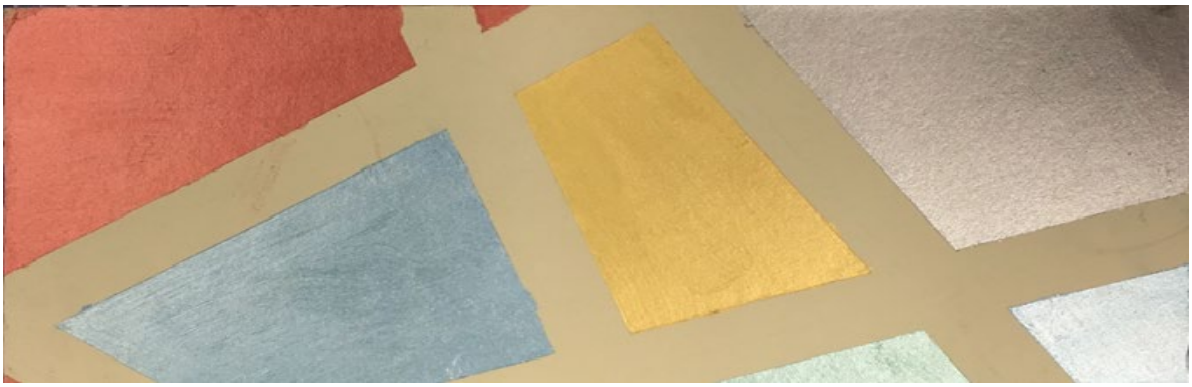

Welcome to the March 2026 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: Senior Judge Hilder lays down her baton; attorneys and failures to consult, and a research corner on anorexia and last resort options.

(2) In the Property and Affairs Report: new OPG guidance, 'third sector' deputyship and a reverse indemnity tangle;

(3) In the Practice and Procedure Report: notes from a fireside chat with DDJ Flanagan, and litigation capacity in the absence of subject-matter capacity;

(4) In the Mental Health Matters Report: conditional discharge and deprivation of liberty – the new regime, and conditional discharge into hospital;

(5) In the Children's Capacity Report: parental responsibility and confinement – the need for an appellate judgment;

(6) The Wider Context: assisted dying / assisted suicide update, Strasbourg's latest word on withdrawing life-sustaining treatment and mental capacity reform in New Zealand.

Circumstances beyond our control mean that we do not have a Scottish report this time.

A reminder that we have updated our unofficial update to the MCA / DoLS Codes of Practice, available here, and that, whilst Chambers have launched a new and zippy version of our website, all the content that you might need – our Reports, our case-law summaries, and our guidance notes – can still be found via here.

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

Contents

HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

Senior Judge Hilder

We are sad to note that HHJ Hilder will be stepping down as Senior Judge of the Court of Protection. We await details of precisely when this will be, and we will at that point publish a full appreciation, but, amongst other things, we owe her a huge debt of thanks for the work that she

did during the pandemic to keep the Court of Protection functioning.

The Court of Appeal, clinical judgment and best interests decisions

As we go to press, we understand that it is likely that the Court of Appeal will be handing down a significant judgment about this issue in the week of 2 March. We will update via the usual channels when the judgment is out.

Short note: attorneys, failures to consult and consequences

Cwm Taf Morgannwg University Health Board v RW & Anor [2026] EWCOP 10 (T3) provides a snapshot of the realities of navigating health and welfare decision-making of a kind that rarely makes it to court.[1] In short compass, it concerns a failure by a hospital to consult with an attorney regarding decision-making about life-sustaining treatment. In the context of a considerable focus on understanding about the MCA in Parliament at the moment, it is important to emphasise that failures to apply the Act are not uncommon, including (here) failures to comply with a clear statutory duty to consult. What is uncommon is that, in this case, the attorney was a professional attorney – an extremely experienced solicitor – who sought to move heaven and earth to correct the situation. The full story is complicated, difficult, and is likely to be the subject of detailed examination in an inquest. For present purposes, what is of importance is both that the Health Board acknowledged its unlawful behaviour in failing to comply with the MCA 2005 by consulting with the attorney, and that it was penalised in costs for doing so on the basis that it was only the bringing of an application by the attorney which led to changes in the man's care and treatment.

It is very much to be hoped that the results of this case will be that this Health Board hews very much closer to the law (and, it appears, its own policy); is it too aspirational to hope that other health bodies will recognise the case as a 'near miss,' so as to carry out their own work in this regard?

Deprivation of liberty in acute hospitals

Drawing heavily, and with credit, on the Law Society's guidance on deprivation of liberty, West Midlands ADASS has published guidance, written by Lorraine Currie, for hospitals and local authorities working together to process applications for deprivation of liberty in acute hospitals. This is an area that we are aware causes very considerable tensions, and the "myth-busting" at the end is very helpful indeed. We very strongly suggest that this is a document which can, and should, be read simultaneously by the relevant leads for local authorities and acute trusts so as to identify whether or not there is a shared understanding of both the substantive law relating to deprivation of liberty here, and of the consequential procedural obligations.

National Mental Capacity Forum Annual Report 2023-2025

Margaret Flynn, the Chair of the National Mental Capacity Forum, has published her annual report (in fact, a double issue) for 2023-2025, drawing on both her own tireless work and that of members of the Forum. Amongst other highlights, contains observations about deprivation of liberty, case studies illuminating

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

both good and bad practice under the MCA 2005, a year in cases (by Alex), work around a consensus statement on DNACPR, reflections on partnerships and networks, and 'back to basics' around DoLS.

Artificial intelligence and assessments

The Ada Lovelace Institute has published a detailed and disturbing report entitled "Scribe and prejudice? Exploring the use of AI transcription tools in social care." Whilst much of its focus is on children's social care, it also addresses adult social care. Of particular concern should be Insight 4:

> *Social workers assume full responsibility for AI transcription tools, but perceptions of the tool's reliability, accuracy and 'human in the loop' vary significantly. The use of AI transcription tools to generate documents creates new mechanisms for people's experiences to be misrepresented in official records. Some social workers observed instances where AI-generated misrepresentations could directly lead to harm. Other social workers were less aware of possible AI risks. This creates inconsistencies in the oversight and evaluation of AI-generated documents.*

An example of a hallucination was given in the report:

> *For example, one social worker recounted an instance where, when using an AI transcription tool to create a summary, the tool had incorrectly 'indicated that there was suicidal ideation', but 'at no point did the client actually, you know, talk about suicidal ideation or planning, or anything'.*

Our clear view is that:

(1) Any reliance upon AI which goes beyond transcription of interviews into the completion of assessments of capacity or best interests (even with 'humans in the loop') are profoundly problematic.

(2) Until and unless the courts have pronounced upon the acceptability of the use of AI in relation to materials put before them (in particular the COP3 form), any reliance upon such AI assistance – especially without making it clear that it has been used – brings with it significant legal risks.

Research corner: Last resort as a justification for compulsory nasogastric tube feeding of adults with anorexia nervosa

In the context of ongoing debates about both 'under' and 'over' treatment in relation to anorexia, we draw attention to this article by Rachel Jenkins and Emma Cave. As the abstract makes clear:

Nasogastric tube feeding may be imposed on adults with anorexia nervosa without their consent. Although it can preserve life, it can also cause significant and lasting distress, and it is widely accepted that the intervention should be employed only as a last resort. However, the concept of last resort remains insufficiently defined. Clinical guidance and case law in England and Wales use the term to guide decision-making, but the thresholds by which a particular action can be considered a last resort are varied and ambiguous. Informed by human rights principles, this article articulates the relevant thresholds for last resort decisions relevant to detention, restraint, and high-risk or speculative treatments, clarifying operative meanings by way of a typology.

PROPERTY AND AFFAIRS

OPG guidance

The Office of the Public Guardian has published two guidance notes:

1. A guidance note on gift giving by deputies and attorneys, outlining the very restrictive circumstances under which such gift-giving be carried out without the authority of the Court of Protection;

2. A practice note on solicitor client accounts, setting out the OPG's approach to the use by solicitor deputies of the use of client accounts to manage deputyship funds, including by reference to the obligations on solicitors under the Solicitors Regulation Authority Accounts Rules 2011.

Property and Affairs Court User Group Minutes

The minutes of the meeting held on 21 January 2026 have now been published, and can be found here. Of particular wider relevance is what Senior Judge Hilder had to say in relation to urgent matters:

> *HHJH explained that the urgency needs to be clearly flagged, with reasons given. There is a box on the application form for doing this, and covering letter-e-mails should do it too.* […] *The process is that staff identify applications marked as urgent, and refer them to the Urgent Business Judge. There are now two UBJs each day – one for paper applications and one for digital applications. The UBJ will need to prioritise (not 'downgrade') the applications as they are referred, which is why it is important that the reason for urgency is clearly explained. Please do not abuse the UBJ system – if everything is considered 'urgent', then in reality nothing can be prioritised. In respect of ongoing PI litigation, there is direct communication between FAH and the KB Masters if/when the Master considers that necessary.*

"Third sector" deputyship – a further iteration of the requirements for appointment

Re AB (Enable & Thrive Ltd) [2026] EWCOP 11 (T3) (Senior Judge Hilder)

Deputies – property and affairs

Summary

In *Re AB (Enable & Thrive Ltd)* [2026] EWCOP 11 (T3), Senior Judge Hilder, not without a certain degree of reluctance, confirmed that a trust corporation which has (corporately) no independent regulatory oversight can, in some situations, be appointed as a property and affairs deputy. That category of trust corporation had been envisaged in an earlier judgment of Senior Judge Hilder, *Various Incapacitated Persons and the Appointment of Trust Corporations as Deputies* [2018] EWCOP 3, identified *Re AB* as "the First Judgment."

Senior Judge Hilder revisited the conclusions of the First Judgment as regards the undertakings that must provided before any appointment of such a trust corporation can be made, thus:

> *25. The conclusion reached at paragraph 31 of The First Judgment still holds good: the information necessary to satisfy the court must be 'built into' the application process. However, in consideration of a Category 3 trust corporation, it is necessary to revisit the undertakings which were there identified as sufficient.*
>
> *a. The first undertaking required is that the entity seeking to be appointed as deputy is indeed a trust corporation within the meaning of section 64(1) of*

the Mental Capacity Act 2005, can lawfully act as such, and will inform the Public Guardian immediately if that ceases to be the case.

The Applicant has already confirmed the trust corporation status of Enable & Thrive Ltd. There is no suggestion that there would be any difficulty in further undertaking to inform the Public Guardian if that ceased to be the case.

b. The second undertaking required is that the trust corporation will comply with the Public Guardian's published standards for professional deputies.

As already proposed at paragraph 44 of The First Judgment, a Category 3 trust corporation should be held to the same standards as any other trust corporation. The Applicant has not yet expressly given this second undertaking, but neither has it or the Public Guardian identified any reason why it could not.

c. The third undertaking required is the crux of the current application, relating to regulation by the SRA. Obviously Enable & Thrive Ltd cannot give either version of this third undertaking.

25. It is helpful to set out in full what is said in The First Judgment as to why the question of external regulation is relevant:

> *"45. … The Court's concern is to protect the interests of the incapacitated person. The most likely risk to an incapacitated party from the actions of a property and affairs deputy is misappropriation/loss of that person's assets. Any person or body appointed as deputy is subject to the Court's power to terminate the appointment and to supervision by the Public Guardian, and the Court routinely appoints as deputy lay people who will be subject to no other regulation. If misappropriation/loss occurs, the prospects of recovering the misused funds are independent of regulation. Regulation is reactive – if a problem arises, a regulated person or body may be subject to sanctions but they are likely to come after the event. What assurance then does external regulation provide?*
>
> *46. Where a lay, and therefore unregulated, deputy is appointed, the deputy is most commonly a family member or acquaintance of the protected person. Such a deputy is not usually authorised to charge for providing the functions of deputyship: he or she performs their duties for free, entitled only to claim reasonable expenses. In contrast, a trust corporation deputy is unlikely to have been previously involved with the protected person and generally anticipates authorisation for the charging of fees. Whereas a lay deputy is likely to be appointed only for a small number of protected persons, a trust corporation is likely to seek appointment for many protected persons, thereby aggregating a large risk.*
>
> *47. Adherence to a regulatory framework provides a marker of standards; and the possibility (threat?) of sanctions for failure to meet prescribed standards will commonly operate proactively as an incentive to compliance. Regulation is not a guarantee of*

> *anything but it is, as Mr Rees describes, "a further check on what the deputy does….[because there is] someone else sitting on their shoulder." The court must of course consider every case on its facts but where there is a requirement to comply with appropriate external regulation, the Court can derive assurance of the likelihood that a potential deputy will behave in an appropriate fashion to meet the best interests of P; and if he does not, that other agencies are likely to step in."*

27. Neither the Applicant nor the Public Guardian has suggested otherwise, so I infer that Ms. Allchurch's personal involvement in Enable & Thrive Ltd is, for the purposes of SRA regulation, the same as if Enable & Thrive Ltd were a Category 2 trust corporation. […]

28. [The regulatory obligations imposed by the SRA] *are not insignificant regulatory demands on Ms. Allport. She is clearly aware of her professional obligations. As she says in her latest statement "As a practising solicitor, I take my obligations to clients very seriously, ensuring that they receive a high standard of professional serve that is also affordable. … Any impropriety within Enable & Thrive would jeopardise not only my practising certificate but also my reputation and livelihood…" It may be expected that this type of leadership would have a positive effect on the conduct of the organisation as a whole.*

29. However, any SRA intervention as a result of these regulatory obligations would be solely in respect of Ms. Allchurch herself - not the Enable & Thrive Ltd trust corporation, not the non-solicitor co-director, and not the non-solicitor employees. Chapter 10 of the SRA Code (written notices to provide information, explanation and documents) would not apply, funds held by Enable & Thrive Ltd would not be protected by the Solicitors Fund Act 1974, and its clients would neither have right to claim on the Solicitors Compensation Fund nor be able to make a complaint to the SRA or the Legal Ombudsman about the trust corporation itself. All of that is the same as for Category 2 trust corporations, and the reason why The First Judgment (paragraph 62) required the third undertaking.

