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MENTAL CAPACITY REPORT: COMPENDIUM

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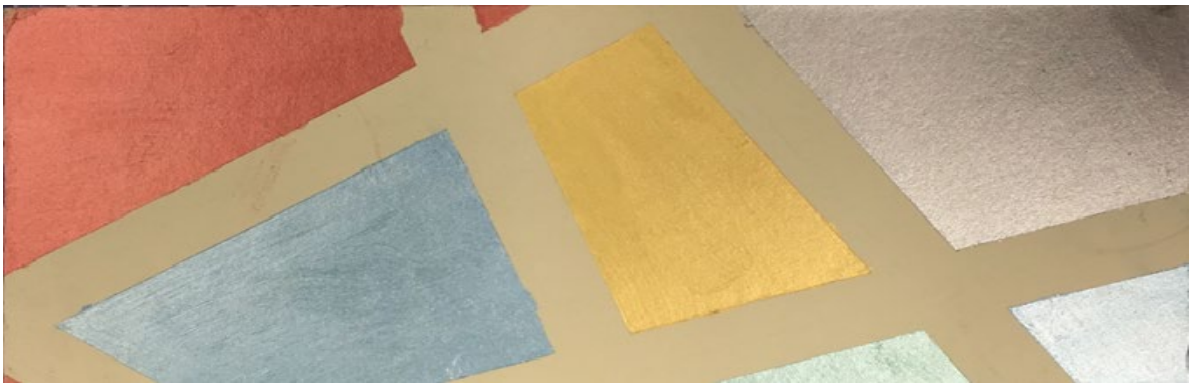

Welcome to the September 2026 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: an update on post-*AGNI* developments, two capacity conundrums in one case and 'over-litigation' in a PDOC case;

(2) In the Property and Affairs Report: an update from the Property and Affairs Court User Group meeting and the OPG is recruiting lawyers;

(3) In the Practice and Procedure Report: the Court of Appeal resets the approach to personal welfare deputies, and cross-border cases involving Scotland;

(4) In the Mental Health Matters Report: recent cases concerning the relationship between the MHA and the MCA and an excoriating judgment on "detainability;"

(5) In the Children's Capacity Report: *AGNI* and children and the Joint Committee on Human Rights reports on the human rights of children in care;

(6) In the Wider Context Report: litigation capacity complexities, and recent medical guidance documents concerning consent, voluntarily stopping eating and drinking, and eating disorders and critical care.

(7) In the Scotland Report: a Practice Note that has caused some consternation.

A reminder that that whilst Chambers have launched a new and zippy version of our website which may look unfamiliar, 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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HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

AGNI update

The DHSC has yet to publish the further guidance that it has promised following what seems now to be universally known as *AGNI*.

Alex continues to update his resources page on the case. Of most immediate relevance to our readers are likely to be the following:

- The initial flurry of webinars has started to slow; we draw your attention, in particular, to the National Mental Capacity Forum webinar.
- On 15 July 2026, ADASS published an updated Deprivation of Liberty Safeguards (DoLS) Priority Tool to prioritise the allocation of new requests to authorise a

deprivation of liberty, reflecting the AGNI judgment.

- West Midlands ADASS has published updated DoLS forms to reflect the judgment – there are no statutory forms for the DoLs process, but these forms are used by many local authorities, and the updated forms represent an operationalisation of the judgment (note, the relevant updated forms say April 2026, but they were prepared in June 2026).

- The Joint Committee on Human Rights wrote on 8 July to the Secretary of State for Health and Social Care to ask a number of questions about the Government's proposed response to the judgment.

The minutes of the Property and Affairs Court User Group meeting held on 1 July also record the Senior Judge's update on the court's approach:

- ***Existing authorisations:*** *Existing authorisations remain valid and there is no need to apply to discharge them.*

- ***Pending applications:*** *Pending applications should proceed as normal. On referral, the judge will apply the new test and may direct a COP24 statement if further information is required.*

- ***COPDOL11 applications:*** *Fewer COPDOL11 applications are expected, although the streamlined route remains available for review applications.*

- ***Deputies:*** *Where there is no DoLS authorisation, a deputy seeking to sell P's property can now file a COP24 addressing the relevant Article 5 factors, including P's wishes, living arrangements and the care provider's views. This avoids requiring the deputy to confirm an authorisation that is unlikely to exist.*

  HHJ Hilder indicated that this is likely to be the approach directed by the court.

  Tenancies are different: the question there is one of best interests, rather than a AGNI question.

- ***COP9/COP24 applications to end a DoL:*** *The court was asked whether these applications need to be made by a solicitor. HHJ Hilder treated this as a Mazur issue (CILEX v Mazur [2026] EWCA Civ 369), rather than an AGNI issue. The ordinary post-Mazur rules on delegation therefore apply, with no separate COP-specific exception.*

The first reported case to consider *AGNI* was *Oxfordshire County Council v P* [2026] EWCOP 33 (T2). It makes very interesting reading, but it is very important to emphasise that it does not represent a judicial interpretation of *AGNI* which represents a precedent to follow, as opposed to application to the facts of a particular case. We emphasise this because it is, with respect, an application which is not entirely easy to square with the decision of the Supreme Court in *AGNI*. Paragraphs 16-18 (where *AGNI* is considered and applied), show how strong the gravitational pull of *Cheshire West* remains; given that the facts of *P*'s case demonstrate (on their face) rather fewer of the 'multi-factorial' components of deprivation of liberty were satisfied than did MEG's case, it would have been very helpful had the judgment explained why, in light of the Supreme Court's clear statement that MEG was not deprived of her liberty, P in the Oxford case was nonetheless "very likely" to be so.

AGNI features in the Practice and Procedure, Mental Health Matters and Children's Capacity sections of the Report below as well (a special prize for those playing *AGNI* bingo who can spot all of the appearances).

Finally for these purposes, and whilst not referencing *AGNI*, we noted with interest the case of *CP v Spain* [2026] ECHR 114, handed down on 11 June 2026. The concerned the compulsory admission of a woman to hospital to give birth pursuant to a judicial order despite her wish to give birth at home. Much of the decision focused on Article 8 ECHR, the court ultimately finding that there had been no breach of the woman's Article 8 rights. The reasons for this related largely to the specific Spanish legal provisions relating to the rights of the foetus, which differ to those in England & Wales. However, CP also asserted that she had been unlawfully deprived of her liberty. In light of the commentary on *AGNI* and the extent to which the Supreme Court correctly analysed the Strasbourg case-law, it is perhaps of some interest to set out the 'multi-factorial' approach adopted by the ECtHR:

> *The court's case-law*
>
> *126. To determine whether someone has been "deprived of his liberty" within the meaning of Article 5 of the Convention, the starting point must be his or her specific situation and account must be taken of a range of factors such as the type, duration, effects and manner of implementation of the measure in question. The difference between deprivation and restriction of liberty is one of degree or intensity, and not one of nature or substance (see Aftanache v. Romania, no. 999/19, §§ 78, 26 May 2020, with further references; and Nada v. Switzerland [GC], no. 10593/08, § 225, ECHR 2012). The Court attaches importance to factors such as whether it is possible to leave the restricted area, the degree of supervision and control over the movements of the person concerned, the extent of that person's isolation and whether they can have contact with the outside world (see Guzzardi v. Italy, 6 November 1980, § 95, Series A no. 39, cited above, and H.M. v. Switzerland, no. 39187/98, § 45, ECHR 2002-II). Article 5 § 1 may also apply to deprivations of liberty of a very short duration (see, among many authorities, Creangă v. Romania [GC], no. 29226/03, § 93, 23 February 2012; M.A. v. Cyprus, no. 41872/10, § 190, ECHR 2013 (extracts)); Gillan and Quinton v. the United Kingdom, no. 4158/05, § 57, ECHR 2010 (extracts); and Siedlecka v. Poland, no. 13375/18, §58, 31 July 2025). Where mentally disordered persons are placed in an institution, the Court has held that the notion of deprivation of liberty covers more than merely a person's confinement in a particular restricted space for a not negligible length of time. A person can only be considered to have been deprived of his liberty if, as an additional subjective element, he has not validly consented to the confinement in question (see Stanev v. Bulgaria [GC], no. 36760/06, § 117, ECHR 2012, with a further reference). The absence of handcuffing or other measures of physical restraint is not decisive in establishing whether there has been a deprivation of liberty (see M.A., cited above, § 193 in fine), and nor does the characterisation or lack of characterisation given by a State to the facts (see Creangă, cited above, § 92) or the purpose of the measures taken by the authorities which deprived the applicants of their liberty (ibid., § 93). In Ulisei Grosu v. Romania (no. 60113/12, §§ 27-32, 22 March 2016) the Court found that taking of a person by the police to a psychiatric hospital against his or her will could amount to "deprivation of liberty". In Aftanache (cited above, §§*

81-83) it reached a similar conclusion in respect of an applicant who had been held against his will by ambulance personnel and the police for about six hours.

Application to the present case

127. The Court notes at the outset that in this case the hospital made a formal application supported by reasons for an order for the applicant to be compulsorily admitted to hospital (see by contrast Aftanache, cited above, § 97). The necessity of the measure was considered by a competent court which had issued a reasoned decision of 24 April 2019 granting it (see, for the Court's assessment of its lawfulness and proportionality under Article 8 of the Convention, paragraphs 98-117 above). Although the applicant disagreed that there had been any medical emergency, it followed from the medical professionals' conclusion that her admission to hospital was required, given the risk to the foetus (see, for the hospital's submissions and the courts' findings, paragraphs 16, 17, 19, 40 , 45and 59 above; see further, mutatis mutandis, O.G. v. Latvia (dec.), no. 6752/13, § 29, 30 June 2015).

