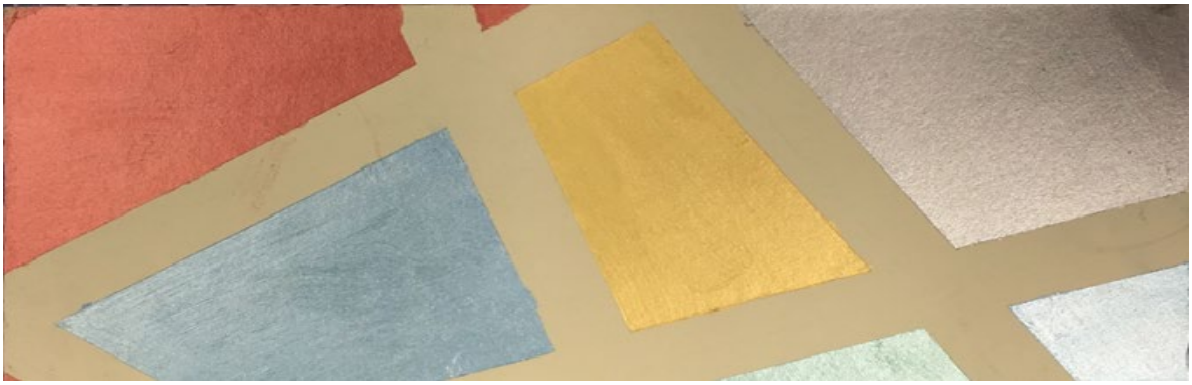

Welcome to the March 2026 Mental Capacity Report. Highlights this month include:

(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.

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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,[1] 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

[1] 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.

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 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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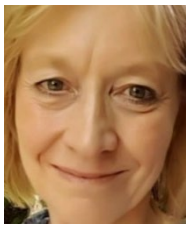

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Conferences

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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