30. So, the current application requires the Court to evaluate how far this more limited SRA oversight impacts on the suitability of the applicant trust corporation for appointment as deputy:

> *a. funds protection via the Solicitors Act 1974 was already noted to be of 'marginal' benefit (paragraph 63(e) of The First Judgment);*
>
> *b. being unable to claim from the Solicitors' Compensation Fund is a relative disadvantage, but it is to be noted that awards from that fund are discretionary and the possibility of recourse to recovery via the security requirement of deputyship remains;*
>
> *c. avenues of complaint can provide a significant service in addressing senses of grievance, but they come into play after the event rather than operating in a directly protective fashion.*

31. On the other side of the balancing scale, the Court must bear in mind that:

a. deputyship appointment may be, and often is, held by persons outside any regulatory framework. The issue of aggravated risk arises here (because Enable & Thrive Ltd has already made applications for deputyship appointment for other individuals, and clearly plans to provide a commercial service rather than meeting a single individual need) but it arises too in respect of a number of other 'third sector' deputyship providers, and has been considered manageable;

b. there is a general need to ensure a reasonable diversity of deputyship providers to meet the needs of vulnerable people with estates of varying types (from modest to sizeable assets, simple to complex administrative requirements) to be managed at proportionate cost;

c. Enable & Thrive Ltd has satisfied the Public Guardian in respect of all those matters which were considered important at paragraph 67 of The First Judgment;

d. so long as Ms. Allchurch is a director, there is "someone else sitting the shoulder" of Enable & Thrive Ltd such as to provide some assurance to the Court that the organisation will behave in an appropriate fashion. The limitations of the regulatory oversight would be a factor to be considered, alongside the availability of professional indemnity insurance, when the security requirement of deputyship is determined in accordance with Re H (A Minor and Incapacitated Person); Baker v. H and the Official Solicitor [2009] COPLR Con Vol 606.

32. Taking all these factors into account, and notwithstanding the deficiencies in the early stages of this particular application as identified at paragraph 9(a), (b) and (d) above, after cautious consideration I am satisfied that the inability of Enable & Thrive to give the third undertaking of The First Judgement is not such as to render it unsuitable for appointment as property and affairs deputy for as long as there is some degree of regulated involvement at director level. Ms. Allport's professional obligations even whilst acting for the trust corporation, rather than directly as a solicitor, have value in themselves and in the impact they are likely to have on the organisation as a whole.

33. In lieu of the third undertaking of The First Judgment, the following wording should be adopted:

'(i) Enable & Thrive Ltd is a Category 3 trust corporation within the meaning of Various Incapacitated Persons and the Appointment of Trust Corporations as Deputies [2018] EWCOP 3 but the following of its directors is/are a solicitor regulated by the SRA: [name(s)].
(ii) only the [named solicitor directors] will be listed on any client account where Enable & Thrive Ltd acts as deputy.'

34. The COP4 declaration with this version of the third undertaking in each application for the appointment of Enable & Thrive Ltd as deputy should be signed by (one of) the person(s) named in the first part of this revised third undertaking.

> *35. The fourth undertaking of The First Judgment is that the trust corporation will inform the Public Guardian if there is any change to the matters set out in the third undertaking. This should also be required of a Category 3 trust corporation in respect of the amended third undertaking.*
>
> *36. The fifth and sixth undertakings of The First Judgment relate to the insurance cover in respect of the trust corporations discharge of the functions of deputyship. Ms Allport's account of the insurance in place for Enable & Thrive Ltd does not suggest that these undertakings could not or should not be required.*

In a slightly unconventional, but pragmatic, approach:

> 1. *The original version of this judgment was issued on 24th October 2025 to Enable & Thrive Ltd and the Public Guardian as a "Preliminary View, Subject to Parties' Further Written Submissions". There have been no attended hearings. At all times the proceedings have proceeded 'on the papers' and therefore in private.*
>
> 2. *The Court has received from both Enable & Thrive and the Public Guardian written submissions confirming that they do not seek to challenge the conclusions set out in the Preliminary View document. It is therefore now issued as a judgment pursuant to Rule 4.2(2) of the Court of Protection Rules 2017 and an order which prohibits publication of any information which may lead to the identification of AB.*

This meant that the parties must be taken to have agreed with Senior Judge Hilder's preliminary view at paragraph 38 in relation to charging fees that:

> *38.* […] *the authorisation should appropriately be for fixed costs at the solicitor's rate (but limited to that rate.) In respect of any individual appointment it would remain open to the Applicant to seek authorisation for SCCO assessment of costs but, if Enable & Thrive Ltd is indeed to provide the affordability of service for which Ms. Allchurch advocates (paragraph 18 of her statement dated 13th June 2025), such application should be clearly reasoned.*

Personal injury payments, reverse indemnities and charging for care costs

R(CGT) v West Sussex County Council [2026] EWHC 293 (Admin) (HHJ Auerbach, sitting as a s.9 Judge)

Summary

CGT (acting through his father, SGT) as litigation friend, brought a judicial review of a decision taken by West Sussex County Council in June 2024 to:

1. Refuse to provide care and support to CGT on the basis that he did not financially qualify; and
2. Refuse to reimburse CGT for discretionary funding he had been provided since June 2020.

CGT was born in 1994. He suffered a brain injury as an infant which led to his having a severe cognitive impairment, visual impairment, epilepsy and other life-long difficulties. He has lived in supported accommodation since 2013, and has been found to lack capacity to make decisions regarding his property and affairs and to conduct litigation. His mother was appointed

as his property and affairs deputy in 2011; following her death in 2013, SGT was appointed as CGT's property and affairs deputy. It was entirely undisputed that his needs were such that he met the eligibility criteria for care and support under the Care Act 2014.

In 2012, CGT received an award of more than £3.5m from the Criminal Injuries Compensation Authority (CICA), which was paid into a discretionary personal injury trust of which CGT was the sole beneficiary and the Official Solicitor was sole trustee. £2.6m of the award were made in respect of future care costs. The then-deputy (CGT's mother) and the Official Solicitor gave undertakings to CICA in accepting the award in terms the relevant parts of which are set out at paragraph 5 thus:

> *"… dependent on my giving the following undertaking and so is in the best interests of [CGT] as defined by section I (5) of the Mental Capacity Act 2005*
>
> *The undertaking sought by the Criminal Injuries Compensation Authority is that:-*
>
> *…(2) I, Official Solicitor shall seek from the Court of Protection a limit to the authority of the Deputy whereby no application for public funding of [CGT's] care under section 21 of the National Assistance Act 1948 can be made unless it is in his best interests either because the funds provided by the Criminal Injuries Compensation Authority for his future care no longer provide for his reasonable care needs or because the restriction is contrary to his best interests for some other reason.*
>
> *(3) Before making any application for public funding of [CGT's] care under section 21 of the National Assistance Act 1948 I, [RGT] (Deputy) shall seek a declaration from the Court of Protection that such an application is in his best interests either because the funds provided by the Criminal Injuries Compensation Authority for his future care no longer provides for his reasonable care needs or because the restriction is contrary to his best interests for some other reason and shall not make the application unless the Court of Protection provides such a declaration.*
>
> *(4) I, [RGT] (Deputy) shall notify the Criminal Injuries Compensation Authority of any application to seek such a declaration from the Court of Protection or to otherwise vary this undertaking and/or any order consequent upon it. I will not object to the Criminal Injuries Compensation Authority making submissions to the Court of Protection in respect of any such application."*

The Form of Acceptance was signed in November 2012. SGT was appointed as CGT's deputy by the Court of Protection in 2014, and no application was made to the Court of Protection to restrict SGT's ability to seek public funds; SGT has not made any undertakings that he would not do so.

SGT requested that the local authority undertake a needs assessment (now under the Care Act 2014) in December 2017; the process was protracted, and it appears that the local authority took the view that CGT's care needs should be met by the PI trust. However, in June 2020, the local authority began to made without prejudice payments to CGT's care provider.

In October 2023, the local authority "*applied to the COP seeking to have the terms of SGT's Deputyship varied, to introduce a condition in respect of any application for public funding of the claimant's care needs, along the lines envisaged in the 2012 CICA undertakings. On 27 October 2023 the COP dismissed that application and awarded costs against the defendant*" (paragraph 11).

In June 2024, the local authority stated that he would cease to make payments towards CGT's care, and would seek to recoup the amounts spent from 2020-2024, and that the cost of CGT's care needs should be met from the PI Trust. This was primarily on the basis that CGT's having publicly-funded care constituted double recovery.

Reviewing the statutory framework, the court identified that Schedule 2 of the Care and Support (Charging and Assessment of Resources) Regulations (by reference to the Income Support Regulations) made provision to disregard capital held in a personal injury trust from the calculation of capital. This is explicitly echoed in the Care and Support Statutory Guidance, which specifically references personal injury trusts which arise out of CICA payments. The position was the same prior to the introduction of the Care Act 2014 under the National Assistance Act charging framework.

The local authority contended that the relevant regulation *'should be interpreted as requiring funds in a PI trust to be disregarded, when assessing capital resources, save in respect of the element of a payment provided for the purpose of funding care needs.'* [56]

After surveying *Peters v East Midland Strategic Health Authority* [2008] EWHC 778 (QB), *Tinsley*, *WNA* and *BJB*, HHJ Auerbach readily found that capital in a PI trust is disregarded for the purposes of determining a person's financial resources under the Care Act 2014, whether or not it is designated for the purposes of meeting care needs. HHJ Auerbach set out at paragraph 57 that:

> *The short answer to this argument is that the language of reg.12 of the 1987 Income Support Regulations, setting out the test which is adopted by para.15 of the 2024 Regulations is, to borrow the words of Dyson LJ in Peters at [30], "clear, unambiguous and unqualified." In this case the funds in the PI trust are derived from a payment made in consequence of a personal injury to the claimant. Para.33(h) of the Annexe to the Guidance specifically confirms that that applies to such funds provided by the CICA. The reference in reg.12 to "the value of the trust fund and the value of the right to receive any payment under that trust" plainly and unambiguously applies to the whole of the fund and is unqualified in any way.*

The court gave short shrift to the local authority's argument that a 'purposive' reading 'through the prism of public policy' should be given which would serve to reverse the plain meaning of the Regulations. The court similarly found that it was not 'unconscionable' for CGT to seek double recovery, reiterating the extremely clear language of the Court of Appeal in *Tinsley* on this point.

The court also rejected an argument by the local authority that CGT should be barred from claiming state funding because his mother as predecessor deputy had made this undertaking. The local authority argued that it would be wrong for CGT to benefit from his subsequent deputy resiling from the predecessor deputy's position. HHJ Auerbach that such an argument had been "*roundly rejected*" in *Tinsley*, and did not consider that the CICA context made any relevant difference. There was no deception by the predecessor deputy, and no evidence that the undertakings had not been given in good faith. There was no deception by SGT, who acted on advice. HHJ Auerbach further considered that the basis on which the undertakings have been made "has since been recognised in authority as inappropriate and ineffective" (paragraph 67), apparently relying on *BJB*.

The court similarly declined an invitation to use its discretion to decline relief on the basis that the court should actively intervene to prevent double recovery. It was stated in the judgment that *Peters* undertakings are 'no longer generally sought or given' (though the judgment did not address the issue of reverse indemnities). HHJ Auerbach found that:

> *75. My starting point is that the double-recovery principle discussed in the relevant authorities is a principle that pertains to the assessment of damages in tort for personal injury. It therefore bears upon a court which is engaged in determining such an award, or considering whether to approve such a proposed award negotiated by the parties. It derives, ultimately, from the principle that damages in tort are (ordinarily) compensatory and not punitive….*
>
> […]
>
> *93. Mr Paget described the Decision Letter as a public law decision taken to protect the public purse. He relied on the fact that the CICA funding and local authority funding both draw upon public money. But it cannot be right that the court should proceed on the basis that different public bodies, with different sources of public funding, governed by different funding regimes, should be treated as if they were one. Further, to take such an approach would be to ride roughshod over the principled distinction between the position of the tortfeasor (be they a public or private body – the authorities draw no distinction) and that of a local authority which is subject to statutory duties. It is simply not the function of the local authority when carrying out those duties to concern itself with such questions. The statute and the Regulations tell it how to perform the relevant calculations.*

Drawing on *Tinsley* and *Reeves*, HHJ Auerbach noted that concerns about double recovery are to protect a tortfeasor, not a public body. HHJ Auerbach made some notable comments about the effects of undertakings made by COP-appointed deputies in PI proceedings:

> *84. Should the court nevertheless exercise its discretion to refuse relief in the particular circumstances of this case, in particular having regard to the fact of the 2012 CICA undertakings? Ms Elliot submitted that the undertaking given by RGT was personal to her and not binding on SGT (or, indeed CGT) relying in particular on the observations of the High Court in Peters at [77] (echoed by the Court of Appeal at [57]) about Mrs Miles recognising that any undertaking by her would be personal and could not bind her Deputy.*
> *85. I interpose that at first blush it might be thought surprising that something done by a Deputy would not be treated as done in that capacity on behalf of the beneficiary, and so binding on a successor in that capacity. But I apprehend that the rationale in Peters was that what was being proposed in that case, was an undertaking to the court; and such undertakings are, in their nature, inherently commitments which are personal to the giver (and it was not suggested to me that an undertaking to the CICA fell into a different category).*

HHJ Auerbach quashed the local authority's decisions of June 2024, refused an application for indemnity costs, and ordered that costs be paid on a standard basis. The parties had agreed a sum due to be remitted to the CGT in respect of past payments, and CGT had since been found to be eligible for CHC, making the issue of future payments for his care by the local authority otiose.