128. The Court observes that the duty court in the present case did not order that the applicant be detained, arrested or otherwise deprived of liberty, within any pending criminal or administrative proceedings or otherwise (see paragraph 19 above and contrast, for instance, Zelčs v. Latvia, no. 65367/16, § 37, 20 February 2020; and M.A. v. Cyprus, cited above,§ 194). The role of the police was narrowly defined by the same order as "accompanying" the applicant to the hospital and making sure that she went there in a medically equipped vehicle (see paragraph 20 above), which cannot be equated to detention.

129. As regards the first of the periods referred to by the applicant, the Court notes from the police report and the parties' submissions that the disputed period lasted from 3.30 p.m., when the police arrived, to 5.30 p.m., when the applicant was admitted to the hospital (see paragraphs 22 and 28 above), that is, for a short period of time. At no point was the applicant arrested or detained during that period (see, by contrast, Stelian Roşca v. Romania, no. 5543/06, § 60, 4 June 2013). Neither the police officers nor the ambulance personnel entered the applicant's home. Importantly, there is nothing to suggest that, should the applicant have refused to comply with the order, the order would have enabled the officers to enter her home, let alone to arrest her. As submitted by the Government and not disputed by the applicant, they could only have done that if they had obtained a separate order for arrest for disobedience of the first court order.

130. In any event, it is not for the Court to speculate how the events would have unfolded if the applicant had disobeyed the order of 24 April 2019. The facts of the case are that the police spent more than an hour persuading the couple to go to the hospital without entering her home (see paragraphs 22 and 25 above). The officers engaged in an extensive conversation with the midwife and the applicant's partner who told the applicant what was being said (and the midwife contacted her lawyer). Then, at 4.50 p.m. the applicant accepted

that she had to go to the hospital. While the parties are in dispute about whether she went to the hospital of her own free will or as a result of pressure by the officers, the Court does not detect elements of coercion which affected the applicant's liberty within the meaning of Article 5 of the Convention (see, by way of contrast, Venskutė v. Lithuania, no. 10645/08, § 73, 11 December 2012; and compare to Guenat v. Switzerland (dec.), no. 24722/94, Commission decision of 10 April 1995). It is noteworthy that the applicant's submission that the police officers had put pressure on her was made for the first time in her observations to the Court and not in the domestic proceedings (compare paragraphs 26 and 27 above).

131. Once she agreed to go to hospital, the applicant was given time to prepare for the journey, and then she was taken to the hospital by ambulance (see paragraphs 23 and 27 above). The police officers were not present in the ambulance. The applicant's partner asked the officers to give him a lift as he was unable to drive (see paragraph 23 above). The Court finds that the way in which the applicant was taken to hospital does not in itself raise an issue under Article 5 § 1 of the Convention, nor did it go further than normal practical arrangements for taking someone for hospital treatment.

132. Having regard to the specific circumstances discussed above and the short duration of the disputed period (see, mutatis mutandis, Vadym Melnyk v. Ukraine, nos. 62209/17 and 50933/18, § 84, 16 September 2022), and bearing in mind the domestic legal framework, the reasons given by the court for its order and the way the order was carried out, the Court finds that the applicant's situation between 3.30 p.m. and 5.30 p.m. on 24 April 2019 did not amount to a deprivation of liberty.

133. As regards the second period referred to by the applicant in her observations (from her admission to the emergency department to the time the child was delivered), the police officers had left immediately on the applicant's admission to the emergency department (see paragraph 24 above, and contrast Udaltsov v. Russia, no. 76695/11, §§ 130 and 136, 6 October 2020). As labour was not induced, the medical personnel provided assistance to the applicant as she continued in labour (see paragraphs 31 and 34 above). As regards the applicant's allegations that she had been under enhanced supervision by the supervising nurse, she referred to nurse's notes made in the clinical history which stated that the applicant should "no longer" be considered "in custody". However, the Court, applying its established case-law, does not find sufficient indications of coercion or any intention on the authorities' side to detain the applicant within the meaning of Article 5. Contrary to the applicant's submissions, the supervisory nurse's notes of her exchange with a duty doctor on 24 April 2019 and in the early hours of 25 April 2019 (see paragraph 29 above) clearly suggest that the applicant did not need supervision, and was perceived by the medical personnel in the same way as "any other patient" and treated as such.

134. Lastly, in respect of both periods,

> *the applicant was not isolated or unable to contact the outside world. It is uncontested that she was accompanied by her partner at all times, apart from the very short period of the journey to the hospital, and she was free to communicate with the midwife during the disputed period.*
>
> *135. Based on the above considerations the Court concludes that the applicant was not deprived of liberty within the meaning of Article 5 § 1 of the Convention between 4.30 p.m. of 24 April 2019 and 1.40 a.m. of 26 April 2019.*

The guidance provided in 2014 by Keehan J in *Re FG* as to the steps required where deprivation of liberty may arise in the obstetric context will require updating in light of *AGNI*. *CP* will need to be taken into account in doing so. In that process, we suggest there are two important points to remember:

1. In identifying whether there is a deprivation of liberty, a key element in determining the presence of the coercion which Strasbourg repeatedly identified as necessary is whether there are coercive measures envisaged in any court order which may be in play. If there is a Court of Protection order providing for entry to property and removal to hospital, together with measures designed to prevent P leaving hospital (even if P has gone to hospital without force), we suggest that questions of deprivation of liberty are very likely still to arise;

2. However, arguably, this is a second order issue. It is notable that in *CP*, the first question was whether the intervention designed to bring about the birth in hospital was justified by reference to Article 8. If it is not, then steps taken to restrain – let alone confine – the person are likely to be unjustified.

By way of early indication of such an approach, we note that in the obstetric treatment case of *University Hospitals of Derby and Burton NHS Foundation Trust & Anor v HH* [2026] EWCOP 35 (T3), Theis J identified that:

> *In the proposed order the Trusts also provide that to the extent which the care and treatment provided to HH in accordance with the care plan amounts to a deprivation of liberty such deprivation of liberty is authorised in the exercise of the court's inherent jurisdiction. Miss Richards accepts the multi-factorial approach the court should now take in the light of the decision Re AGNI [2026] UKSC 16. She recognises that the purpose of any restraint would be to support the proposed care plan, that it is likely to be for a relatively short period of time and that her transportation to the hospital could, arguably, be permitted under s 17(3) MHA. However, where the care plan authorises up to 6:1 and provides for both physical and chemical restraint and where it is likely HH would be objecting to those arrangements, in the circumstances of this case, the restrictions amount to a deprivation of liberty.*

The Official Solicitor agreed with this analysis; although Theis J did not expressly endorse it, it appears from the tenor of her judgment (focused very much on HH's best interests) that she, also, agreed with the proposition.

Two capacity conundrums in one case

A Local Authority v AC & Ors (Consent to Marriage) [2026] EWCOP 31 (T3) (Hayden J)

Mental capacity – assessing capacity

Summary[1]

In this case, Hayden J considered an application relating to AC, who was 20 years old and had a moderate learning disability and developmental delay. In 2024, AC visited Pakistan with her family and married in an Islamic ceremony. The position of AC's family was that the ceremony had "*not been planned in advance of the trip and that AC and the proposed husband formed an attraction to each other when they met and quickly wanted to be married*," and they "*believed that AC had the capacity to make the decision*" (paragraph 2).

AC returned to the UK with her family (rather than remaining with her husband). Shortly thereafter, a report was made to the police about the validity of the marriage. A police officer met with AC and took the view that AC "*lacked capacity to make 'her own choice to marry'*"" (paragraph 3). Her family were charged with offences relating to causing a person lacking capacity to marry. Forced Marriage Protection Orders orders were made in respect of AC and her siblings.

A finding the AC lacked capacity was "*an explicit and necessary constituent of the counts on the* [criminal] *indictment*" (paragraph 10). The present judgment arose due to requests for capacity assessments in the criminal proceedings:

> *In April 2025, the defence solicitors in the criminal proceedings indicated that they too had arranged for a capacity assessment for AC which was to take place on 8th May 2025. In the correspondence between AC's representatives in these proceedings and the defence solicitors, it was agreed that the assessment in the criminal proceedings would be delayed to enable this Court to consider whether any assessment of AC's capacity, for the purposes of the criminal proceedings, required the authorisation of this Court.* (paragraph 5)

Hayden J decided that he needed to consider "[w]*hether any decision for P to undergo a capacity assessment, for the purposes of criminal proceedings, is in itself a best interests decision pursuant to section 4 of the Mental Capacity Act 2005. If so, whether the best interests decision is one which must be taken by the Court of Protection.*"

The CPS was joined to the proceedings, and submitted that "[o]*rdinarily, no pre-assessment of P's capacity to consent to participate in an assessment of their capacity is required. Here, the assessment of capacity is being carried out not in order that a best interests decision can be made about P's care or treatment, or to inform the exercise of statutory duties towards P for example duties to provide care and support. It is being carried out at the request of defendants in criminal proceedings to support their case in those proceedings.*"

Hayden J found that the decision of whether to undergo an assessment of capacity (at least in this context) was a welfare decision, such that "[w]*here P lacks capacity, the Court must decide whether undergoing an assessment is in P's best interests (Section 4 MCA 2005) and is, accordingly, a decision to be taken by the Court of Protection.*" While the decision to admit a capacity assessment into proceedings will be one for the Crown Court judge, Hayden J held that the decision of whether to consent to participate in a capacity assessment was one taken under the MCA, although he also observed that "[t]*his is not "a capacity assessment per se* […]

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

but an assessment specifically focused on the impact on AC of participating in an assessment. There are clearly significant consequences for AC in both outcomes, i.e. whether the assessment takes place or not" (paragraph 9).

