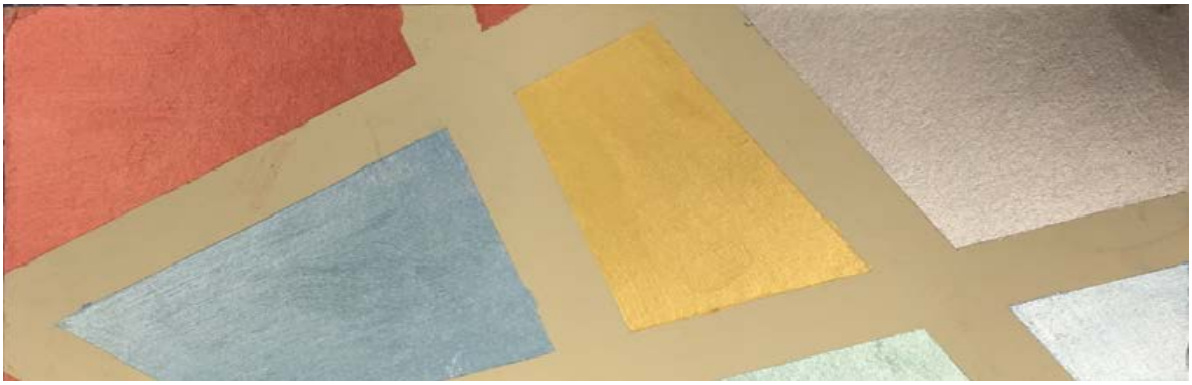

Welcome to the February 2026 Mental Capacity Report. Highlights this month include:

(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.

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

AWI 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 [1]. 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)

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

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.

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. 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 the Court of Protection Practice (LexisNexis). To view 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 2022). 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

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