Comment

The primary finding that the Charging Regulations mean what they say and should not be read to mean the opposite is unsurprising in light of the Court of Appeal decision in *Tinsley*. The Charging Regulations (incorporating the Income Support Regulations) are clear in reference to capital disregards that the following are disregarded:

> *'Where the funds of a trust are derived from a payment made in consequence of any personal injury to the claimant or the claimant's partner, the value of the trust fund and the value of the right to receive any payment under that trust."*

There is no ambiguity in this provision for capital disregard of personal injury payments held in a trust fund, which applies on an indefinite basis.

The local authority placed significant weight on the fact that the Charging Regulations contain a separate provision for a capital disregard of 'any payment made to the claimant or the claimant's partner in consequence of any personal injury to the claimant or, as the case may be, the claimant's partner,' which excluded 'any payment or any part of any payment that has been specifically identified by a court to deal with the cost of providing care.' This disregard does not require that the funds be held in a personal injury trust to apply; however, this applies only for a period of 52 weeks, a fact which does not appear to have been brought to the court's attention. The two provisions serve different purposes: one is an indefinite disregard of funds paid as a consequence of personal injury which are held in trust, and the other is a short-term disregard of any personal injury payment (which may not be held in trust), save as it provides specifically for paying for the cost of care.

I would also note that, in any event, if CGT was living in a supported living accommodation or in the community, the local authority would have been obligated to arrange CGT's care even if it found he was a self-funder if it had been asked to do so under s.18(3) Care Act 2014 (though the judgment is somewhat unclear as to whether CGT was in a care home or supported living accommodation). Where CGT did not receive periodical payments, the court did not have occasion to grasp the nettle of the far more ambiguous provisions regarding income disregards for periodical payments, which are not so clear-cut as the capital disregards for personal injury awards.

For mental capacity practitioners, it is perhaps a shame that the court was not asked to consider the extent to which the undertaking given bound CGT himself. This issue was considered to some extent at paragraphs 84 to 86 of the judgment:

> *84. Should the court nevertheless exercise its discretion to refuse relief in the particular circumstances of this case, in particular having regard to the fact of the 2012 CICA undertakings? Ms Elliot submitted that the undertaking given by RGT was personal to her and not binding on SGT (or, indeed CGT) relying in particular on the observations of the High Court in Peters at [77] (echoed by the Court of Appeal at [57]) about Mrs Miles recognising that any undertaking by her would be personal and could not bind her Deputy.*
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> *suggested to me that an undertaking to the CICA fell into a different category).*
>
> *86. Mr Paget said he accepted that the 2012 CICA undertakings were not binding in contract or in any way in private law* […]

This is an issue which arises relatively commonly in cases where a person has an indemnity or reverse indemnity which was the subject of undertakings at the time of the settlement, but the identity of the deputy has now changed. It is perhaps a matter which is deserving of greater attention by the courts.

OPG webinar series

The Office of the Public Guardian is putting on a webinar series designed to support professionals in the health and social care sector to better understand:

- OPG's role and responsibilities
- Attorneys, deputies and decision-making under the Mental Capacity Act (MCA) 2005
- Managing concerns about attorneys and deputies.

The webinars will take place from 12.30 to 13:30 on 5 March, 15 April and 20 May.

Further details about the webinars and how to register can be found at OPG webinar series | Eventbrite.

PRACTICE AND PROCEDURE

Personal welfare deputies, principle and pragmatism

Position statements and observers

The appeal in the *AB* case, concerning the provision of position statements to observers, will be heard by the Court of Appeal on 25 March 2026. We anticipate that the appeal will be live-streamed as usual.

"Fireside chat" with Deputy District Judge Flanagan

With grateful thanks to DDJ Flanagan and the Court of Protection Bar Association, we draw to your attention the notes of the 'fireside chat' she did for the Association in February, providing, amongst other things, invaluable tips and tricks from the judicial perspective about preparation and advocacy.

If you are a barrister working in or interested in the Court of Protection, we strongly encourage you to join the Court of Protection Bar Association, via this link.

A Welsh white leopard? Litigation capacity in the absence of subject-matter capacity revisited

SJ v Cardiff & Vale University Health Board & Anor [2025] EWCOP 54 (T2) (HHJ Muzaffer)

Mental capacity – litigation

Summary

Whether you can have capacity to conduct proceedings about a decision you lack capacity to make is a question that infrequently, but consistently, troubles the Court of Protection. Mostyn J once memorably describing the potential for such a scenario to be as rare as a white leopard. *SJ v Cardiff & Vale University Health Board & Anor* [2025] EWCOP 54 (T2), a case decided before Christmas, but which has only recently come onto Bailii,[2] contains a very thorough analysis of whether a white leopard had been spotted. The court in that case was faced with the situation where there was unanimity amongst the (many) professionals who had assessed the capacity of the woman in question, SJ, that she had litigation capacity but lacked capacity to make decisions in respect of her care, residence, and diabetes management. Her litigation capacity had been recorded in an order in 2023, and she had proceeded without a litigation friend thereafter. However, her legal team had had increasing concerns about her capacity to conduct the proceedings.

As HHJ Muzaffer noted:

> *71. It is right that SJ's legal team invite the court to consider the question of her capacity to conduct proceedings. They have a professional obligation to raise doubts about capacity with the court, regardless of any evidence, and are right to say that this is something that must be kept under review.*
>
> *72. The evidence of Dr. Radcliffe and Dr. KR creates a conceptual difficulty in that it becomes necessary to divorce SJ's capacity to litigate from the underlying subject matter. As I framed the issue at the outset, how is*

[2] Note, some might wonder why we do not give references to the National Archives caselaw service given that this is the 'official' hosting services for judgments. This is not just out of loyalty to Bailii (which is a charity badly in need of your support), but also because the National Archives service remains, we are afraid, a very long way behind Bailii in terms of ease of use for all purposes Mental Capacity Act 2005 related.

it said that SJ has capacity to conduct litigation about matters that she lacks capacity to determine herself? On the face of it, it is a premise that is entirely illogical, although it is clearly one open to the court to find as a matter of law.

73. In closing, Mr. Hadden [for SJ] *pointed to the fact that the issue had never been the subject of active judicial determination. The declaration that SJ had capacity to conduct the proceedings dated 17th November 2023 was made by consent and the evidence before the court at the time went untested. In any event, two years have since passed, and the evidence is that the symptoms of SJ's schizophrenia have grown more prominent in recent months.*

74. Mr. Hadden voiced his particular concerns about the impact of SJ's increased delusional beliefs on her ability to understand the issues in the proceedings. He invited me to consider that both Dr. Radcliffe and Dr. KR had not properly grasped what it is to conduct litigation, and that it was incumbent on the court to grapple with the unusual conclusions that they had reached.

75. On the other hand, neither the Health Board nor the Local Authority invited the court to go behind the declaration made in November 2023. It was said that that Dr. Radcliffe and Dr. KR's conclusions had been tested in evidence, and there was no evidential basis on which to rebut the presumption of capacity. Mr. Wenban-Smith further pointed to the coherent way in which SJ had litigated her desire to return home, with her active engagement evident throughout the proceedings.

HHJ Muzzafer identified that:

76. Unusual cases require the court to return to first principles. The presumption that SJ has capacity to conduct proceedings at the present time can be rebutted only if there is sufficiently cogent evidence that she lacks capacity to do so. It must be proved that it is more likely than not that SJ is not capable of understanding, with the assistance of such proper explanation from legal advisors and experts in other disciplines as the case may require, the issues on which her consent or decision is likely to be necessary in these proceedings.

77. The requirement is to consider the question of capacity in relation to the particular transaction, its nature, and its complexity. At its heart, this case is a dispute about SJ's ability to manage her diabetes in a way that ensures her health and safety, both in the past and in the future. However, the litigation also spans to include several other issues, including her care, residence, and potential deprivation of liberty. These are not straightforward issues, particularly so given the way they are enmeshed with one another.

78. I also have regard to the nature of the legal proceedings themselves and the demands that they make on litigants. I note Dr. Radcliffe's view that SJ was able to provide sufficient explanations of the proceedings to convince him that she understood the relevant information required to make decisions about proceedings, including "the reasons for the proceedings, those involved, the process by which evidence is

submitted and received, and how the outcomes of proceedings are achieved and enacted."

79. Dr. Radcliffe concluded that SJ had the ability to instruct solicitors to act on her behalf, although noted that she requires the proactive assistance to counteract the negative symptoms of her schizophrenia. The availability of legal professionals to mitigate SJ's avolition was plainly key to the conclusions of both Dr. Radcliffe and Dr. KR [SJ's responsible clinician for purposes of the MHA 1983]. *This is consistent with the principle set out at s.1(3) MCA 2005 that a person should be facilitated to make a capacitous decision on the matter in issue by the taking of all practicable steps to help them to do so. Dr. Radcliffe was of the view that SJ's delusions alone were not sufficient to render her without capacity to conduct proceedings, when the delusions did not themself go to the question of the conduct of the litigation.*

80. I have some difficulty with this conclusion. SJ's recent intensification of delusions includes her stating that she never required a hospital admission for her diabetes. In addition, SJ does not perceive herself to be at risk because she considers that she has "excellent and error free skills" in managing her diabetes. Dr. Radcliffe highlights how this evidences that SJ is unable to retain information from her own lived experience, or use information that substantiates the rationale for her support and treatment plan. This drives the conclusion that she is unable to retain the important information to be used to manage her treatment safely and appropriately. Dr. KR also touches on SJ's inability to access lived experience, describing her as having a "chronic cognitive inability" to use this crucial information.

81. Clearly, I acknowledge that, in principle, SJ's delusional beliefs about the subject matter of the proceedings do not necessarily preclude her from being able to instruct her legal representatives with sufficient clarity to allow them to advise her appropriately, or to understand and make decisions on the advice that she receives. However, it is extremely difficult to envisage how this could work on the ground given the particular issues being litigated. SJ's history of diabetes management is clearly a central feature of the case. From this, everything else flows. If SJ's delusions mean that she is unable to retrieve relevant information from her lived experience and understand the problem at the heart of the matter, she is plainly unable to use and weigh that information in the context of providing instructions to her lawyers. In turn, this inhibits her lawyers from providing advice in a way that SJ could be expected to understand and act upon, wisely or unwisely, regardless of the high level of experience and skill at her disposal. No amount of input from her legal representatives to mitigate SJ's symptoms of avolition will resolve this critical underlying problem.

82. I acknowledge the care with which Dr. Radcliffe has approached this question (as well as that of Dr. KR, although he did not specifically consider it as part of his s.49 report), but have concluded that the evidence of SJ's delusional beliefs has not been adequately accounted for in the question of her capacity to conduct proceedings. I accept the point made by Mr. Hadden that both Dr. Radcliffe

> *and Dr. KR have presented a somewhat superficial understanding of what it is to conduct litigation. I have no doubt that SJ can describe matters such as the reason for the proceedings, those involved, and how and outcome is reached. She is an articulate individual that has progressed through a court case lasting three years. However, as McDonald J made clear in TB v KB and LH, court proceedings are a dynamic process and demand a certain level of engagement from litigants. I am not satisfied that either of the experts in this case really explored how SJ might engage in the process in a way that meets the demands placed upon her.*
>
> *83. Returning to first principles, although the circumstances are without doubt unusual, I am satisfied that the evidence before the court provides a cogent basis to rebut the presumption that SJ has capacity to conduct proceedings. I find it more likely than not that SJ is not able to understand, with the assistance of such proper explanation from legal advisors, the issues on which her consent or decision is likely to be necessary in the course of these proceedings, as a result of an inability to recall and retain relevant information and use and weigh that information as part of making the decision about steps to be taken in the litigation. This is on account of her symptoms of delusions, which is directly attributable to an impairment of, or a disturbance in the functioning of SJ's brain, namely the diagnosis of schizophrenia.*

In light of this, as HHJ Muzafer noted, it was necessary to decide how SJ was to participate in the proceedings, given the terms of the COPR r.1.2. Pragmatically, counsel before the court, and HHJ Muzzafer, considered that this question could in effect be held in abeyance until it was clear whether the court was going to make final orders:

> *84.* […]. *If it does, it is arguable that no further steps are necessary or proportionate having regard to the matters identified at CoPR r.1.2(1)(a)-(d). However, should the court determine that a trial at home should take place and list a further hearing, the court ought to appoint either a litigation friend or accredited legal representative pursuant to CoPR r.1.2(4).*

This then led onto the question of whether SJ had subject matter capacity, which she strongly asserted, and – importantly – asserted via Counsel. The challenges she made merit setting out in full, as they represent common challenges to expert evidence:

> *85. Notwithstanding the above, SJ's primary case in closing submissions was that she has subject matter capacity in all respects. In the first instance, Mr. Hadden submitted that limited weight should be afforded to Dr. KR's evidence for three reasons; that his analysis had been infected by the protection imperative, that he had failed to have regard to the appropriate relevant information, and that he had erroneously incorporated questions of SJ's insight into his assessment (n.b. on this point CT v Lambeth LBC [2025] EWCOP 6).*

HHJ Muzzafer's analysis was careful:

> *86. In respect of each:*
>
> > *a. It is right that the court must exercise caution when considering the evidence of an individual's treating clinician, and remain vigilant to the pull of the protection*

imperative. I disagree with Mr. Hadden that this was evident here. Whilst there was a degree of conflation of the different issues relevant in a clinical assessment and a capacity assessment, Dr. KR was able to explain where the line was drawn. I accept some overlap as inevitable given his pre-existing role as clinician, but it is not a given that this then undermines the totality of his evidence without further cause.

b. Dr. KR accepted that he did not have regard to any of the checklists/guidance set out in case law regarding appropriate relevant information (although I note that he did not have the benefit of a letter of instruction to assist him in that regard). When asked about this on the question of residence, he was able to identify some of the broad considerations that applied. Otherwise, Dr. KR considered that "he had enough information to be able to make a judgment regarding capacity with the information that I thought necessary and pertinent to her circumstances." Taking Dr. KR's written and oral evidence together, I was left satisfied that he had a good grasp of the salient details and the information relevant to the areas of decision making in question.

c. In terms of insight, Dr. KR confirmed that he considered this relevant to his formulation of SJ's mental illness, and referred to "needing to consider the level of insight" when considering capacity. When challenged on this, Dr. KR reiterated that insight might apply when considering capacity, but accepted that a lack of insight was not indicative of a lack of capacity. I accept Mr. Hadden's submission that it was unclear how Dr. KR had treated insight in his assessment of capacity. However, what is clear is that insight was not the focus of Dr. KR's assessment, which centred on the core questions of delusional and persecutory beliefs and avolition. Whilst greater clarity as to how Dr. KR saw insight as relevant would have been helpful, his reference to it was not in any way determinative of his conclusions.