Hayden J considered that the following factors were relevant to AC's decision to participate in a capacity assessment for the purposes of the criminal proceedings:

> *(i) AC must be able to understand, retain, use or weigh the fact that there are **criminal proceedings** against CA, DD and BC;*
>
> *(ii) AC must be able to understand that there has been a **marriage** between herself and the proposed husband;*
>
> *(iii) AC must be able to understand, retain, use and weigh the fact that she has been assessed as lacking capacity to **marry / engage in sexual relations**;*
>
> *(iv) AC must be able to understand, retain, use and weigh the fact that CA and BC have been **arrested and charged** with **forcing her** to be married;*
>
> *(v) AC must be able to understand, retain, use and weigh the fact that CA and BC's **defence in criminal proceedings** is that AC does have capacity to make **her own decisions** to marry and to enter into sexual relationships [my emphasis];*
>
> *(vi) AC must be able to understand, retain, use and weigh the fact that the reasonably foreseeable consequence of her not having a further assessment would be that the conclusions of the current assessment would remain in place;*
>
> *(vii) AC must be able to understand what further reasonably foreseeable consequences might arise if such an assessment did not take place* (paragraph 12).
>
> Further:
>
> *(i) **The nature of the assessment**... it would be a retrospective assessment of her capacity to enter into marriage, i.e. in 2024; and*
> *(ii) AC must appreciate that the expert has an overriding duty to the Court, irrespective of who has instructed them.* (paragraph 13)
>
> And
>
> *AC must understand that the report may be obtained but not disclosed by the defendants* (paragraph 14)

Hayden J noted statistics from the CPS that there have typically been between 1-6 prosecutions for forced marriage annually (which may or may not have been based on a person's incapacity to marry) and thus considered that the decision was unlikely to have a significant impact on the work of either the Crown Court or the Court of Protection.

Hayden J then went on to consider the test for capacity to marry:

> *17 … [M]any, I suspect most, practitioners consider the case law generates a test which can be overly burdensome and lacking the flexibility required in understanding the different approaches to marriage and / or its obligations in a multicultural society. Moreover, the "obligations of marriage" and what constitutes "the contract of marriage" are not ubiquitous, they are subtle, nuanced and mutable. There is a real danger that an unnecessarily sophisticated test might operate to the disadvantage of those struggling with capacity, requiring them to evaluate issues which many others might find no need to address at all, or*

> *even struggle to address, as capacitous adults. Some couples enter marriage with carefully negotiated prenuptial agreements, contemplating the meticulous division of financial assets in the event of divorce. Others give the matter absolutely no thought at all and are entirely ignorant of the applicable law. It requires to be acknowledged that the authorities are contradictory on some key points. I also note that there has been some discussion in the criminal proceedings as to whether a definitive test for capacity to marry exists in law at all.*

Hayden J considered that while marriage may vary depending on culture, "*the assessment of capacity to marry should not impose overly complex concepts*" (paragraph 18); "[t]h*e terms of a contract of marriage will vary in differing cultures, religions, and now, following developments* […], *in same sex marriages*" (paragraph 23). However, he considered that "*the capacity for 'marriage' is, in some respects, conceptually more complex than that of 'consensual sexual relations'. It engages various mutual obligations, altered legal and, in some circumstances, social status; it is long term and status specific*" (paragraph 18).

Hayden J noted that it had now been 22 years since *Sheffield City Council v E & Anor* [2004] EWHC 2808 (Fam), and

> *This has been a period of significant social change. In the intervening years, we have seen: Marriage (Same Sex Couples) Act 2013, granting same-sex couples the same status as opposite-sex couples in marriage and divorce; Civil Partnership (Opposite-sex Couples) Regulations 2019, granting opposite-sex couples the opportunity to choose civil partnership rather than marriage should they prefer to do so; Divorce, Dissolution and Separation Act 2020, permitting couples the opportunity to divorce without attributing blame, applying equally to civil partnerships; Equality Act 2010, consolidating anti-discriminatory legislation, and protecting individuals from discrimination on a wide variety of grounds, e.g. sexual orientation, race, religion or belief, age, sex and many others; Children and Families Act 2014, endeavouring to secure the active involvement of both parents in a child's life following separation of the adults. All this legislation both has an impact on family life and is reflective of changing attitudes to marriage, children and families.* (paragraph 20).

Hayden J considered that "*it is the fact of the "contract" which is the salient and unifying feature of marriage, not its terms. As Treitel (The Law of Contract) stated, 'a contract is an agreement giving rise to obligations…'. Agreement is a far more accessible word than contract, but it has very similar meaning"* (paragraph 25). Where religious and civil marriages differ in their context and expectations, "*it is the fact of the 'agreement' itself which requires to be understood, not the fairness of the terms or the wisdom of the consent. This is a secular Court; we are not involved in cultural relativism*" (paragraph 27). Further:

> *It is no function of a judge to intervene, paternalistically, to protect a party from a marriage which might seem to some to be regressive, patriarchal or counter feminist. I would note, with some diffidence, that arranged marriages frequently generate happy, successful and enduring relationships. Nor is it necessary or indeed appropriate to evaluate P's understanding of these differences. That would impose an additional test upon her which would not be imposed on an individual whose capacity was not in question. It would sublimate rather than promote her autonomy, an outcome which would be wholly contrary to the philosophy of the*

> *MCA. At risk of repetition, I emphasise, what is required is an understanding that an agreement has been made which changes status and is intended to endure. This, I think, captures the essence of the issue in terms which are simple and accessible.* (paragraph 28)

In considering other case law, Hayden J elaborated that he did not "*consider a couple's expectations of what marriage might involve is a pre-requisite to establishing capacity. It is the understanding of an agreed change of status from that of an individual to that of a couple which is the universal essence of any marriage*" (paragraph 38).

Hayden J considered the proposition that capacity to marry will 'generally' include capacity to make decisions around sexual relations, noting that not all marriages are sexual. However, and he considered that it was "vanishingly unlikely" that a person would have capacity to marry, but lack capacity to engage in sexual relations; even if this was theoretically possible, and contrary to the decision of Mostyn J in *NB v MI* [2021] EWHC 224 (Fam), Hayden J held that the test for capacity to marry must include capacity to engage in sexual relations:

> [t]*he link between sexual relations and marriage is a theologically consistent tenet of most established religious traditions. Marriage has been, and in many cultures still is, the only gateway to sexual relations. The two have been interlinked for thousands of years. Sex is regarded not merely as something which happens within marriage; rather, it is seen as one of the ways in which the marital relationship may be both expressed and nourished. This may underpin religious perspectives, but it is equally valid in a secular context. Sexual relations are not, for all the reasons Mostyn J discusses, a necessary component of marriage, but in entering into a marriage, an understanding of the nature and mutuality of sexual relations must be. To this degree, it is integral to the construct of marriage and not divisible. The vulnerability of a person who understands, in broad terms, the nature of marriage but lacks an understanding of the essential elements and consequences of a sexual relationship is manifest, particularly where that involves an inability to comprehend the indivisibility of consent to sexual relations. To reason otherwise requires distortion of the objectives and philosophy of the Mental Capacity Act, which is intended to promote the autonomy of the vulnerable, enabling them to take decisions, be they wise or foolish. It would corrode the Act to interpret it in a way which exposed vulnerable and incapacitous adults to abusive situations in which they have no agency to protect themselves* (paragraphs 43-44).

Hayden J concluded at paragraph 45 that:

> *marriage is a formal agreement between two adults in which the fact of the agreement requires to be understood, not the fairness of the terms nor the wisdom of the decision. It requires a simple recognition by two people that they are making a commitment for their lives to be joined together, and that they wish that status to be recognised by others. It is necessary to understand that a formal process is required to enter into marriage and to leave it. Further, and for all the reasons set out above, both parties to a marriage must have capacity to engage in sexual relations, whether they choose to do so or not.*

Comment

Capacity to have one's capacity assessed

We agree with the view expressed by the CPS that ordinarily, a 'pre-assessment' of a person's capacity to decide whether to engage in a capacity assessment (which would appear to be a necessary pre-requisite to make a best interests decision on behalf of the person) is neither necessary nor desirable.

We suggest strongly that the observations made by Hayden J should be limited in the first instance to the very specific context of the case, in which AC's family wished for her to participate in a report they hoped would be exculpatory – but there appeared to be a clear concern about whether doing so was in her best interests.

There may also be some analogies between the situation under consideration by Hayden J with the situation where the person is 'voluntarily' seeking to have confirmation of their capacity, most obviously to grant an LPA or make a will.

However, as a general proposition, we suggest that, both legally and practically, the approach is very different:

- As a matter of legal analysis, the decision of whether to conduct a capacity assessment is not typically taken "on behalf of" the person. Others take the view that one is required so that they know the basis upon which they are discharging a power or function. The decision that they make that they have sufficient grounds to consider the person's capacity in a specific area or areas that they need to assess it is one for them, not for the person. It is therefore not a decision covered by the MCA at all.
- At a practical level, it is not feasible to 'decide' on behalf of an incapacitous person that they will undertake a capacity assessment: the person either will or they will not engage, and an external decision that would be in their best interests to do so will not change this. Many assessments of capacity proceed with less than complete engagement of the person, and simply have to make findings of what information is available. Whether a capacitous decision or incapacitous preference, engagement in the assessment depends on what the person is willing to do, not what others considers best for them to do.

We are also duty bound to note a 'pre-assessment' of capacity to engage in a capacity assessment appears to run the risk of staring down an infinity well – would a capacity and best interests decision need to be taken in respect of the pre-assessment?

Alex has written further about this issue here.

Sex and marriage

It is unfortunate that we now have Tier 3 judgments pointing in diametrically opposite directions as regards the question of whether it is possible to have the capacity to marry without having the capacity to decide to engage in sexual relations. We suggest that this is an issue which requires appellate consideration; such appellate consideration also should encompass (we suggest) whether it is still correct in light of *JB* to say that the capacity to marry is a 'status' rather than a 'person' based test.