A failure to consider the potential for support was also levelled:

87. Otherwise, the thrust of SJ's argument was that neither Dr. Radcliffe nor Dr. KR gave adequate weight to the potential for practicable steps to help SJ make capacitous decisions. Mr. Hadden pointed to the evidence that SJ would respond and engage in her diabetes management when prompted by her carers, and drew an analogy with the assessment that SJ's negative symptoms of schizophrenia could be successfully mitigated by her legal representatives in the context of her capacity to litigate.

88. On that point, I accept the evidence that even with the current level of support available to SJ at Z Placement, there was still evidence of avolition in the management of her diabetes. The wider evidence suggests that the steps taken by SJ's carers are not leading her to make capacitous decisions, but are rather a necessity to ensure that her health needs continue to be met – a recent example being the response required to SJ's drop in blood sugar levels on 5th November 2025. As Mr. Wenban-Smith put it in closing submissions, the constant prompting of her carers is not a reasonable practical step leading to SJ maintaining capacity, but rather a compensating factor relevant to the promotion of her best

interests.

The conclusion was, perhaps, inevitable in light of this analysis:

> *89. Ultimately, I found the evidence of Dr. Radcliffe and Dr. KR consistent and persuasive on the question of subject matter capacity. The evidence is that SJ has suffered a recent intensification in her schizophrenia, and this has had a significant impact on her management of diabetes and making decisions about her support. I conclude as follows:*
>
> > *a. I am satisfied that SJ is unable to understand, retain, and use the information relevant to decisions regarding the management of her diabetes, including the nature and impact of her diabetes, and why a management regime is required.*
> >
> > *b. In respect of her care, I am satisfied that SJ is unable to understand, retain and use the information relevant to the support she requires and the consequences of not receiving the correct support.*
> >
> > *c. Finally, in respect of residence, I am satisfied that in keeping with the above, SJ is unable to understand, retain and use information regarding the sort of support that she would be provided within any residence option. However, once this is removed from the equation, I accept that SJ is able to understand, retain and use information relevant to decision making in this area.*
>
> *90. I accept the evidence that SJ's delusional beliefs and avolition are at the heart of SJ's inability to take decisions in these areas, which is directly attributable to an impairment of, or a disturbance in the functioning of SJ's brain, namely the diagnosis of schizophrenia. I am also satisfied that my conclusions in this regard are supported by other aspects of the information before the court beyond the expert evidence, as I shall consider below when addressing the question of SJ's best interests.*
>
> *91. It follows that I am satisfied that there is cogent evidence to rebut the presumption that SJ has capacity in these domains, and I find on the balance of probabilities that she does not.*
>
> *92. I note that the court does not need to resolve the slightly different views as to the scope of fluctuation in SJ's presentation and any potential for SJ to regain capacity in the future, given that there is agreement between Dr. Radcliffe and Dr. KR that re-assessment is warranted should there be a clearly identifiable significant positive change in SJ's presentation.*

HHJ Muzzafer's analysis of the question of best interests was as full and as careful as his analysis of capacity:

> *132. The court must start by identifying the potential options in relation to SJ's residence, care and diabetes management. In this case, it is agreed that there are two:*
>
> > *a. remain at Z Placement with the current care package; or,*
> >
> > *b. a 6-week transition plan for a trial at home with a care package that would consist of 4 daily visits by specially trained domiciliary carers (5 hours per day on Monday and Fridays, 4 hours all other days), the attendance of the district nurse to assist and administer rapid acting insulin if necessary, and the use of a pendant alarm in the event of an emergency.*

133. The point is made on SJ's behalf that a trial at home with this type of care package has not been attempted previously. It is said that this may well be her last chance of living independently, subject to a significant improvement in the management of her diabetes. A decision not to proceed with a trial at home will have the likely consequence of her tenancy being surrendered by her Deputy, and as such the decision carries an air of finality.

134. A trial at home would clearly be in accordance with SJ's wishes and feelings. In assessing the weight to give to these, I note the strength and consistency of her views. She has been clear that she wants to return home from the outset, and whilst she accepts that she is happy at Z Placement, this is not where she wants to be. SJ's desire to live at home is voiced with great clarity. It is where she lived and created a life with her children, watching them grow from young children to young adults. It is steeped in memories, including the photographs and certificates that continue to adorn the walls. I accept that to SJ, it must feel as if her life has been placed on hold. I know that she wants nothing more than to pick up where she left off and genuinely sees a long future living independently as she did prior to 2021.

135. SJ's desire is entirely understandable, although perhaps inevitably, there is a degree of unrealistic optimism about her view. She does not appear to understand the extent of the work required to restore the house to its former warmth, nor the difficulties that might come in funding this. In the context of her beliefs as to involvement of a third party at the house, I accept this will likely prove particularly problematic. There is also little reference to the very limited quality of life that she must have had in the years preceding her admission, or the social isolation that came with behaviours that were perceived as challenging. Although I understand why SJ wholeheartedly agrees with the proposed package of care, I am unclear that she appreciates the impact on her independence that will come with a requirement to be home at fixed times for up to five hours a day.

In an observation which helpfully picks up on the sometimes blithe optimism which surrounds conceptions of less restrictive options, HHJ Muzzafer continued:

136. With this last point in mind, I note that Mr. Hadden suggests that "the option of a trial at home is arguably less restrictive than her current placement" (my emphasis). Mr. Hadden is right to put this in such a measured way, because it is by no means clear to me that it will be. The extent of the support that SJ will require at home will inevitably curtail her freedom. SJ's current arrangements allow her a degree of spontaneity, with carers available to facilitate ad hoc changes to her routine to accommodate visits to family members or engage in social activities. This will be lost on a return home, with the visit plan adding to the list of rules that she already must live with.

137. The Health Board and the Local Authority's case in opposition to a trial at home focusses on risk (although I note that there also remains some uncertainty surrounding logistics with W Care Agency yet to confirm it would take on the role of domiciliary carers in any event). I am bound to accept the evidence of Dr. BM and Miss West in respect of the core questions associated with any risk assessment.

a. In terms of the type of harm that may arise, SJ is at risk of severe hypoglycaemia and diabetic

ketoacidosis if she fails to control her blood sugar levels.

b. The likelihood of this arising is high given the brittle nature of her diabetes, which is entirely independent of anything that SJ may or may not do. The evidence is that SJ's diabetes is unpredictable and particularly complex to control.

c. The severity of the consequences if the harm arose include a very rapid decline in health, a loss of physical and mental functioning, a loss of consciousness, multiple organ failure through sepsis, and death.

138. In respect of the steps that could be taken to reduce the likelihood of harm or to mitigate its effects, these are set out in the array of support and management plans before the court. In principle, they are comprehensive and provide a clear pathway to successfully managing SJ's diabetes.

139. However, the reality is that these plans are entirely dependent on SJ's initiative and engagement to achieve their aims. It is apparent from all the recent evidence that SJ relies heavily on prompting and motivating from her ever-present care team, in addition to district nurse visits, to prevent her suffering serious and life-threatening incidents. I also accept the evidence that SJ continues to ignore or fails to follow advice about simple measures to keep a diabetic attack at bay, including drinking sufficient fluids or maintaining an appropriate diet. The periods between visits would leave SJ unacceptably vulnerable. I accept the evidence that serious diabetic complications could arise in the intervals and overnight, and that the risk of SJ coming to significant harm is "near a certainty".

140. I am conscious that the court is invited to take a short-term decision for a trial at home. Mr. Hadden submits that the court's rationale and approach to risk ought to be different when compared with a decision about returning home on a long-term basis. In the circumstances of the case, I respectfully disagree with this proposition. This is not a case where SJ has a progressive illness or is approaching the end of her life, and the imperative to commence a trial is driven by time. It is also not a case where the court might be concerned about a 'slow burn' risk to an individual (for example, self-neglect), where a trial could be assessed as failing and brought to a halt before undue harm is caused. The risks identified, the time in which any risk may materialise, and the consequences of those risks are all such that the court must be certain in its decision making both in the short and long term.

141. Ultimately, I do not accept that the risks to SJ are manageable to any acceptable degree, even in the context of a trial at home. I reach that conclusion sadly, and I wish it could be different for SJ given the strength of her wishes. However, I do not consider that her views can be properly accommodated within the assessment of what is in her best interests. I am very mindful of the impact that this will have on SJ, but take some reassurance from her stated happiness at Z Placement (save for the now time-limited issue of the resident who assaulted her) and the fact that she will continue to benefit from so much whilst living there – freedom to see her family, engage in activities that she enjoys, and enjoy the camaraderie that she shares with her carers. I am satisfied that Z Placement provides the best balance to promote her quality of life, including her physical health, safety, and emotional welfare.

> *142. Accordingly, I find it to be in SJ's best interests that she continues to reside at Z Placement and in receipt of the package of care that she currently receives. This is the necessary and proportionate response to her circumstances. I note that whilst SJ's diabetes continues to present its challenges, the care and support that she currently receives has proved transformative in terms of keeping SJ safe and free from the frequent serious ill-health and hospital admissions that she endured prior to 2021.*

It followed inevitably that there would be a deprivation of liberty at the placement, but before that could be authorised, there would need to be in place appropriate representation to secure SJ's Article 5(4) ECHR rights (as analysed in *Re PQ (Court Authorised DOL: Representation During Review Period* [2024] EWCOP 41 (T3)). That representation was not in place, but HHJ Muzzafer gave the Health Board 15 working days to identify appropriate representation, failing which the case would need to return to court.

Returning, finally, to SJ's participation, the court was not invited by any party to defer consideration of subject matter capacity or best interests to allow for a litigation friend or ALR to be appointed:

> *146.* […] *The court had a significant amount of information about SJ before it, her wishes and feelings have been conveyed to the court both direct and via her legal representatives, and the Health Board's witnesses have been challenged in keeping with the case she wished to put.*
>
> *147. However, although my orders bring an end to the proceedings, and in that sense the matter is no longer contentious, I take the view that it is necessary to make a direction under CoPR r.1.2(2). There remain two issues on which SJ's participation needs to be secured. The first is hypothetical, at the time of writing at least, namely consideration of any application for permission to appeal my decision. The second is the question of anonymisation and publication of the judgment, to be determined with reference to the Transparency in the Court of Protection, Publication of Judgments, Practice Guidance dated 16th January 2014.*
>
> *148. I am satisfied that the proportionate approach in all the circumstances is to appoint SJ's solicitor, Miss Sarah Newport, as her ALR* [Ms Newport having previously indicated that she would agree to such a course of action] *This will ensure that SJ's participation in these narrow issues is safeguarded whilst also maintaining continuity and an in-depth knowledge of the current circumstances. The appointment shall last until such time that a suitable r.1.2 representative for SJ has been appointed to monitor the implementation of her care.*

Comment

The thoroughness of this judgment reflects in part, we suspect, the thoroughness of the case put by SJ's representatives. It is an interesting thought experiment as to whether more cases should not be conducted on the Schrodinger's Cat basis that the person has capacity to give direct instructions to their representatives during the 'operational' part of the proceedings, with the court finally jumping one way or another at the conclusion. In practice, of course, this is how lawyers acting on behalf of P seek to act even when instructed by a litigation friend (or 'self-directing' as ALR), but I would hazard a guess that a person such SJ would be acutely aware of

the difference between the situation where she is calling the shots, and where she is having to persuade a litigation friend / ALR to call the shots on her behalf.

The observations of HHJ Muzzafer in relation to the operation of the support principle in relation to litigation capacity are particularly interesting. Different judges have expressed somewhat different views about the extent to which it is necessary to take this into account (and the fact that this was not considered by the Supreme Court in *Dunhill v Burgin* does not help), but the approach in this case appears to us to be entirely right. In other words:

1. It must be considered as a matter of law: if the test for capacity to conduct proceedings is governed by the MCA, both legal representatives and, ultimately, the court, can only reach a conclusion that the person lacks that capacity if all practicable steps to support them to have it have been taken without success;

2. The presence of legal representatives where this is a potential reality (e.g., for instance where the person is eligible for legal aid, such that there is a non-trivial chance that they will be able to access such legal representation) has to be taken into account;

3. It remains, however, necessary to examine the situation whether the person can understanding, retain, use and weigh the information relevant to conducting the proceedings even with the benefit of legal representation.

Staying on the support theme, this line in relation to SJ's capacity to make decisions about diabetes management is one which is important (and chimes also with similar observations in the 'Stitch' case):

> *As Mr. Wenban-Smith put it in closing submissions, the constant prompting of her carers is not a reasonable practical step leading to SJ maintaining capacity, but rather a compensating factor relevant to the promotion of her best interests.*

It is, in other words, always necessary to be clear-eyed as to where support ends and best interests decision-making starts.

Justice and the further expert

Re DA (Whether to replace a Single Joint Expert) [2026] EWCOP 7 (T2) (HHJ Burrows)

Practice and procedure (Court of Protection) – other

Summary

Re DA (Whether to replace a Single Joint Expert) [2026] EWCOP 7 (T2) is a decision which, as its name helpfully makes clear, is about a procedural point that sometimes arises, namely where one party to a joint instruction of an expert (here a psychiatrist) is sufficiently discontented with their report that they want another run at matters. On the facts of the case before him, HHJ Burrows rejected the criticisms of the expert levelled at him by a number of the parties, both as to whether he had acted improperly in having a discussion with the solicitor for the applicant, and as to the quality of his report. However, that was not the end of the matter, as he asked himself:

> *50.* […] *, is there a reason why the Respondents 2-7 should not be permitted to instruct an expert? I have been reminded of the cases decided in the early days of the Civil Procedure Rules. In Daniels v Walker [2000] 1 WLR 1382, Lord Woolf, M.R at [1387] said (my emphasis):*

> *"…Where a party sensibly agrees to a joint report and the report is obtained as a result of joint instructions in the manner which I have indicated, the fact that a party has agreed to adopt that course does not prevent that party being allowed facilities to obtain a report from another expert or, if appropriate, to rely on the evidence of another expert.*
>
> ***In a substantial case such as this, the correct approach is to regard the instruction of an expert jointly by the parties as the first step in obtaining expert evidence on a particular issue.*** *It is to be hoped that in the majority of cases it will not only be the first step but the last step. If, having obtained a joint expert's report, a party, for reasons which are not fanciful, wishes to obtain further information before making a decision as to whether or not there is a particular part (or indeed the whole) of the expert's report which he or she may wish to challenge, then they should, subject to the discretion of the court, be permitted to obtain that evidence."*

51. This was subsequently distilled by HHJ MacDuff, Q.C. (as he then was) in Cosgrove v Pattison [2001] CPRLR 177 into this:

> *"Where a party requests a departure from the norm and makes what one can term a Daniels v Walker application,* ***all relevant circumstances are to be taken into account but principally the court must have its eye on the overall justice to the parties****. This includes what I have called the* ***balance of grievance test****. The application will only succeed in circumstances which are seen to be exceptional and to justify such a departure from the norm."*

52. These cases were both cited by Mr Justice Eady in Bulic v Harwoods & Ors [2012] EWHC 3657 (QB) who considered further when it was proper to allow a party to instruct an expert. He said (at [16]) (my emphasis):

> *"The importance of the overriding objective was often emphasised. Judge MacDuff, for example, referred to "overall justice to the parties". Moreover, Lord Woolf stressed the point in Daniels v Walker at p.1386H:*
>
> > *"If, having agreed to a joint expert's report a party subsequently wishes to call evidence, and it would be unjust having regard to the overriding objective of the CPR not to allow that party to call that evidence, they must be allowed to call it."*
>
> ***What represents justice between the parties will very much depend upon the facts of each case****. For that reason, it can be distracting to focus too analytically on the reasoning in other cases, however authoritative, where the facts were not truly comparable. There are different factors to*

> *be taken into account and the importance of each is likely to vary according to the particular facts. For example, the saving of time and money is likely to assume greater significance in inverse proportion to the centrality of the issues. Where the court is concerned with a relatively "peripheral" issue, as in Kay, it is likely to be only in unusual circumstances that the services of a single joint expert will be dispensed with: see e.g. at [35]-[36]."*

53. It seems to me in this case that the following factors are in play.

54. First, expert evidence in this case is foundational, not only to the jurisdiction of the Court, but also as to whether there has, or has not been exploitation or abuse.

55. Secondly, Respondents 2-7 are adamant that DA's presentation normally, including when he met with me, is different from the way he was portrayed in Dr Parvez's report, which is as being less intellectually able than he actually is.

56. Thirdly, DA himself is unhappy with Dr Parvez's conclusions, and the method he used to examine him. It must be made clear, this is DA's own view, not a point put forward by those acting on his behalf.

57. Fourthly, the evidence is of a technical nature, and it appears that assessing DA's capacity was not a straightforward issue for Dr Parvez.

58. There is ongoing litigation about transactions abroad over yachts that make the determination of capacity more urgent in this case.

59. There is a good chance there will be no extra delays if the expert chosen by Respondents 2-7 examines DA.

HHJ Burrows therefore held that:

60. In applying r.15.3(1) and PD 15A of the COPR 2017, I am satisfied that expert evidence is necessary to assist the Court to resolve these proceedings, and that permitting the Respondents 2-7 to obtain a further report is a proportionate departure from the single joint expert norm in this particular case. Capacity is foundational to jurisdiction and to the substantive welfare/property issues. DA himself disputes Dr Parvez's conclusions and method; the issues are technically complex; and the additional focused report can be obtained without material delay. I have considered the saving of time and cost but, given the centrality of the capacity issues, I am satisfied that overall justice between the parties justifies the limited departure from the usual approach, while retaining the current expert.

61. Since circulating the draft of this judgment, the Official Solicitor has sought to be involved in the instruction of the Respondents 2-7's chosen expert, and they have agreed. I have no objection to this and approve that approach.

62. I was also asked why I had not made an order enabling the other parties to instruct their own expert or a new jointly instructed expert, or, at least explain why I did not. The answer is simple. The other parties were happy with Dr Parvez. Dr Parvez can remain an expert, and the Court will consider his evidence in the light of further evidence for the other expert, should that not agree with him.

> *Allowing the other parties to instruct their own expert, or to instruct a different jointly instructed expert would likely increase cost and delay, and it is not necessary to ensure fairness to them in this case.*

Comment

To the best of our knowledge, this is the first reported case to address the issue of the further instruction of an expert in such circumstances (although it is definitely not the first the time it has occurred). Alex and his colleagues had drawn upon *Daniels v Walker* in the Court of Protection Handbook in addressing this situation, and it is very helpful that HHJ Burrows considered that the approach applied, notwithstanding that the test for permitting expert evidence is higher under the tighter under the CoPR than it is under the CPR ('necessary' under r.15.3(1) COPR 2017 compared to 'reasonably required' under r.35.1 CPR 1998). Whilst he did not explain precisely why this was the case, it is clear that he directed himself by reference to the COPR test. It may be that in a future case - especially one where P is legally aided and any instructing party may have to account to the Legal Aid Agency - a more detailed explanation will be necessary, but this case will undoubtedly give assistance in such a situation.

Short note – jigsaw identification

Lieven J has considered arguments about the naming of an NHS Trust in the context of care proceedings. The judgment in *A Local Authority v A Mother* [2025] EWHC 3598 (Fam) contains some observations that have some relevance to the Court of Protection as to the risks of jigsaw identification when a hospital Trust is named and the specific hospital where the patient is being treated is therefore easy to figure out. On the facts of that case, Lieven J considered that naming Great Ormond Street Hospital did not pose a significant risk of jigsaw identification as it is a very large hospital and treats children from other areas. Lieven J accepted that "*people closely associated such as parents, carers or professionals may be able to identify the child, or speculate which child is referred to. But, as is clear from Mr Justice Munby's judgment in* ***Re B****, the reality is in very many cases that there is a cohort of people, whether friends, parents at the school gate or in the local community, people in the same ward, who will know or guess who the child in the report is*" and that was not a reason in itself to require anonymity.

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MENTAL HEALTH MATTERS

Mental Health Act 2025 (very partially) into force and Explanatory Notes

The first parts of the Mental Health Act 2025 to come into force were commenced on 18 February 2026, and Explanatory Notes to the Act have now been published.

Sections 30(2), 32, 35, 36(1) and (3)(b), 38 and 39 of the MHA 2025 came 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). Unfortunately, something, somewhere appears to have gone slightly awry in relation to the conditional discharge provisions.

In 2018, in *MM*, the Supreme Court upheld the ruling of the Court of Appeal that neither the Secretary of the State nor the Mental Health Tribunal had the power under the Mental Health Act 1983 as it then stood to impose conditions on the discharge of a restricted patient which would amount objectively to a deprivation of the patient's liberty.

As we set out at the time in our comment on the case, there were three reasons for this

1. The first was one of high principle. As the power to deprive a person of his liberty is by definition an interference with his fundamental right to liberty of the person, it engaged the rule of statutory construction known as the principle of legality, as explained by Lord Hoffmann in *R v Secretary of State for the Home Department, Ex p Simms* [2000] 2 AC 115, at 131:

> *… the principle of legality means that Parliament must squarely confront what it is doing and accept the political cost. Fundamental rights cannot be overridden by general or ambiguous words. This is because there is too great a risk that the full implications of their unqualified meaning may have passed unnoticed in the democratic process. In the absence of express language or necessary implication to the contrary, the courts therefore presume that even the most general words were intended to be subject to the basic rights of the individual.*

Lady Hale took the view that Parliament had not been asked – as they would have to have been – as to whether the relevant provisions of the MHA:

> *Included a power to impose a different form of detention from that provided for in the MHA, without any equivalent of the prescribed criteria for detention in a hospital, let alone any of the prescribed procedural safeguards. While it could be suggested that the FtT process is its own safeguard, the same is not the case with the Secretary of State, who is in a position to impose whatever conditions he sees fit. (paragraph 31)*

2. The second was one of practicality. The MHA confers no coercive powers over conditionally discharged patients; as Lady Hale noted (although many may not realise): "*[b]reach of the conditions is not a criminal offence. It is not even an automatic ground for recall to hospital,*

although it may well lead to this." The patient could therefore:

> *… withdraw his consent to the deprivation at any time and demand to be released. It is possible to bind oneself contractually not to revoke consent to a temporary deprivation of liberty: the best-known examples are the passenger on a ferry to a defined destination in Robinson v Balmain New Ferry Co Ltd [1910] AC 295 and the miner going down the mine for a defined shift in Herd v Weardale Steel, Coal and Coke Co Ltd [1915] AC 67. But that is not the situation here: there is no contract by which the patient is bound. (paragraph 32).*

3. That led on to what Lady Hale identified as the third and most compelling reason, namely that she considered that to allow a person to consent to their confinement on conditional discharge would be contrary to the whole scheme of the MHA. The MHA provided in detail for only two forms of detention (1) in a place of safety; and (2) in hospital. Those were accompanied by specific powers of conveyance and detention, which were lacking in relation to conditionally discharged patients – "*[i]f the MHA had contemplated that such a patient could be detained, it is inconceivable that equivalent provision would not have been made for that purpose*" (paragraph 34). There was, further, no equivalent to the concept of being absent without leave to that applicable where a patient is on s.17 leave, it again being "*inconceivable*" that "*if the MHA had contemplated that he might be detained as a condition of his discharge […] that it would not have applied the same regime to such a patient as it applies to a patient granted leave of absence under section 17*" (paragraph 36). Finally, the ability of a conditionally discharged patient to apply to the tribunal is more limited than that of a patient in hospital (or on s.17 leave), this being *"[a]t the very least, this is an indication that it was not thought that such patients required the same degree of protection as did those deprived of their liberty; and this again is an indication that it was not contemplated that they could be deprived of their liberty by the imposition of conditions."*

In 2018, also, the independent Review of the Mental Health Act 1983 recommended that:

> *Given the Supreme Court judgment, we suggest that the Government should legislate to give the Tribunal the power to discharge patients with conditions that restrict their freedom in the community, potentially with a new set of safeguards. If a solution is not found, the numbers of offenders held in hospital will continue to rise because they are unlikely to get out again. Not only is this clearly wrong for the individuals concerned, it also means they are taking up valuable bed space, and obstructing efforts to transfer people in from prison.*

Fast forward to February 2026, and the first provisions of the Mental Health Act 2025 have come into effect to amend the MHA 1983 to provide for conditional discharge subject to conditions amounting to a deprivation of liberty. Guidance has been produced by both the First Tier Tribunal and HM Prisons and Probation Service[3] as to their operation. What

[3] Note, the HMPPS guidance refers to 'supervised discharge.' This is not a term which appears in the MHA 1983 as amended, and we would strongly suggest not using it; the Tribunal guidance says "[t]his term has fallen

both sets of guidance suggest, on their face, is that the intent to reverse *MM* may not have been achieved.