Capacity and the questionably consenting partner

Nottinghamshire County Council v LM & Anor [2026] EWCOP 38 (T2) (HHJ Rogers)

Mental capacity – sexual relations

Summary

In this case HHJ Rogers has added to the growing jurisprudence on capacity to engage sex in the post *JB* era – specifically, where capacity

is contingent on P's ability to assess the consent of a prospective partner.

The application in this case was brought by the local authority – with support from the relevant healthcare trust – to determine LM's capacity to engage in sexual relationship and to consent to the sharing of information in respect of sexual offences. The parties otherwise agreed that he lacked capacity in relation to litigation, care, residence, contact with others and internet and social media use.

LM was described as a middle-aged man who had been living in a residential placement for the past decade or so. He had an IQ of between 52 and 60 and experienced a troubled childhood. He had a brief occupational history punctuated by the misuse of alcohol and cannabis.

LM also had a 2009 conviction for the rape of a vulnerable man and a history of "intense" relationships with men and women, and an active online presence through which he has forms such relationships.

The Official Solicitor on LM's part supported the conclusions reached by the consultant forensic psychiatrist instructed in the case, Dr Rebecca O'Donovan, namely that he retained capacity with regard to both engagement in sex and the sharing of his offending history. She emphasised the *"profound, sensitive and far-reaching nature of the question in issue"* and the significant potential invasion of personal autonomy in a *"paternalistic or overly protective approach"* (paragraph 13).

In his analysis of the relevant legal framework, HHJ Rogers reviewed the relevant principles from *JB* [2021] UKSC 52 and the (unsuccessful) argument put forward on behalf of the Appellant in *JB* by John McKendrick KC (as he then was) that "*sexual activity, and decisions about engaging in sexual relations for a person of full capacity, are largely visceral rather than cerebral, owing more to instinct and emotion than to analysis. On this basis he argued that to include as part of the information relevant to the decision the fact that the other person must have the capacity to consent to the sexual activity and must in fact consent before and throughout the sexual activity imposes a discriminatory cerebral analysis on the potentially incapacitous. I reject that submission. As the Court of Appeal observed, at para 96, "amongst the matters which every person engaging in sexual relations must think about is whether the other person is consenting" (emphasis added). If that is properly viewed as cerebral or as involving a degree of analysis, a decision to engage in sexual relations is necessarily cerebral or analytical to that extent*." (*JB* at paragraph 19).

HHJ Rogers also noted (albeit that he ultimately dismissed the potential relevance of the decision of Poole J in *PN (Capacity: Sexual Relations and Disclosure)* [2023] EWCOP 44, in which the latter found that P retained capacity to engage in sex because, notwithstanding a pattern of impulsivity ad inappropriate, non-consensual sexual touching, this arose as a result of PN's "disregard" of the need for consent rather than an inability, due to an impairment of or disturbance in the functioning of the mind or brain, to understand the need for consent in a sexual partner (paragraph 22, citing *PN* at [16]) .

Ultimately, HHJ Rogers rejected the Official Solicitor's acceptance of Dr O'Donovan's conclusions, noting that:

1. LM did not understand the concept of age and, even after education, while he was aware that sex was legal at "one and a six" could not the understand if sex with a 14 year old or 18 year old was legal (paragraph 28);

2. LM reportedly struggled with understanding his own or others' ages in chronological terms (paragraph 41);

3. The argument pursued on behalf of the Official Solicitor that "*LM understands consent, but and in any event any perceived difficulties, in the moment, are attributable to his innate urges not to intellectual deficit, so that, applying the legal test, the essential causal nexus is not there. In terms of authority. Miss Gardner submits that this case is akin to PN and should be dealt with similarly* (paragraph 50).

HHJ Rogers concluded:

> *56. Variously, as set out above,* [Dr O'Donovan] *describes LM as having difficulty processing information, cognitive rigidity and reduced impulse control, all consistent with his diagnosis. She notes his limited insight into his offending and his difficulty in interpreting the actions of others. In her analysis section in G30, Dr O'Donovan notes LM's inability to interpret information about prospective partners. She recognises the difficulty in interpreting and processing information and says in terms "he may find it difficult to determine if an individual was unable to consent to sexual relations in the absence of overt visual and verbal cues." In conclusion, Dr O'Donovan's view is that "as LM's decision to engage in sexual relations largely relies on the interpretation of his own internal world, he is able to process the necessary information to make this decision.*
>
> *57. I confess to being unclear precisely what Dr O'Donovan means when referring to LM's internal world but to the extent she is regarding consent as irrelevant to LM's thinking in the moment as he is overwhelmed by his desires, that may be true in the moment for him, but it is no answer, in my judgment, to the question of whether he is able to understand, retain, use and weigh the points relevant to consent.*
>
> *58. Therefore, for reasons which are not entirely obvious, I am satisfied that Dr O'Donovan's conclusion on this aspect is flawed. I find much of her analysis to be sound. It seems to me to tend towards the opposite answer to that she alighted upon. In my judgment, she focussed too much upon LM's reaction to the offence of rape. She is correct, of course, in a strict criminal law sense that his plea of guilty to rape must mean that the Crown Court was satisfied as to his fitness to plead and the mens rea. Without more information and aware that the strict criminal law position does not always demonstrate the precise practical nuances, I am loathe to draw such a firm conclusion as to LM's understanding of consent. The disposal by way of a hospital order does not undermine the correctness or implications of the conviction but shows the complexity of the situation.*
>
> *59. I agree with Mr Brownhill's submission that Dr O'Donovan appears to have taken a sequential approach, in discounting questions of consent given her view that the driving forces would overwhelm LM to act as he chose to do so. In my judgment, as Mr Brownhill submits that is a misunderstanding of the law as set out in JB. Just because a particular outcome in a real-life situation may in the end be determined by an overwhelming need for sexual gratification, driven not by intellectual deficit but by personality or early life experiences, that does not mean that the test relating to the issue of consent in the overall assessment of engaging in sexual activity does not arise. That first stage may not be dispensed with. I agree with Mr Brownhill that to do so would run directly counter to the approach dictated by JB.*
>
> *60. The same points arise in respect of Dr O'Donovan's addendum report. Strikingly she acknowledges that LM*

> *might not recognise that a sexual partner freezing is consistent with withdrawal of consent and yet, as before, discounts that in terms of relevance because of LM's need for sexual gratification which she believes will override other thoughts. That, in my judgment, is a misunderstanding of the legal text to be applied and a further example of sequential thinking.*
>
> *61. I agree with Dr O'Donovan that LM's sexual drive is not attributable to his intellectual deficit. Where I respectfully disagree is where she concludes that the essential casual nexus is not established. The relevant nexus is not with the sexual drive and therefore the overriding feelings in the moment but in relation to LM's inability to negotiate the elements of consent which the evidence demonstrates, and I find, is plainly and directly because of his intellectual deficit.*

HHJ Rogers ultimately rejected the comparison with Poole's *PN* judgment (see paragraph 65).

On the question of sharing information regarding his offending history, HHJ Rogers noted that the question had been raised, unhelpfully, in a vacuum, with no actual best interests decision in issue (paragraph 68). He declined to give guidance on the issue but at paragraph 71 pointed instead to the *PN* judgment in which (at paragraph 25), Poole J had observed that:

> *However, for present purposes I assume that the relevant information will include the risks to others that arise from the previous offending, how the disclosure of information might be given so as to allow others to avoid or mitigate such risks and prevent P from committing offences which could have adverse consequences, and the reasonably foreseeable consequences of sharing or not sharing the information. In PN's case there are a large number of possible ways in which he might share information, from providing strangers with a long list of previous behaviour, to saying to someone with whom he has formed a relationship, "I have been accused of touching women inappropriately before, but I will not do so with you."*

Comment

The Court of Appeal has recently held that recourse to autonomy is (we paraphrase) apt to lead people astray when it comes to best interests: see the *HB* case discussed in the practice and procedure section of this Report. It might be thought that this case shows how recourse to autonomy can be equally apt to lead people astray when it comes to the assessment of capacity. Dr O'Donovan's desire, matched by that of the Official Solicitor, to uphold the 'autonomy' of LM arguably led to an approach to capacity which downplayed the effect of LM's cognitive impairments. HHJ Rogers, by contrast, took what might be thought to be a more detached view – and a view which (on its face) more obviously accords with the law as set down in *JB*.

A side point is that it seems that the Official Solicitor's position was in part influenced by LM's decision to plead guilty to rape historically (see paragraph 58). However, as the Supreme Court emphasised in *JB,* the criminal law and the civil law in respect of sexual activity are separate and distinct areas. Further, in the criminal context, the essentially procedural concept of 'fitness to plead' and the substantive concept of 'mens rea' are both concepts which appear to be linked to mental capacity, but derive from different places and should not be confused. See further in this regard, generally, our webinar on "When P is an offender,' and, specifically with reference to the law relating to sex, Alex's article What place has

'capacity' in the criminal law relating to sex post JB?

PDOC, expertise and over-litigation

NHS North East London ICB v FHR [2026] EWCOP 43 (T3) (McKendrick J)

Best interests – medical treatment

Summary

FHR, aged 28, sustained a catastrophic hypoxic brain injury in January 2020 when he tried to hang himself. He had been in a prolonged disorder of consciousness ever since: cortically blind, mostly paralysed, PEG-fed, with a cuffed tracheostomy requiring deep suctioning every half hour, daily digital rectal evacuation and worsening contractures. He was cared for at his adapted home by an ICB-commissioned package from August 2020 until April 2025, when – in the third set of Court of Protection proceedings about his residence and care since December 2020 – he was moved on an interim basis to a care home so that a PDOC assessment could be undertaken. Since then he had five emergency hospital admissions for infections. The serious medical treatment issue was only transferred to Tier 3 in October 2025, prompting King LJ, refusing permission to appeal, to describe the case as having been "*subject to egregious delay*" (paragraph 22). McKendrick J was blunter still: the proceedings had been "*highly charged and over-litigated*" and "*at times* [FHR] *has been lost in the litigation*" (paragraph 4).[2]

By the final hearing FHR had undergone 12 CRS-R, 23 WHIM and 2 SMART assessments. Much of the three days of evidence was consumed by a dispute as to whether he was in a vegetative state, MCS- or MCS+, which the judge found "*doctrinaire*" with "*more than a hint of professionals following their own beliefs*" (paragraph 9). The single joint expert on awareness, Ms Gill-Thwaites, had found a vegetative state on SMART assessment in January 2026 but flagged an unverified response to "*stick out your tongue*"; after a court-directed programme of optimisation and further testing, command-following could not be verified, but two episodes of tears and a smile in the presence of family led her to revise the diagnosis to MCS-. Dr Allanson, engaged to carry out one of Ms Gill-Thwaites' recommendations, but sent a letter of instruction by the mother's solicitors which went well beyond it, concluded that FHR was minimally conscious with "*some chance*" of change, and recommended a medication review, a trial of neuro-stimulants and removal of the tracheostomy. Dr Nair, the single joint expert on best interests, considered FHR to be in a permanent vegetative state with no trajectory towards emergence, that pain must be assumed, and that "*it is the giving of daily digital rectal evacuation, half hourly-to-hourly deep tracheal suctioning, frequent hospital admissions and ongoing CANH that must be justified and not the withdrawal*" (paragraph 117). Professor Wade, the ICB's clinical adviser, was admitted as a witness with expertise rather than a Court of Protection Rules expert (paragraph 46) and supported Dr Nair. A best interests meeting in March 2026, chaired by an independent palliative care consultant, had concluded that CANH should continue to allow optimisation and a return home; its chair told the court that the conclusion was provisional and the decision was for the court.

FHR was a Muslim from a close family. His mother exhibited a fatwa from the Islamic Council ruling that withdrawal of CANH would

[2] McKendrick J took the unusual step of setting out in an appendix the procedural history of the case.

not be permissible (paragraph 76). His father said he could not say his son would want to continue living in his current condition, and that a young man who had taken pride in his appearance and independence "*would have found a life in which he was dependent on others for every aspect of care* […] *very hard to accept*," before counterbalancing that with the importance of his faith (paragraph 87). His sister made an impassioned plea for more time.

McKendrick J concluded that CANH was no longer in FHR's best interests (paragraphs 1, 126). Preferring Dr Nair's evidence, he found it more likely than not that FHR was in a permanent vegetative state; but if he was in MCS- it made no difference and *"may even make for a stronger best interests case*" because it would increase his awareness of pain, discomfort and the futility of his existence (paragraph 134). He experienced pain; he was subjected to an arduous care regime; and there was no reliable evidence of awareness leading to joy, comfort or pleasure:

> *… Love has the power to impair our objectivity. There is no reliable evidence before the court of awareness leading to joy, comfort or pleasure. No witness has explained how it is that FHR cannot stick his tongue out when asked, but he has the awareness and cognition to be able to produce the emotions necessary to cry when his father speaks to him of Allah or to smile when his football team is mentioned. I am satisfied these are not meaningful responses but are reflexive.* (paragraph 143)

The judge accepted that FHR would want his life and death to take place within the teaching of Islam and that family mattered greatly to him, but, adopting Lieven J's approach in *NHS West and North London ICB v MP* [2026] EWCOP 36, would not speculate as to whether he would have wished to continue living in his massively diminished state (paragraphs 145-147). The family's largely unchallenged evidence of responses was their perception, shaped by love. To continue CANH even for six to twelve months of further testing was "*wrong in principle and wholly unfair on FHR*" (paragraph 126). A s.16 order was made for palliation at a specialist unit able to manage the tracheostomy, with permission to apply for it to be varied so that FHR could die at home, which the judge hoped could be achieved (paragraphs 153-155). The transparency order was directed to be discharged 21 days after his death.

Comment

Three key things stand out. First, the judgment is a forthright application of the post-*Aintree* orthodoxy, echoed in the RCP 2020 Guidelines and in *NHS North Central London ICB v PC* [2024] EWCOP 31, that the VS/MCS label is not the question; the trajectory and whether P could ever recover a quality of life they would value is. But it goes a step further. The 'double edged sword' reasoning at paragraph 134 – that greater awareness, in the presence of pain and no prospect of improvement, strengthens rather than weakens the case for withdrawal – inverts the intuition, common among families, that any sign of consciousness is a reason to carry on. Practitioners should expect that argument to be deployed in future PDOC cases.

Second, in relation to evidence, an ICB may rely on its own clinical adviser without appointing him as an expert under the Rules (ss1, 3(2) of the Civil Evidence Act 1972). A clinician engaged to carry out one of the single joint expert's recommendations reports to the single joint expert, not to the party who sends a letter of instruction, and one who writes to the judge directly after listening to the opposing expert risks the finding, however gently expressed, that she may have inadvertently "*transitioned from clinician to advocate for the family*" (paragraph

128).[3] And a best interests meeting under the RCP Guidelines which concludes in favour of continuing CANH so that further testing can take place does not bind the court, particularly where the chair accepts its conclusion was provisional.

The third key point relates to the delay. FHR was diagnosed as being in a vegetative state in 2020. Three sets of proceedings about residence and care followed before anyone squarely raised the treatment question, and only in October 2025 was the case recognised for what it had always been. Where CANH for a PDOC patient is, or is likely to be, contested, that issue must be identified and listed at the outset rather than allowed to sit behind disputes about where P lives and who cares for him. The fatwa is also worth noting: the court accepted FHR's faith and its relevance under s.4(6)(b) MCA, but a religious ruling that withdrawal is impermissible was not treated as evidence of what FHR himself, confronted with his actual circumstances, would have wanted.

Epsom and clinical practice

Readers interested in thinking more about the impact of the decision of the Court of Appeal in the *Epsom* case may wish to read the report of an expert workshop held at Green Templeton College on 19 March 2026 which has now been published.

[3] McKendrick J's allusion to the debates having become "*doctrinaire*" is perhaps rather harsh, but we are aware that there can be some very strong feelings at play amongst clinicians working in this area. They echo (in our experience) some of the debates that can arise in relation to eating disorders, where disagreements about apparently narrow technical points can mask much more fundamental – often ethical – disagreements. It is not obvious to us that these disagreements are well suited for resolution in the court room.

PROPERTY AND AFFAIRS

Property and Affairs Court User Group – 1 July 2026

A Court of Protection User Group meeting for Property and Affairs was held on 1 July 2026. These meetings are held regularly and are chaired by Senior Judge Hilder. The next meeting is on 21 October 2026.

The minutes show that the headline updates from the Court[4] were:

- Caseload: Around 200 new P&A applications are awaiting logging, currently around 7 days old. Orders are being issued approximately 15 days after they are made. Additional Birmingham-based staff are being trained with the aim of reducing this to a 5-day turnaround.
- Costs order errors: A number of lay deputy orders were issued with incorrect provisions relating to professional deputy costs. Corrective COP9 applications are currently taking 4–8 weeks to process. The underlying templates have now been corrected.
- Draft orders welcomed: HMCTS has asked applicants to submit a draft order up front for streamlined applications seeking non-standard powers.
- Digital: The "We Are Group" support service has launched. The New Trustee digital journey is awaiting Practice Direction sign-off, with a summer go-live planned. The P&A pro bono duty desk, which has operated monthly since May, is going well.

[4] This excludes the update around the response to *AGNI*, which we have included in the Health, Welfare and Deprivation of Liberty section of the Report.

OPG recruitment

The OPG are growing their legal team due to increasing demand in the MCA context. There are three positions open for suitably qualified lawyers: for more details and to apply, see here; you can also contact Peter Boyce at the OPG if you have specific queries.

PRACTICE AND PROCEDURE

Short note: personal welfare deputies – a reset

In *Re HB (Appointment of Personal Welfare Deputy)* [2026] EWCA Civ 960, the Court of Appeal gave authoritative, appellate level guidance, as to the appointment of personal welfare deputies. In giving the lead judgment, Sir Stephen Cobb, the new President of the Court of Protection, expressly moved away from the approach of the previous Vice-President, Hayden J, in the *Lawson* case. At paragraph 63, Sir Stephen indicated that deputyship may well be appropriate in cases involving "some or all of the following features:"

> *i) The applicant for the PWD stands in some special relationship in relation to P, such as in this case where the applicants are his parents with a special ability to understand and communicate with and for P;*
>
> *ii) Where P's wishes and feelings, their beliefs and values and the things which are important to them (see Aintree at §32 above) would be likely to be enhanced by the appointment of a PWD, to make choices for them as an individual human being;*
>
> *iii) In circumstances in which it is likely that more than one decision will need to be made in the foreseeable future (see the Code at 8.39, Watt and Parr above); a series or "stream" (Parr) of decisions in respect of P is reasonably anticipated;*
>
> *iv) When P is moving from childhood to adulthood and transitioning between children's and adult's services, where it may well be in P's best interests to have someone acting as his agent for decision-making; transitional difficulties for young adults with lifelong impairments may justify short-term solutions;*
>
> *v) The appointment may be particularly appropriate where it can be shown (as here) that public bodies have failed, or threaten to fail, properly to apply the MCA 2005 framework, particularly in relation to consultation with families;*
>
> *vi) Decision-making in the foreseeable future needs to be prompt and agile in order to respond to an evolving set of circumstances.*

Importantly, the Court of Appeal also made clear that:

> *It is important to remember in this case and in others like it that the statutory scheme permits the disclosure and sharing of relevant information about P, as appropriate, where it is in P's best interests and necessary for meaningful consultation; such a practice is entirely in accordance with the current Code of Practice (see para.16.19-16.23). There are many examples in the post-Lawson caselaw to which we were taken of authorities failing to consider this important information-sharing power under the provisions of sections 4 and 5 MCA 2005 (see for example, Cwm Taf Morgannwg University Health Board v RW & Anor [2026] EWCOP 10 (T3), and NHS South East London Integrated Care Board v JP (by his litigation friend, the Official Solicitor) & others [2025] EWCOP 8 (T3), London Borough of Lewisham v SL (by her litigation friend, the Official Solicitor) [2025] EWCOP 51 (T3)). Indeed, in this case the Judge rightly acknowledged this point (see again §21 above: "the system of collaborative decision making … does not always run as the statute intends"). I accept Mr Ruck Keene's argument that concerns about the failure of this type of information-sharing between professionals and P's family does not of itself justify the appointment of a*

> *deputy: I caution myself against treating deputyship as a mechanism to overcome professional hesitation or institutional risk-aversion. I further accept that appointing a deputy cannot alter the limits of public law decision-making; decisions by public authorities (e.g., as to resource allocation) must remain constrained by public law principles. A PWD cannot compel the creation of options or override resource-based decisions by asserting that a particular course is in the individual's best interests. (emphasis added)*

The latter point can be seen as an (implicit) confirmation that, whatever else the *Epsom (Townsend)* case means in the context of medical treatment, those exercising functions under the MCA 2005 cannot magic up more in the name of best interests than would be available were the person to have the relevant decision-making authority.