Whilst the MHA 1983, as amended, provides for the Secretary of State and the Tribunal to impose conditions on a conditional discharge giving rise to deprivation of liberty, both the Tribunal and HMPPS appear to take the view that such conditions are not enforceable. The former states:

> *Does a patient have to consent to being subject to conditions which deprive them of their liberty?*
>
> *A patient may or may not have the capacity to consent, but the legislation does not refer to capacity in this regard. The relevant question to ask in each case is whether the patient either agrees with (or at least does not object to) the condition which deprives them of their liberty. If they do object to it, then it is unlikely they will comply with it and so it should not be imposed. It is essential to remember that the new legislation cannot force a deprivation of liberty condition onto an unwilling patient and the Tribunal making a CD (Dep) does not give any power to the placement to restrain a patient who, in breach of a condition, chooses to leave their accommodation unaccompanied.*

The latter states that the new provisions are

> *2.2 […] not suited to patients whose risks to the public would be very difficult to manage in the community, recognising that the conditions of a conditional discharge are not enforceable and there is a requirement for the patient to accept supervision.*

There is, with respect, something of a logical conundrum in relation to the positions being adopted, given that the definition of deprivation of liberty within the MHA 1983 as amended is, via its linking to the MCA 2005, directly linked to Article 5 ECHR (see s.145 MHA 1983). As the law stands at present, the domestic interpretation of Article 5 is that a deprivation of liberty is:

1. A confinement to a restricted place for a non-negligible period of time, tested by asking whether they are free to leave that place, and subject to continuous supervision and control;
2. To which the person either cannot or does not consent,
3. Which is imputable to the state.

By definition, therefore, that means that the conditions under consideration must be ones which give rise to a non-consensual confinement, otherwise the person will not be subject to a deprivation of liberty at all. That, in turn, means that:

1. Asking whether the patient is agreeing / not objecting is not an immediately obvious question;
2. It appears that we may be in a Schrodinger's Cat situation of the person being labelled both as being confined but at the same time not actually be subject to any framework which enforces that confinement.

into common parlance when referring to the new provisions which will allow the Tribunal to conditionally discharge with conditions which deprive the patient of their liberty. Nowhere in the new Act's provisions is the term 'supervised discharge' used. It is not a new legal concept. It is not a new form of discharge. It is not an alternative to a conditional discharge."

We anticipate, unfortunately, therefore, that:

1. It is likely that these provisions will be before the courts soon, although perhaps not until after the Supreme Court has handed down its decision in the *Attorney General for Northern Ireland's Reference* where it is examining the domestic interpretation of Article 5 ECHR; and

2. Trusts may well be continuing in the meantime to look to s.17(3) MHA 1983 (and / or, where relevant, the DoLS framework under the MCA 2005) as providing a clear route actually to deprive individuals of their liberty in the community.

For members of the Court of Protection Bar Association, the webinar with HHJ Simon Burrows on "Conditional Discharge and deprivation of liberty: Getting our Acts together", on 16 March 2026 at 5pm will be required watching.

Nottingham inquiry

The statutory inquiry chaired by HHJ Deborah Taylor into the killings committed by Valdo Calocane started on 23 February. The inquiry has a website on which recordings of the hearings can be found; the hearings themselves are broadcast on a dedicated YouTube channel.

Short note: conditional discharge into hospital

D*B v Humber Teaching NHS Foundation Trust and SSJ* [2026] UKUT 57 (AAC) was the appeal of a decision in the First Tier Tribunal (Mental Health) that it was not permissible to conditionally discharge a patient who would then remain in hospital as an informal patient. We would note that the facts of this are somewhat unusual, as many secure hospitals are unwilling to allow informal patients to remain in hospital; however, in the present case, the patient was not in a secure hospital, and the hospital was content for DB to remain on an informal basis.

DB was detained under ss.37/41 MHA 1983, and was later conditionally discharged. He was recalled to hospital on 27 November 2024 on the basis that his mental health had declined. He was referred to the First-Tier Tribunal and his case was ultimately heard on 24 April 2025, at which point the FTT declined to discharge him. The FTT found that DB's treatment could only be given if he were detained. It was 'tentatively' put to the Tribunal "*that the Tribunal could have discharged the section on the basis that DB was able to remain on a voluntary basis at [the] ward. Having considered this matter subsequently and in reaching its decision, the Tribunal was satisfied that this was also not a possible option for the Tribunal – see Lady Hale in Secretary of State for Justice v MM [2018] UKSC 60, para 20, where she says "discharge' in …section 73(2) when referring to the conditional discharge of restricted patients, cannot mean discharge from the liability to be detained, because the patient remains liable to be detained. It must therefore mean discharge from the hospital in which the patient is currently detained.*"

The Upper Tribunal (UTJ Jacobs) considered that the FTT was in error in determining that it did not have the power to conditionally discharge DB while he remained in hospital as an informal patient for the following reasons:

1. Under s.131 MHA, which governs informal admissions,"'[s]*ubsection (1) deals with two possibilities: (a) a patient who is admitted informally: and (b) a patient who remains informally after ceasing to be liable to be detained. If DB were to remain informally in hospital once the conditional discharge took effect, he would technically be admitted informally under possibility (a). Although he would in practice remain in the hospital, possibility (b) would not apply, because he would not cease to be liable to be detained*"

(paragraph 20);

2. "*Detention cannot be a condition of discharge under section 73(4)(b). But a patient may remain in the hospital, or later be admitted, informally during a conditional discharge. This possibility is one of the factors that may be taken into account when deciding whether to discharge a patient conditionally*" (paragraph 21).

Comment

While the FTT in this case did not grant the conditional discharge, the decision appears to raise some difficult questions about how discharge to informal status might be used, particularly under the new conditional discharge regimes which allows conditions to be imposed which amount to a deprivation of liberty (though with no apparent authority to enforce such conditions). If the FTT was convinced that a patient could be managed informally while arrangements in the community were finalised, would the FTT be obliged to make conditions for the patient to reside in the hospital 'informally,' though in reality, the breach of this condition might amount to a recall? For such a patient, once the community arrangements were ready, the patient would have already been conditionally discharged, and there would appear to be no mechanism for the FTT to revert to consider what more appropriate conditions would be used to manage the patient in the long-term. These questions will need to wait for further consideration of this issue, which appears likely given the complexities it may cause.

Short note: psychological distress and Personal Independence Payments

In *AH and AK v SSWP* [2026] UKUT 50 (AAC) the Upper Tribunal has given guidance on the proper approach to psychological distress in cases under the Personal Independence Payment ("PIP") regulations.

In conjoined appeals heard before a three-judge panel – reflecting the importance of the issues of law under review – the UT was presented with difficult issues of law regarding the proper interpretation and application of the meaning of "mobility activity" in Schedule 1 of the Social Security (Personal Independence Payment) Regulations 2013 (S.I. 2013/277) ("the 2013 Regulations").

The cases concerned AH and AK. AH applied for PIP in January 2022. She suffered from anxiety, depression, panic attacks, back problems and fainting. In her PIP2 questionnaire she said she did not really leave her home and, if she did so, she usually had someone with her, as "I don't go without support". Rather than invite her to assessment, the DWP assessed AH's PIP entitlement on documentary evidence from her GP which included a telephone call to a friend, acting as an informal representative. The healthcare professional advising the DPW advised that AH should be awarded AH mobility descriptor 1e – *"Cannot undertake any journey because it would cause overwhelming psychological distress to the claimant"*. On the basis of this advice, the DWP awarded AH 13 points for PIP daily living activities (descriptors 1.d, 3.b, 4.c, 6.c, 9.c and 10.b) and 10 points for PIP daily living activities (mobility descriptor 1.e) which resulted in an enhanced daily living component for PIP but the standard rate only for the mobility component.

AH requested mandatory reconsideration, maintaining that she ought to have been awarded descriptor 1.f (12 points) in relation to mobility. The First-tier Tribunal determined that in order for AH to score points for mobility descriptors 1.d and 1.f, she would need to demonstrate the passive presence of another person would be sufficient on the facts to reduce

her psychological distress below a level where it was overwhelming (citing *AA v SSWP (PIP)* [2018] UKUT 339 (AAC).

AK' s claim for PIP dated back to June 2021. He declared a number of conditions including anxiety, depression, eczema and sight loss in one eye. Following a telephone assessment with a healthcare professional, AK was awarded no points for PIP activities. He appealed to the FTT and was awarded 13 points for daily living activities (descriptors 1.e, 3.b, 4.c, 6.c, 9.b and 10.b) and 10 points for mobility activities (descriptor 1.e). The mobility activity descriptors. He brought an appeal challenging the mobility component which was refused in April 2024, the Tribunal determining that : *"The law provides that where a person satisfies descriptor 1e, the Tribunal should not go on to consider 1f."*

AK disputed the AK Tribunal's decision to award him mobility descriptor 1.e instead of descriptor 1.f. On 01 August 2024, having been refused permission to appeal by the First-tier Tribunal, AK renewed his application to the Upper Tribunal.

The Upper Tribunal on appeal considered a number of previous Upper Tribunal decisions that had considered how regulation 4(2A) should be applied in the context of a "cannot do" descriptor for PIP activity 9 (Engaging with other people face to face). It also considered the relevant sections of the Welfare Reform Act 2012 and the Social Security (Personal Independence Payment) Regulations 2013 (S.I. 2013/277) ("the 2013 Regulations"). This included in particular both Regulations 4(2A) and 7 of the 2013 Regulations and Schedule 1, Part 3 which deals with Mobility Activities and sets out in table of descriptors and the points to be awarded for each, these being

> *a. Can plan and follow the route of a journey unaided.*
> *b. Needs prompting to be able to undertake any journey to avoid overwhelming psychological distress to the claimant.*
> *c. Cannot plan the route of a journey.*
> *d. Cannot follow the route of an unfamiliar journey without another person, assistance dog or orientation aid.*
> *e. Cannot undertake any journey because it would cause overwhelming psychological distress to the claimant.*
> *f. Cannot follow the route of a familiar journey without another person, an assistance dog or an orientation aid.*

On the basis that it was the "*the logical path to adopt, consistent with the decision-maker's task, but it also provides a workable means of applying regulation 4(2A) in a manner that respects the structure of these descriptors, the wording of regulation 4(2A) and the underlying purpose of PIP and the 2013 Regulations*" (paragraph 71), the UT determined the correct approach to applying the descriptors for mobility activity 1. In so doing, the Upper Tribunal made clear that, it was not simply a case of moving through (a) to (f), but rather, to proceed in an order which reflected an increasing level of limitation, namely 1.a, 1.b, 1.c, 1.d, 1.f and then 1.e. The Upper Tribunal also set out a two-part inquiry required in relation to descriptors 1.d and 1.f to address the situation of those with psychological distress, which are

> *82.* […] *aimed at those who cannot follow the route of an unfamiliar / familiar journey safely, to an acceptable standard, repeatedly and within a reasonable time period unless they have the benefit of one of the forms of assistance referred to in those descriptors. If the person in question is unable to undertake these activities to the regulation 4(2A) standard even with the prescribed forms of assistance then the decision-maker will need to proceed*

to consider whether descriptor 1.e applies.

This was important for those who experience psychological distress:

83. We have concluded that the regulation 4(2A) criteria are to be applied to both aspects of descriptors 1.d and 1.f in the way we have just described, for the following reasons. If the regulation 4(2A) criteria were only to be applied to the first part of descriptor 1.f (assessing whether the claimant cannot follow the route of a familiar journey to a regulation 4(2A) standard when unaided), then descriptor 1.e would be otiose for those suffering from psychological distress, as every claimant suffering from certain levels of psychological distress would satisfy descriptor 1.f on the basis that they cannot follow the route of a familiar journey to the regulation 4(2A) standard even if accompanied. However, applying the regulation 4(2A) standard also to the second aspect of descriptor 1.f means that a person who, with another person, assistance dog or orientation aid, is still unable to follow the route of a familiar journey to the regulation 4(2A) standard does not satisfy descriptor 1.f and so consideration must be given to descriptor 1.e.

CHILDREN'S CAPACITY

Parental responsibility and confinement – the need for appellate authority continues (and a Gillick conundrum)

East Riding of Yorkshire Council v The Mother & Ors [2026] EWHC 181 (Fam) and *Medway Council v The Father & Anor* [2026] EWHC 236 (Fam)

Article 5 ECHR – children and young persons

Summary

The decisions of Henke J in *East Riding of Yorkshire Council v The Mother & Ors* [2026] EWHC 181 (Fam) and *Medway Council v The Father & Anor* [2026] EWHC 236 (Fam) are two more in a line of first instance decisions which just reinforce how badly the question of the scope of parental responsibility relating to confinement for those under 16 requires consideration by the appellate courts.

The cases were a little different to some of those which we have commented on previously, in that there was active argument as to the scope of the ability of the parents in question to consent to the confinement of their child (but we understand that there will be no appeal in either case).

The East Riding case

In the *East Riding* case, the child in question, L, was 12, and was accommodated pursuant to s.20 Children Act 1989. Her parents specifically, and additionally, contented to her confinement (L herself was not Gillick competent to consent).

We reproduce the material passages of Henke J's judgment discussion and analysis.