The decision also contains a discussion of the concept of autonomy which – spoiler alert – is not likely to be assistance in deciding whether to appoint a deputy or indeed (we suggest) more broadly in relation to the MCA 2005, given its "*inherent elasticity in a range of contexts* [which] *makes it, in my judgment, an uncertain and inapposite tool*" (paragraph 69). For more on the ethical issues in play here, you may find this book and /or podcast of interest.

We will be keeping a very close eye on whether the judgment leads to the increase in the number of personal welfare deputies that social media 'chat' suggests that it is likely to.

Confidentiality and collateral use of documents

Hinduja v Hinduja & Ors [2026] EWCOP 34 (T3) (Bacon J)

Practice and procedure (Court of Protection) – other

Summary

The issue in this case was crisply summarised by Bacon J in the opening paragraph: "[t]*his hearing concerns the latest development in a long-running family feud between members of the Hinduja family. The issue before the court is whether documents disclosed into the Court of Protection proceedings concerning the late Srichand Parmanand Hinduja (SP) should now be permitted to be used in other actual or contemplated proceedings, and if so on what terms*."

Much of the decision is concerned with (necessary) micro-analysis of specific documents / classes of documents and whether they were covered by specific orders and /or legal privilege. However, of wider relevance is Bacon J's analysis of two issues that arise relatively often in Court of Protection proceedings: (1) the principles that apply where a party seeks to release / vary the confidentiality restrictions imposed in those proceedings; and (2) what (if any) used can be made by a party of documents disclosed into Court of Protection proceedings for other purposes (so-called 'collateral use' of documents).

As to the first issue, Bacon J reviewed the case-law, including the recent decision of the Court of Appeal in *Gardner*, and held that they

> *53.* […] *indicate that where one or other party to proceedings in the Court of Protection seeks to release or vary the confidentiality restrictions imposed in those proceedings, including after the death of the person the subject of the proceedings, the following general principles will apply:*
>
> *i) The court will need to consider on a case-by-case basis the justification for*

disclosure of the relevant documents, and it will be for the person seeking disclosure to justify their request.

ii) The question to be asked is whether the specific interest in disclosure outweighs the ongoing interest in the protection of the confidentiality of personal and sensitive information contained within documents filed or disclosed in the Court of Protection proceedings, given the sensitive context in which those documents were provided, and the legitimate expectations of confidentiality on the part of all those involved in the proceedings.

iii) If disclosure is granted, it should be limited to what is essential to achieve the particular objectives justifying disclosure.

As to the second issue, that of collateral use, Bacon J noted the similarities between COPR 5.10 and the equivalent provision (CPR 31.22) in the Civil Procedure Rules, and (at paragraph57) the "well-established" principles in the latter governing the circumstances in which permission will be given by the court under CPR r. 31.22(1)(b) for collateral use, such as use in other proceedings. In particular:

i) The court will only grant permission under CPR r. 31.22(1)(b) if there are special circumstances that constitute a cogent reason for permitting collateral use: Tchenguiz v SFO, §66(i). The grant of permission is exceptional, in the sense that it is not routinely given: Duke of Sussex v MGN [2023] EWHC 1617 (Ch), §6.

ii) The burden is on the party making the application to demonstrate cogent and persuasive reasons for allowing the collateral use sought: Lakatamia v Su, §53. That burden is a particularly heavy one where the permission is sought by or for the benefit of a person who is not a party to the action in which the documents were disclosed: ACL Netherlands v Lynch [2019] EWHC 249 (Ch), §30.

iii) The court must also be satisfied that there is no unwarranted prejudice to the disclosing party. That means prejudice beyond the mere fact that the documents are able to be used for collateral purposes. Ultimately the court must balance the legitimate interests of the party seeking permission against the legitimate interests of the disclosing party: Duke of Sussex, §§6–7.

iv) What constitutes "use" of a document for the purposes of CPR r. 31.22 is very broad, and is regarded as extending to reviewing the documents for the purposes of considering whether they are relevant to other proceedings. Accordingly, absent some provision in the relevant order, doing anything other than realising, in the course of review for the purposes of the proceedings in which documents are disclosed, that a document or documents would be relevant to actual or contemplated other proceedings, may constitute a collateral use: Tchenguiz v Grant Thornton [2017] EWHC 310 (Comm), [2017] 1 WLR 2908, §§29–31; Lakatamia v Su, §§57, 59(i).

v) The appropriate course is therefore a two-stage approach. First, as soon as it is identified that there may be documents relevant to actual or contemplated other proceedings, the relevant party should seek permission to review those documents in order to determine whether it is desirable to use them in those other proceedings. Secondly, once that review has taken place, the relevant party can seek permission to deploy those documents in the other proceedings: Lakatamia v Su, §59(ii)–(iii).

Bacon J held at paragraph 58 that the principles set out should apply for applications for permission under the equivalent provision in COPR 5.10(1)(b). At paragraph 59, she also endorsed the observations of the leading textbook on disclosure that applications for permission:

> *"ought to specify clearly the documents in respect of which permission is sought and similar care should be taken in drawing up any order, listing the documents by way of schedule in appropriate cases so there can be no doubt which documents are covered. In general, it is inappropriate to seek a release in respect of disclosed documents wholesale, not least because the court needs to carry out a balancing exercise and it is only in special circumstances that the restriction or undertaking is to be modified."*

Such that:

> *60. In general, therefore, a blanket application for permission in respect of an entire set of documents is unlikely to be appropriate; rather the application should normally be made by reference to specific documents, in order to demonstrate why the circumstances are such as to justify the use of those documents for the collateral purpose sought. A targeted approach is, moreover, likely to be particularly important in Court of Protection proceedings in light of the particular context in which documents have been disclosed in those proceedings, as discussed above.*

One observation about privilege is relevant, namely Bacon J's endorsement of the common ground of the parties that "*the Court of Protection's ability to waive privilege on SP's behalf came to an end when SP died, and that any request for further waiver of privilege must now be made to SP's personal representatives, whoever they are*" (paragraph 63).

Comment

The Court of Appeal in *Gardner* invited the Court of Protection Rules Committee to consider the issues of practice and procedure arising out of the provision (strictly, not the disclosure) of position statements to observers of proceedings. This case makes clear that the observations in *Gardner* are of wider relevance in terms of reaffirming the core proposition that Court of Protection proceedings attract a (necessary) degree of confidentiality, and that any lessening of that confidentiality needs to be accompanied by suitable safeguards.

Scottish orders before the English courts (1)

CW v Hartlepool Borough Council and Scottish Borders Council [2026] EWCOP 40 (T3) (Theis J)

International jurisdiction of Court of Protection - Recognition and enforcement

Summary

CW, aged 33, had emotionally unstable personality disorder, cognitive deficits and epilepsy. In December 2022 Scottish Borders Council placed her in a care home in Hartlepool under a three-year welfare guardianship order made by Jedburgh Sheriff Court. The placement was intended to be temporary whilst alternative placements closer to home were being sought. No application was made to recognise and enforce the order under Schedule 3. When the care home sought a DoLS authorisation in February 2023, Hartlepool initially rejected the request because it had not placed CW but ultimately granted a standard authorisation in March 2023 and a subsequent authorisation was challenged s.21A in June 2025. Two months later the guardianship order expired unrenewed,

Scottish Borders having been unable to obtain the medical report needed to renew it.

In October 2025 HHJ Boothroyd declared, on an agreed but 'finely balanced' basis, that CW remained habitually resident in Scotland. Scottish Borders duly applied to the Sheriff Court for a fresh order in January 2026. The Sheriff found that CW consistently did not want to return to Scotland, that the council had no intention of moving her and that there was no suitable placement north of the border, and on 29 May 2026 dismissed the application for want of jurisdiction. Scottish Borders then came to the Court of Protection – which had meanwhile been authorising CW's deprivation of liberty under paragraph 7(1)(d) of Schedule 3 – for a declaration that CW was now habitually resident in England and Wales. CW, through the Official Solicitor, supported that; Hartlepool was neutral.

Applying the principles summarised in *Aberdeenshire Council v SF* [2023] EWCOP 28, and noting that an earlier determination did not prevent the court revisiting the question (*Neath and Port Talbot CBC v CK* [2025] EWCOP 47), Theis J held that CW's habitual residence had moved to England (paragraph 59). None of the factors was determinative but together they support that conclusion: over three and a half years in Hartlepool; a placement no longer regarded as temporary, with no active search for alternatives; the council's own change of position, accepted by the Sheriff; and CW's now stable wish not to return to Scotland, even though she described the care home as a "*mental prison*" and her room as a "*cell*" and wanted to live elsewhere in Hartlepool. Her integration in the community was minimal but, as the judge observed, a deprivation of liberty regime "*by definition limits her ability to integrate*" The court cautioned against placing too much weight on the passage of time, or on any suggestion that a person is 'settled', where they are subject to compulsory confinement (paragraph 58). CW's ordinary residence, in contrast, remained in Scotland under Schedule 1 to the Care Act 2014, so Scottish Borders continued to fund and case-manage the placement (paragraph 51).

Of wider significance is the agreed list of good practice points for cross-border placements which Theis J endorsed with "*modest modifications*" (paragraphs 14-20). Before placing, the Scottish authority should follow Chapter 21 of the Care and Support Statutory Guidance and notify the English authority. After placing, there should be a "*timely application*" for recognition and enforcement under paragraph 19 of Schedule 3 "*to provide a clearly understood legal framework for decision making*;" the receiving authority should be told of any deprivation of liberty, which can be drawn to its attention through the unauthorised deprivation of liberty route in paragraphs 67-73 of Schedule A1; the *RF* requirements and the *DM* measures should be considered, along with Articles 6 and 8 ECRH, even where Article 5 is not engaged; habitual residence should be kept under review throughout; renewal should be considered in good time, with an application to the Court of Protection before expiry if habitual residence has shifted; and the judicial protocol for direct communications between the UK jurisdictions should be used to share determinations, particularly on habitual residence, without delay.

Comment

The guidance at paragraph 15 perhaps deserves a caveat. Scottish Borders' solicitor described it as 'unfortunate' that the 2022 order was never 'ratified' in England (paragraph 45), and the good practice list treats a Schedule 3 application as a matter of course. But such active steps in relation to a Scottish guardianship order are only necessary if the guardian is going to insist on their decision-making authority in this jurisdiction. In Scotland there is no equivalent of

s.5 MCA 2005, which is why the guardian needs formal authority there (see *Argyll and Bute Council v RF (No 2)* [2026] EWCOP 41 (T3) at paragraph 45. However, the Adults with Incapacity (Scotland) Act does not limit the authority of the guardian by reference to the presence of the 'adult' in Scotland; further, by paragraph 19(1) of Schedule 3 to the MCA 2005, a 'foreign' protective measure taken on the basis of the person's habitual residence in the other jurisdiction is recognised by operation of law. There is, therefore, no need for any application under Schedule 3 so as to ensure the recognition of the status of guardian. Once the adult is in England, s.5 MCA 2005 protects those delivering their care and treatment, and any deprivation of liberty is authorised by DoLS or the court.

Therefore, if the guardian is happy to let s.5 MCA 2005 take its course, and not to insist on their decision-making authority, the Scottish order can simply continue in the background without further formality. Thus, for three and a half years CW's care and confinement in Hartlepool were lawful on the basis of s.5 MCA and Schedule A1, not the Jedburgh order, and the order's expiry in August 2025 changed nothing on the ground. Recognition – and more to the point a declaration of enforceability – matters where: (1 the guardian wants to do something that s.5 does not cover – eg to override the English decision-makers or to convey the adult back across the border against their will; or (2) where the order itself is to be relied upon as the authority for the deprivation of liberty, at which point the Article 5 scrutiny in *RF(1)* and *DM* is required.

Two other points are worth noting. For someone not ordinarily resident in the area of any English or Welsh local authority, the DoLS supervisory body is the local authority for the area in which the care home is situated (Schedule A1, paragraph 182(3)), and paragraph 16 of the guidance now spells out how an unauthorised deprivation of liberty should be brought to the receiving authority's attention. Second, the case illustrates how habitual residence and ordinary residence can part company: the Court of Protection now has jurisdiction over CW's welfare while a Scottish council, whose Sheriff Court has disclaimed jurisdiction, remains responsible for funding and managing her care. It also shows the ratchet by which a 'temporary' placement becomes a permanent one – not by decision, but by the absence of one. Once the Sheriff had declined jurisdiction, it is difficult to see what other conclusion was open; the alternative was a legal vacuum filled indefinitely by paragraph 7(1)(d).

Scottish orders before the English courts (2)

Argyll and Bute Council v RF (No 2) [2026] EWCOP 41 (T3) (Theis J)

International jurisdiction of Court of Protection - Recognition and enforcement

Summary

Sixteen months after the application for recognition and enforcement of RF's Scottish guardianship order foundered in *Argyll and Bute Council v RF* [2025] EWCOP 12 (T3) ('*RF(1)*'), the council returned with a new order and succeeded. Although by the time of the hearing the Official Solicitor supported the application, Theis J considered it important to set out why the second attempt succeeded where the first had failed.

RF, aged 65, had a learning disability and a personality disorder. Born and raised in Scotland, where his two siblings still live, he had been at a placement in London since December 2023 following a series of failed Scottish placements, hospital admissions and six months in prison. The doors were locked, he was supervised at all times (2:1 in the community), he wanted to return

to Scotland and he could not visit his family as he wished, so he was deprived of his liberty on the multifactorial test in *Attorney General for Northern Ireland's Reference (Deprivation of Liberty)* [2026] UKSC 16 (paragraph 76). He remained habitually resident in Scotland. In *RF(1)* the court had refused to recognise a three-year order because RF had not been given an opportunity to be heard, which was a breach of natural justice (Schedule 3, paragraph 19(3)), and because recognition would have been inconsistent with a mandatory provision of the law of England and Wales and manifestly contrary to public policy (paragraph 19(4)). In the meantime the Court of Protection continued to authorise his deprivation of liberty under its temporary jurisdiction in paragraph 7(1)(d) of Schedule 3 (paragraph 19).

The council went back to the Sheriff Court. The 2025 order was first reduced from three years to one and then, on 13 February 2026, a fresh one-year order was made re-appointing the Chief Social Work Officer as welfare guardian with powers including residence, conveyance and return, access, the level of care and supervision, and restraint. This time RF was present and represented by a legally qualified safeguarder, appointed for the duration of the order; the Sheriff had psychiatric and mental health officer reports and a report from an independent advocate commissioned by the council. Two statements from the safeguarder explained the review machinery: the advocate visited RF monthly and reported to the safeguarder; advocate and safeguarder conferred every three months; the safeguarder could act of her own motion, including by applying for recall or variation under ss.71 and 74 of the Adults with Incapacity (Scotland) Act 2000, independently of the council; and she was 'confident' that legal aid would be granted for any such application.

Measured against the seven Article 5 requirements distilled in *RF(1)* at paragraph 56 (repeated at paragraph 57), Theis J was satisfied that the one-year duration now aligned with the MCA 2005 framework in this jurisdiction which, whilst not a determining factor, was a relevant consideration and a "useful guide" to the reasonable interval for review (paragraphs 73, 78). The internal review structure required by Article 5(4) was provided by the monthly visits, the reporting and the quarterly meetings (paragraph 79), and RF's ability to take proceedings was secured by the safeguarder's standing, independence and likely funding (paragraph 80). RF had been heard for the purposes of paragraph 19(3), the Winterwerp criteria were met, and recognition was neither manifestly contrary to public policy nor inconsistent with a mandatory provision (paragraph 81). The order was recognised and enforced; Theis J also made clear that paragraphs 18 and 19 of Mostyn J's Schedule 3 checklist in *Re SV* [2022] EWCOP 52 should be updated accordingly (paragraph 83).

Comment

Read with *Midlothian Council v DM* [2025] EWCOP 61 (T3),[5] this decision completes the picture. Two models of Article 5 compliance have now passed muster: Midlothian's review clause on the face of the order plus council-funded advocacy and litigation, and now Argyll and Bute's legally qualified safeguarder appointed for the life of a one-year order, with a monthly advocate and with a route back to the Sheriff Court funded by the Scottish Legal Aid Board. The common denominators are a twelve-month order, the adult present and independently

[5] A decision which did not make its way to the archives until July 2026, for some reason.

represented when it is made, somebody independent seeing the adult regularly, and a real (and funded) means of getting back to court. Scottish authorities placing adults in England should no longer be arriving at the Court of Protection with the bare three-year order that failed in *SF* and *RF(1)*.

Two features nonetheless merit attention. First, the Official Solicitor rightly pressed that where the same public body both confines and authorises, anxious scrutiny is called for even on a limited review, and that the 2026 order contained no specified limits on the deprivation of liberty of the kind an English order would carry (paragraph 63): what has been recognised includes open-ended powers to convey, return and restrain. Second, the funding of any challenge rests on the safeguarder's confidence that legal aid would be granted rather than on a guarantee. That was enough here, but it is less than the council's unconditional commitment in *DM*, and the advocate on whom the monthly monitoring depends is commissioned by the detaining authority.

Perhaps the more sobering point is chronological. Proceedings began in May 2024, RF has been confined in London against his wishes on interim authorisations for over two years, and the placement in Scotland to which everyone agrees he should return has still not been found (paragraphs 17, 75). Recognition and enforcement gives his detention a lawful framework but it has not got him home (yet).

MENTAL HEALTH MATTERS

The MCA and the MHA

Three recent cases have considered the interaction between the MCA and the MHA in some detail.