> *50. L is a very much loved 12-year-old whose parents wish to do their best for her. L's unique characteristics are such that she requires a package of care and support. That is provided by the local authority under s.17 CA 1989. L's parents' consent to that package of care. L's parents have accepted reluctantly that they cannot care for her themselves (because L's behaviours were impacting adversely on her siblings at home) and have agreed to her accommodation pursuant to s.20 CA 1989. L's parents retain parental responsibility for her throughout the period of accommodation. They can withdraw their consent to her accommodation at any time they wish.*
>
> *51. L is currently placed at Rainbow Cottage with a care package to meet her unique needs. Rainbow Cottage is a registered care home. At Rainbow Cottage L is alone. There she is under continuous supervision on a 2:1 basis always in the home and the community day and night. She is never left alone without staff nearby, even when she requests space. Staff may prop her door open and maintain visual checks to ensure safety. Within the home L's movement is restricted. The outside gate is always locked. The external doors are locked unless L is outside with staff. The door from the dining room to the kitchen while staff are cooking and preparing food is locked for the reasons already given. In addition Team Teach behaviour support (physical intervention) is used when necessary and in line with approved techniques by appropriately trained staff to prevent L causing harm to herself and others; to prevent L leaving the placement of her own accord; for the purposes of transport to and from the placement and educational provisions/appointments and to return L to the placement if she absconds. Those restrictions on her liberty are necessary and, in her welfare, best interests, but that does not mean that limb a of Storck is not*

met. Indeed, on the facts, it is indisputable that the implementation of the restrictions means that L is kept under complete supervision and control. She is not free to leave the place where she lives. L is now aged 12. It was held by Sir James Munby P in Re A-F [2018] 3 WLR 138 (Fam) that once a child who was under constant supervision had reached the age of 12 the court would more readily come to the conclusion that he was being confined. In my judgment it is thus rightly accepted by all before me that L, on the facts of the case, is confined within the meaning of limb (a) of Storck. That confinement is undoubtedly attributable to the State which is the provider of her placement, the staff therein and the services L receives. Limb (c) of Storck is met. The contentious issue before me is whether L's parents can provide valid consent to L's confinement within the meaning of limb (b) of Storck.

52. As already stated, L's parents have consented to her confinement and the specific restrictions which amount to that confinement as well as the care package. L's mother has previously described herself as overwhelmed by the decisions she needs to make for her daughter, but she and L's father have persevered. They have considered the options for their daughter and made difficult, informed decisions. They have done that because they want to make the decisions for L to ensure she is safe and her needs are met. The decisions that they have taken include their decision to consent to L being subject to restrictions which amount to confinement within Storck limb (a) They consider, as do all parties before me, that the measures which fulfil limb (a) of Storck are in L's welfare best interests and are necessary and proportionate. The fact that L's parents accept that they cannot care for her themselves is but one factor which was taken into account when they considered where L was best placed, the care that is to be provided to her under her care package and her containment within limb (a) of Storck. They have also considered her safety, her need for care and support and her need for protection.

53. L's parents have actively engaged with the local authority which is providing care and support for their daughter under s.17 CA 1989. They have engaged with the planning process and communicate regularly with L's social worker. They also engage with the staff at Rainbow Cottage about the day-to-day care L receives. They advocate for their daughter and where appropriate, they provide challenge. Each of L's parents visits her once a week at Rainbow Cottage. Their visits are social, family time but they are also a vehicle for effective scrutiny of what is happening on the ground and an opportunity to judge whether their daughter's needs are being appropriately met. The visits enable L's parents to monitor their daughter's welfare and intervene where necessary.

54. Rainbow Cottage is a registered children's home. The relevant statutory scheme in England is provided by the Care Standards Act 2000 and associated regulations, requiring all children's homes to register with Ofsted before operating, making unregistered operation a criminal offense. This scheme mandates inspections, compliance with standards and ensures appropriate care, management, and

provision for children in residential settings, with Ofsted enforcing rules and assessing quality. The Children's Homes (England) Regulations 2015 (2015 regulations) apply and National Minimum Standards are required.

55. It is accepted before me that L's parents can consent to L being deprived of her liberty provided that the decision falls within the zone of parental responsibility: Munby P in Re A-F (above) at paragraphs 11; Mr Justice Keehan in Re D [2015] (above); Mrs Justice Knowles in Re Z (above); and Mrs Justice Lieven in TGA (above) applied. However, the zone of parental responsibility although extensive is not limitless. The ambit of parental responsibility, the extent of the zone of parental responsibility, in any particular case is to be ascertained by reference to general community standards in contemporary Britain: Munby P in Re D [2017] EWCA Civ 1695 at paragraph 37 and repeated at paragraph 11 in Re A-F. Mrs Justice Knowles' decision in Re Z is an example of where on the facts of the case before her she considered the limit of parental responsibility lay.

56. The real question in this case is whether the decisions that L's parents have made in relation to her confinement fall within the zone of parental responsibility. For the reasons I set out below, I consider on the acts before me that they do.

57. L is 12 years old. Most parents would expect to make most, if not all, significant decisions for a 12-year-old. L's parents are no different. L's maturity and level of understanding is relevant to her parents' need to make decisions for her. L is autistic. Her autism impacts her maturity and level of understanding. She does not have the capacity to make decisions for herself. It is accepted before me that L is not Gillick competent. I have described in earlier paragraphs of this judgment, L's presentations and behaviours. They are relevant to the risks that she poses to herself and others. Any parent of a 12-year-old would expect to take decisions to enable their child to be protected and would regard such decisions as coming within their zone of parental responsibility. Any parent when considering how to ensure their child's safety would take into account that child's behaviours and presentation and the risks that flow from them. That is exactly what L's parents have done here. In this case, L's parents have given their consent to the elements of her plan which amount to confinement within Storck limb (a). They have done so to ensure her care needs are met and that whilst she is accommodated away from them, she is safe. The decisions they have taken in that regard are acknowledged to be in L's best interests.

58. That brings me to the restrictions that amount to L's continuous supervision and control. In my judgment the 2:1 supervision, the locking of doors and windows etc are all matters that fall squarely within the zone of parental responsibility in relation to a 12-year-old who presents as L does. The issue of physical restraint however is less clear and requires careful consideration. I do not accept the local authority's submission that the Team Teach interventions are part of L's care and treatment. I have set out in an earlier paragraph how that intervention has been used to "unstick" her. Whilst it

may be used for that purpose, the local authority also candidly state in the social worker's statement that Team Teach will be used to prevent L causing harm to herself and others; to prevent L leaving the placement of her own accord to keep her safe; for the purposes of transport to and from the placement and educational provisions/appointments; and to return L to the placement if she absconds. In those circumstances, the restraint used is, in my judgment, objectively a component of her confinement and falls within limb (a) of Storck.

59. Further I do not accept the local authority's submission that the purposes for which restraint is used in this case fall squarely within regulation 20 of the [Children's Homes (England) Regulations 2015]. *Only regulation 20 (1)(a) and (b) would be applicable to L. The scope of those paragraphs is limited. The purpose of restraint and the circumstances in which restraint may be used, if necessary, in L's case quite clearly go beyond the ambit of regulation 20(1)(a) and(b).*

60. On behalf of the Guardian, it is submitted that consent to such restraint is outside the zone of parental responsibility in this case. I do not agree. In my judgment the consent to restraint as provided here is part and parcel of L's parents' exercise of parental responsibility to ensure her safety and welfare when she is outside their care. It would be neglectful for them to not consent. Without the use of restraint for the purposes already described, L would not be safe.

61. There is one further element to which L's parents' consent, and which concerns the Guardian. That is advance consent to L being administered medication including antipsychotics if deemed necessary by medical professionals. At first blush that may appear extreme but on further consideration, I remind myself that L is under 16 and not Gillick competent and thus her parents can consent to her medical treatment if they consider that it is in their child's best interests to do so.

62. It is submitted on behalf of the Guardian that parental consent does not provide L with adequate safeguards. It is argued that without prior court authorisation, there is no objective judge of proportionality and necessity. There would be no court consideration of the restraints to be used and how they would be used or indeed any of the other restrictions her parents have agreed. That is true. However, there is no need for a court process here because in L's case her parents are acting in her best interests. They are consenting to that which all agree is necessary and proportionate. L's parents know her and her unique presentations better than anyone. They have watched her grow up and until early last year cared for her daily. They thus are in many ways better placed to make the decision about what is necessary and proportionate for their daughter than others.

63. In terms of the court monitoring the components of L's confinement to ensure they remain necessary and proportionate, the reality is that any final court order authorising L's deprivation of liberty would be limited in duration. That duration is likely to be 6 or 12 months from the date of the final order. Within the duration of a final order there would be no court review. However, when the order

reaches its expiry date the local authority would need to re-apply for a fresh order. That new application would involve the appointment of a Guardian who would make all necessary investigation and represent L's welfare interests. The new application would involve court scrutiny of the restrictions proposed and ultimately the court would make a best interests decision on all the evidence. Thus, I accept that the court process provides an element of investigating, monitoring and safeguarding. However, I balance against that the absence of court scrutiny during the currency of any final order. I also have to factor in that the court process itself is intrusive. As part of the process L's parents would be automatic Respondents. L would need to meet with or speak to her Guardian, if able. The Guardian would be another professional in L's life albeit for the duration of any court process until the final order is made. The Guardian would not have a role once a final order was made.

64. During the period of any final order there may be Child in Care meetings. However, they will only be once every 6 months in L's case. Those meetings could be supplemented by regular, say monthly, reviews of the necessity and proportionality of the restrictions on L's liberty if the local authority were willing to facilitate such meetings but there is no requirement for such a scheme given L's age. L's parents would participate in such meetings as would the professionals, social workers, clinicians etc working with L. The Guardian would not be a participant once a final order is made. Ultimately, I consider that any such meeting is only an effective safeguard if there is someone in the meeting who can object to the continuation of the restrictions proposed if they consider them neither necessary nor proportionate or contrary to L's best interests. Guardians, IROs and social workers can express opinions, but they do not hold parental responsibility and cannot object. The only people that can make an effective objection are L's parents. If they do object and withdrew their consent to L's confinement, then the local authority will have to apply to the court under s.100 CA 1989 for an order authorising the deprivation of L's liberty. They cannot lawfully confine her otherwise. Implicit in the forgoing is my rejection of the submission on behalf of the Guardian that all L's parents can do is withdraw their consent to their daughter's accommodation. That is one option open to them. The other is to withdraw their consent to such restrictions on L's liberty as they do not consider either necessary or proportionate or in L's best interests.

65. In my judgment the appropriate exercise of parental responsibility by L's parents together with the statutory scheme set out at paragraph 54 above, provide effective safeguards for L on the facts of this case.

66. In the circumstances and on the facts of this case, I consider that the consents L's parents have given fall within the zone of parental responsibility. They are valid consents within the meaning of limb (b) of Storck. They are decisions taken in her best interests. Accordingly, L is not being deprived of her liberty for the purposes of Article 5, and these court proceedings are not necessary.

It is perhaps also worth noting an earlier passage in which Henke J considered the judgment in *TGA* relied upon at paragraph 55.

> *38. In NHS Trust v M and F and others* [2024] EWHC 2207 *Mr Justice Francis agreed with Mrs Justice Lieven's analysis in TGA with one caveat which he set out in paragraph 25:*
>
> > *25. I agree with that Judgment of Lieven J, but would add this, perhaps by way of qualification: in [51] above, Lieven J said, "If the parent was exercising parental rights, including consenting to the deprivation of liberty, in a way which was said to be contrary to the child's best interests then such a decision would no longer fall within the zone of parental responsibility". It seems to me that even a decision which was made contrary to the child's best interests could still be a decision made in the exercise of parental responsibility. Every day parents will exercise parental responsibility and will sometimes make decisions that are contrary to their child's best interests. This is still exercising parental responsibility. It is the duty of the State to intervene where a decision is contrary to the best interests of the child, and might cause the child to suffer significant harm […]*
>
> *39. I need not determine the issue between Mrs Justice Lieven and Mr Justice Francis as there is no doubt that in this case L's parents are exercising their parental responsibility in her best interests. However, if they were to act contrary to her welfare interests, then if the local authority considered the relevant thresholds met , the local authority could apply for public law orders under Part IV and V of CA 1989. I remind myself that the State is under an obligation to take appropriate steps to safeguard the lives of those within its jurisdiction – LCB v UK 1998 paragraph 36 and that States are required to take measures designed to ensure that individuals within their jurisdiction are not subjected to torture or inhuman degrading treatment or punishment, including such ill treatment as administered by private individuals – A v UK 1998.*

The Medway case

The *Medway* case concerned a profoundly disabled 15 year old girl, O, cared for by her father. Her circumstances were described thus at paragraph 3:

> *O's father is rightly described as devoted to O. He does all he can for her. O's father provides day-to-day care for his daughter. In addition, O has a package of care provided under an ECHP and a Child in Need welfare plan (s.17 Children Act 1989). As such, O is provided with services and support by the local authority. O is visited by a social worker every 15 days and has a Child in Need review every six-eight weeks. Support workers, an agency commissioned by the local authority, attend within the home for 40 hours per week in term time, 44 hours per week in the school holidays. The Agency workers attend the home twice a day: two hours in the morning to prepare O for school and 4 hours in the evening after school. O attends a special needs school. School staff support O with her personal care as required. All the doors at the school are managed by the keypad and fob locking system; the combination is not shared with O or any of the children who attend that school. If by any chance O was able to leave the premises, she would be followed and returned to school. In addition, O is provided with two nights per month respite care at a short breaks home run by the Local Authority. There,*

> *O receives 1:1 supervision and is not permitted to move freely about the facility or when out in the community for her own safety. O has full 1:1 support always when attending the short breaks home and cannot be left unsupervised. At the short breaks home, a keypad and fob locking system is in place to keep all children safe and ensure they do not venture into harmful areas or leave the premises where they can come to some harm. To ensure that O does not enter other children's rooms during the night, a staff member/s sit near O's door to redirect O quickly back to bed, if she wakes so that O does not disturb others. O requires staff to open doors for her as she has no danger awareness and could not access the community without supervision. The short stay home requires the use of O's wheelchair when in the community as O will drop to the floor and decline to move even if in a dangerous location such as roads or carparks. O does not use a harness when accessing the home's transport, be it in a bus or smaller vehicle, but O does have full 1:1 supervision and needs to sit in a double seat with a staff member next to them. O does not sit on a single seat as this does not keep her safe whilst travelling.*

The local authority issued application for an order under the inherent jurisdiction in relation to O. If permitted to exercise the inherent jurisdiction, they sought an order to deprive O of their liberty for a period of 12 months. Both the Guardian and O's father took the position that the application was unnecessary.

Henke J traversed much of the same ground as she had done in the *East Riding* case in her analysis, confirming her view that the proper construction of the effect of the relevant authorities was:

> *24.* […] *a regime in relation to those under 16 which permits parental consent provided that said parental consent does not leave that child without safeguards. Parental responsibility must be exercised in the best interests of the child. What falls within the zone of parental responsibility is not limitless- see paragraph 55 Re L (above). As a matter of logic, any zone must have boundaries. Where the decisions taken by a holder of parental responsibility are not in the child's best interests, there are safeguards. The measures include applying to the court to authorise the child's deprivation of liberty where the parent does not exercise their parental responsibility and refuses to consent to deprivation of their child's liberty which are necessary and proportionate to safeguard their child. Further if the decision were taken contrary to the child's welfare, then if the local authority considered the relevant thresholds met, the local authority could apply for public law orders under Part IV and V of CA 1989.*
>
> *25. I remind myself that the State is under an obligation to take appropriate steps to safeguard the lives of those within its jurisdiction – LCB v UK 1998 paragraph 36 and that States are required to take measures designed to ensure that individuals within their jurisdiction are not subjected to torture or inhuman degrading treatment or punishment, including such ill treatment as administered by private individuals – A v UK 1998. If a parent were confining their child in a manner which amounted to inhuman degrading treatment or punishment, then the State in the guise of the local authority would need to act.*

Ultimately, therefore, Henke J considered that the question was whether the consent that O's father gave to her confinement fell within the zone of his parental responsibility for her. That

was a fact-specific question, and she considered that, on the facts of the case, they did, such that the application was unnecessary.

Comment

Although, as noted above, we understand that this case will not go further, we would respectfully suggest that it is unfortunate that neither way:

1. Both are paradigm cases of visibly well-intentioned parents seeking to consent to 'high end' restrictions of their children, of a nature which clearly go beyond those which would be expected in relation to children of that age without disabilities. We have no determinative appellate confirmation that it is acceptable to take account of such disabilities when identifying whether parents are acting within the scope of their parental responsibility (the observations of Sir James Munby in *Re D* were obiter insofar as they concerned those under 16, the case not concerning those under 16 by the time it came to the Court of Appeal, and the other observations relied upon all being first instance).

2. It would allow confirmation as to whether a confinement carried out at the hands of a parent is not imputable to the state, as Henke J appears to have considered in the *Medway* case (see paragraph 32). This proposition does not sit easily with the judgment of the Court of Appeal in *SRK* about private confinements or, indeed, with the approach of Lady Hale in *Re D* at paragraph 47:

> *There are two contexts in which a parent might attempt to use parental responsibility in this way. One is where the parent is the detainer or uses some other private person to detain the child. However, in both Nielsen and Storck it was recognised that the state has a positive obligation to protect individuals from being deprived of their liberty by private persons, which would be engaged in such circumstances.*

   In other words, the critical question is not whether the confinement is at the hands of a private person, but whether the state is aware or ought to be aware of the position. Otherwise, it might be said that the right to liberty becomes entirely empty if the state washes its hands of responsibility on the basis that state agents are not, themselves, confining the individual but standing by in awareness of the confinement.

3. It would give the opportunity for the Court of Appeal to consider the position by reference to the expanded regime for authorising deprivation of liberty proposed in the Children's Wellbeing and Schools Bill. To the extent that Henke J's thinking was influenced by working backwards from the scope of safeguards available (a flavour of which comes through in paragraph 64), it would perhaps be important to test that thinking by reference to the potential for the situation to come within the scope of the expanded s.25 Children Act 1989 and the safeguards available thereunder.

A final note. In the throes of writing a book chapter about competence and capacity for those under 18, Alex was particularly struck by Henke J's statement at paragraph 20 of the *East Riding* case that:

> *In Gillick v West Norfolk and Wisbeach Area Health Authority [1985] UKHL 7, it was held in the context of consent to medical treatment that when determining whether the child themselves can consent, consideration should be given to their ability to:*
>
> *(a) Understand the nature and implications of the decision and the*

process of implementing that decision

(b) Understand the implications of not pursuing the decision;

(c) Retain the information long enough for the decision-making process to take place;

(d) Be of sufficient intelligence and maturity to weigh up the information or arrive at a decision;

(e) Be able to communicate that decision.

Alex's immediate thoughts were:

1. "If only." Sadly, the House of Lords did not give anywhere near such granular detail, even if clinicians, DH (as it then was) in the promulgation of the Mental Health Act Code of Practice, and several of Henke J's fellow High Court judges, have sought to read in that level of detail when seeking to analyse whether a child should be understood to be competent to give consent to medical treatment. See further in this regard Chapter 12 of the Law Commission's Disabled Children's Social Care report for more on what might be thought to be the very unsatisfactory state of the law here.
2. In light of the observations of Sir Andrew Macfarlane in *Re S*: should we even be talking about *Gillick* in the context of consent to confinement?

SEND White Paper

The long-awaited SEND White Paper was published on 23 February 2026, with a consultation set to run until 18 May 2026. One meta-observation is that, as with the Law Commission's work on disabled children's social care, the proposals throw a very stark spotlight on:

1. What the Convention on the Rights of Persons with Disabilities really requires: inclusion or the provision of specialist (potentially separate) services and facilities based – ultimately – on some form of impairment;
2. How to ensure that provision based on impairment is not either too 'wide', based solely on an impairment which has no actual impact on the child's life, or too 'narrow,' based on either a very limited category of 'acceptable' impairments (and, linked, what evidence is acceptable) or a very severe set of impacts;
3. Whether appropriate provision can be secured by way of systems-level obligations, or whether only individual legal entitlements to specific services can suffice;
4. What appropriate remedies look like in a situation where, for essentially historical reasons, the SEND Tribunal has powers to direct service provision in a way that no other Tribunal (or indeed court) can.

THE WIDER CONTEXT

Assisted dying / assisted suicide

Jersey passed the Assisted Dying (Jersey) Law on 26 February 2026. Reflecting the constitutional complexities involved, whether it will be implemented will depend, in the first instance, on whether it receives Royal Assent from the King in the United Kingdom. The equivalent legislation in the Isle of Man is still waiting for such Royal Assent nearly a year on, in the face of concerns raised by the (Westminster) Ministry of Justice about its compliance with the UK's obligations under the ECHR.

In light of the fact that it appears increasingly likely that the Terminally Ill Adults (End of Life) Bill will not clear Parliament before the end of the current session, it is perhaps worth making the observation that it would not be easily possible for the Jersey legislation to be replicated in a Bill before the Commons in Westminster. Such a course might hold attractions for many, given the fact that it has been developed as a Governmental initiative, with detailed external oversight, and input throughout from the bodies required to implement it. However, it is fundamentally different to the Terminally Ill Adults (End of Life) Bill in a number of ways, including for the administration of the relevant substance by the medical professional, and for so-called 'waiver of final consent,' to cater for the situation where the person loses the relevant capacity before the point of assistance. The Parliament Act procedure could only be used (as some have suggested it could / should be used) to require the House of Lords to accept legislation coming from the House of Commons if the legislation has been passed twice in the same form.

A recording of and the slides from the webinar on the Westminster Bill put on by the National Mental Capacity Forum on 25 February 2026 can be found here.

Further developments on the Westminster Bill can be followed on Alex's website here.

Withdrawing clinically inappropriate life-sustaining treatment – the latest Strasbourg word

In light of the cases that are coming before the Court of Protection about the dividing line between treatments which are clinically inappropriate (and hence are not on the table), and treatments which are not in the person's best interests (and hence are in principle on the table), *Medmoune v France* [2026] ECHR 27, is of no little importance as the latest Strasbourg word on the position. The judgment is in French (the translations below are informal ones via Google Translate), but concerned a patient who had sought to make an advance directive seeking (in effect) to be kept alive at all costs; in this he was supported by his family. After he had lost capacity following a serious road traffic accident, the medical professionals considered (in effect) that life sustaining treatment was no longer clinically appropriate, and sought to withdraw it in line with the relevant French law.

The ECtHR noted in its judgment that:

> *48. Furthermore, the Court points out that, in the case of the cessation of treatment which artificially sustains life, reference must be made, in the context of the examination of a possible violation of Article 2, to Article 8 of the Convention (see Lambert and Others, cited above, § 142). However, it has held that, while Article 8 guarantees the right to personal autonomy as an element of the right to respect for private life, it does not oblige the Member States to confer binding legal effect on advance directives (see Lindholm and the Estate after Leif Lindholm v. Denmark[no].*

25636/22, § 86, 5 November 2024), this question falls within their discretion (Pindo Mulla v. Spain[GC][I, no]. 15541/20, § 153, 17 September 2024). Furthermore, the Council of Europe's guide "on the decision-making process relating to medical treatment in end-of-life situations", which should be taken into account (see Lambert and Others, cited above, § 143), states that "autonomy does not imply a right for the patient to receive any treatment that he/she may request, in particular when the treatment concerned is considered inappropriate[, since] the decision in the field of health care is the result of the meeting of the patient's will and the assessment of the situation by a professional subject to his professional obligations and, in particular, those arising from the principles of beneficence and non-maleficence, as well as justice".

The ECtHR found the relevant French law to comply, in the abstract, with the requirements of Article 2 ECHR. As regards the specific circumstances of the case, the ECtHR was satisfied that the patient's wishes had been at the centre of the decision-making process, and the views of the family had been appropriately taken into account (see paragraphs 53 and 54), such that "*the medical team took into account the family's opposition to the cessation of care, but considered that, while it could understand it on a human level, it could not endorse it from a medical point of view.*" The court was also satisfied that there had been appropriate mechanisms by which the family could seek to challenge the decision (nb, in England & Wales, and for the reasons set out here, that route is not the Court of Protection if the decision is that treatment is not clinically appropriate). The court appeared to be satisfied that this was a route which was to be used by a person challenging the medical decision – in other words, it did not make any observations about disputes needing to be placed before the domestic courts by the treating body; rather, it was the existence of a potential route of challenge which was important. It was also satisfied that, in the instant case, that route of challenge, once invoked by the family, had been operated appropriately. It therefore found that the patient's rights under Article 2 ECHR had not been violated.

Proxy access to digital health services

The updated NHS England Identity Verification and Authentication Standard for Health and Care Digital, Data, Analytics and Technology Use published in December 2025 contains useful guidance on so-called proxy access to digital services and, in particular, in table 4.2, a clearly defined set of bases of proxy access, covering the relevant variables (i.e. person with capacity, person lacking capacity but with power of attorney or deputy, and person lacking capacity with neither).

Short note: when does vulnerable not mean vulnerable?

In *Khan v Secretary of State for the Home Department* [2026] EWCA Civ 148, the Court of Appeal made clear that the "Joint Presidential Guidance Note No 2 of 2010: Child, vulnerable adult and sensitive appellant guidance" in the First-tier Tribunal did not give rise to free-standing obligations upon the Tribunal, but rather guidance to ensure that parties are able effectively to participate in proceedings and to ensure that their evidence is properly and fairly considered. The Court of Appeal also made clear that it was insufficient simply to assert a vulnerability, as opposed to identifying how that vulnerability on the part of the appellant will affect their ability to give evidence.

Research corner: translating insight – in conversation with Professor Tony David

Some may find of interest Alex's 'in conversation with,' Professor Tony David about his new paper, Insight, the law and psychiatry: Going round in circles or playing nice?. They talk about what 'insight' means clinically, and how law and medicine can have a more productive discussion about applying the concept in a way which better secures the interests of those whose capacity to make relevant decisions may be under examination.

Ending Wardship in Ireland

The National Disability Authority in Ireland has published its new study entitled 'The journey from wardship to supported decision-making: An examination of the process and the experiences of people leaving wardship.' The report, including an Easy to Read version, are available on the NDA website.

Mental capacity law reform in New Zealand

The New Zealand Law Commission has published its final report following its review of adult decision-making capacity law. Alex read the report with particular interest, having had the opportunity to stick his oar in a various stages. Many of the recommendations may have a ring of familiarity for those involved in thinking about mental capacity reform on this side of the world, but two features perhaps stick out:

1. The interaction between 'western' conceptions of mental capacity and Māori conceptions of decision-making, which provide fruitful grounds for considering equivalent interactions in relation to other communities;
2. The clear view of the Law Commission that compliance with the UN CRPD does not mandate abolition of a concept of mental capacity or a framework which recognises and responds to a situation where a person lacks capacity (even with all appropriate support) to make a relevant decision.

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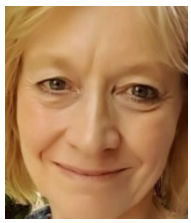

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Conferences

Members of the Court of Protection team regularly present at seminars and webinars arranged both by Chambers and by others.

Alex also does a regular series of 'shedinars,' including capacity fundamentals and 'in conversation with' those who can bring light to bear upon capacity in practice. They can be found on his website.

Advertising conferences and training events

If you would like your conference or training event to be included in this section in a subsequent issue, please contact one of the editors. Save for those conferences or training events that are run by non-profit bodies, we would invite a donation of £200 to be made to the dementia charity My Life Films in return for postings for English and Welsh events. For Scottish events, we are inviting donations to Alzheimer Scotland Action on Dementia.

Our next edition will be out in April. Please email us with any judgments or other news items which you think should be included. If you do not wish to receive this Report in the future please contact: marketing@39essex.com.

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