In the most recent iteration in the very complex and difficult case concerning a woman identified as "Patricia," *Patricia v Cygnet Healthcare Ltd & Ors* [2026] EWCOP 29 (T3). Peel J had to consider the question of whether the Court of Protection could make decisions about the medical treatment for mental disorder of a person subject to Part 4 of the Mental Health Act 1983. Perhaps surprisingly, this issue has not been the subject of express consideration before, although there have been a significant number of cases in which (almost invariably) the relevant treating bodies have sought confirmation from the Court of Protection that further treatment for anorexia is not in the detained person's best interests. The precise jurisdictional basis for this has always been (to use a technical term) slightly fishy, given that s.28 MCA 2005 expressly provides that nothing in the MCA 2005 authorises anyone (a) to give a patient medical treatment for mental disorder, or (b) to consent to a patient's being given medical treatment for mental disorder, if, at the time when it is proposed to treat the patient, their treatment is regulated by Part 4 MHA 1983. It could, perhaps, be justified by reference to the very broad scope of s.15(1)(c) MCA 2005, which provides for the making of declarations of lawfulness of actions in relation to those lacking the relevant decision-making capacity. (Parenthetically, where the question is about further admission, as opposed to treatment, to have the Court of Protection determining that non-admission is in a person's best interests might also be thought to be treading on the public law toes of those charged by statute with determining whether the person meets the criteria for admission).

Peel J made clear that, by virtue of s.28 MCA 2005, if the treatment falls within the definition of medical treatment for mental disorder, the Court of Protection has no power to make decisions on the person's behalf about that treatment. This is not a surprising conclusion when the two statutory frameworks are read side-by-side, but it does have a number of implications. Peel J set some of them out thus:

> *41. Although not directly relevant to the application before me, this case threw up a number of procedural matters in circumstances where an incapacitous patient is detained under MHA 1983 and where, as I find, by reason of s28 of the MCA 2005, the Court of Protection does not have power to make best interests orders in relation to medical treatment.*
>
> *42. Where there is an issue, or any doubt about, whether a particular treatment falls within s63/s145(4) of the MHA 1983, the matter should be brought before the court: **A NHS Trust v A [2013] EWHC 2442 (Fam)** per Baker J (as he then was) at para 80. The court will consider the matter on a "full merits based review" (following the applicable judicial review test on challenges to s63): para 13 of **R (on the application of JB) v Haddock (Responsible Medical Officer) [2006] EWCA Civ 961**. In this case, there is no such doubt.*
>
> *43. Where a patient is receiving treatment under s63 MHA 1983, and agreement is reached as to withdrawing or providing life sustaining treatment, there is no obligation on the parties to come to court: **An NHS Trust and others v Y (Intensive Care Society and others intervening) [2018] UKSC 46**.*
>
> *44. I acknowledge that in some instances the clinicians/hospital/NHS*

Trust prefer to seek the approval of the court for any such agreement. In some reported cases (as noted above), that has taken place in the Court of Protection; in others (noted above), it has taken place in the Family Division under the inherent jurisdiction. And in ***Leeds and York Partnership NHS Foundation Trust v FF and GG [2025] EWCOP 26 (T3)*** *McKendrick J made declarations both under s19 of the Senior Courts and under s16 of the MCA 2005. It seems to me that in respect of treatment encompassed by s63 of the MHA 1983 (whether life sustaining or not) agreed applications should not be brought to the Court of Protection. Rather, they should be brought by way of inherent jurisdiction/declaratory relief under s19 of the SCA 1981. Arguably, the inherent jurisdiction based on the "vulnerable adult" jurisprudence is the preferred route in the light of the Vice-President's comprehensive judgment in the* ***Cumbria case [supra]*** *explaining its existence and applicability where the incapacitous person is detained under s3 MHA 1983.*

45. Where there is disagreement in respect of treatment which falls under s63 of the MHA 1983, Mr Patel KC submitted, and I agree, that relief cannot be sought by the patient under the inherent jurisdiction because the statutory provisions of the MHA 1983 provide the answer, namely that the views of the clinicians prevail. For that reason, the application before me was confined to the Court of Protection.

Other remedies available to Patricia

46. This does not mean that Patricia is without potential remedies. It is common ground that she is entitled to bring judicial review proceedings in respect of the s63 treatment. She is also entitled to bring a Human Rights challenge under s7 of the Human Rights Act 1998. I make no further comment on these matters.

The *Cumbria* case to which Peel J made reference is the decision of Theis J in *Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust & Anor v QF* [2026] EWHC 1621 (Fam), a decision in which the Vice-President of the Court of Protection examined in detail the question of whether and when the inherent jurisdiction of the High Court can be used in such situations. She concluded that:

70. […] whilst each case will need to be considered on its own particular facts:

(1) This court's inherent jurisdiction is, in principle, available in circumstances where there is no remedy or not an effective remedy in accordance with the obligations under the ECHR, or there is some other identified reason for making the application and seeking orders.

(2) This court's inherent jurisdiction is, in principle, available whether the person concerned lacks capacity (see A NHS Trust v A at [92]) or is vulnerable (see DL at [53]-[54]).

(3) Before making an application to invoke the inherent jurisdiction very careful scrutiny must be given by the applicant as to the need for and the basis of the inherent jurisdiction to make any orders sought. In this case Ms Watson's careful analysis provided that, namely (i) QF lacked litigation capacity such that judicial review cannot provide a sufficient, practical or effective remedy; (ii) the decision whether to give, delay or withhold treatment is finely balanced; and (iii) exercising or not exercising the discretionary power to provide that treatment under s63 MHA within a particular timeframe may lead to premature death.

> *(4) If an application is made the applicant should identify in the application the underlying rationale for making the application, set out the orders sought and what, if any, rights are engaged under the ECHR.*

Theis J also made some observations on the procedure required. In the case before her, the proceedings had been brought by way of a claim form under Part 8 of the CPR, used where the question or remedy is unlikely to involve a significant dispute of fact. That had been endorsed by McKendrick J in *Leeds and York Partnership NHS Foundation Trust v FF & Anor* [2025] EWCOP 26. Theis J observed that:

> *72. Whilst it is right that, depending on the circumstances of the case, there may be no factual dispute, that position may not remain. The overriding objective in Part 1 CPR and the courts wide case management powers, together with rule 8.8 CPR, enables the court to keep under review on a case by case basis whether the Part 8 procedure remains the correct procedure.*
>
> *73. As a matter of practice, in circumstances such as this case, a Trust may wish to actively consider securing an external second opinion as a matter of urgency prior to issuing proceedings to support and inform any decision making in these difficult cases and whether an application for orders under the inherent jurisdiction is required.*

74. Once the decision is made to issue an application invoking the inherent jurisdiction in circumstances where declarations are sought, as in this case, the application should be accompanied by a proposed draft directions order and the Official Solicitor should be notified. In addition, if the hearing is to be in public, a draft Reporting Restrictions Order that has complied with the relevant Practice Direction should also be submitted with the application. The application once issued should be allocated immediately to a full time Judge of the Division for directions.

The third case, *Birmingham and Solihull Mental Health NHS Foundation Trust v CG & Anor* [2026] EWCOP 37 (T3), concerned a situation where a Trust had initially sought confirmation from the Court of Protection that it was not required to bring about further compulsory treatment of a woman with anorexia (detained under the MHA 1983). The Trust, however, then sought to withdraw the application; a course of action agreed to by all parties. Theis J gave a judgment explaining why this course of action was in CG's best interests. She agreed with:

> *64.* […] *the observations of Ms Scott on behalf of the Official Solicitor that it would have been of benefit to CG and her legal representatives to have been able to explain to her from the start of the proceedings details of the relief being sought, the powers of the court to grant that relief and the potential consequences for CG and the course the litigation was going to take. The precise declarations being sought should, in my judgment, always be set out in the application.*
>
> *65. In Patricia the issue of the court's jurisdiction was raised at an early stage and determined within a week after proceedings had been commenced on 30 June 2026. In that case the other parties raised the issue of jurisdiction at the first hearing before me on 3 July 2026 and the hearing before Peel J took place on 8 July 2026. Where possible, any issue as to jurisdiction should be raised with the other parties and the court at the earliest opportunity so that directions can be made for an early determination of that issue to avoid*

the disadvantages to P of continuing uncertainty caused by ongoing proceedings.

Theis J identified that:

66. In the joint document submitted by the parties after the conclusion of this hearing they set out the following list of factors that NHS Trusts should consider before deciding whether to make an application to the Court in respect of the proposed treatment plan for a patient with anorexia who is considered to lack capacity to make decisions about their medical treatment, where the decision not to provide treatment (including by way of forcible feeding) may be life threatening.

67. In relation to patients who are not detained under the MHA (irrespective of whether the patient meets or would probably meet the criteria for detention under that Act) they suggest the relevant factors in such cases should include the following:

(1) Is there any dispute that the patient lacks relevant capacity?
(2) Is there any material dispute among the clinicians as to the treatment plan and what treatment is in the patient's best interests?

(3) Does the patient object to the treatment plan?

(4) Is there a dispute as to the treatment plan and what treatment is in the patient's best interests, or as to the need to obtain further medical opinions before a decision is reached:

(a) from those with an interest in the patient's welfare; and or

(b) from any Independent Mental Capacity Advocate appointed in respect of the patient?

(5) Is there any identified medical professional who proposes to offer alternative treatment to that which is in the treatment plan?

(6) Has the NHS Trust obtained an independent external second opinion from an appropriately qualified and experienced clinician (where practicable)?

(7) Is there any material dispute from the author of the second opinion as to the treatment plan and what treatment is in the patient's best interests?

(8) Has the NHS taken all reasonable and practicable steps short of making an application to the Court to resolve any material dispute?

(9) Is the way forward finely balanced?

(10) What impact would the NHS Trust bringing / the patient participating in legal proceedings have on the patient's welfare?

68. The parties agree that, if the answer to any of (1) – (5) or (7) – (9) is "yes", that would suggest that the NHS Trust would be 'well advised' to make an application to the Court, but if the answer to all of (1) – (8) is "no" then the NHS Trust should consider very carefully whether there is any need to make an application.

With her characteristic prudence, Theis J noted that:

69. In considering the matters listed above it is important to remember that

each case is fact specific and any action will need to be considered in the light of the particular facts of that case. However, I do consider the non-exhaustive list of factors set out above provides a helpful framework to inform decision making as to whether an application needs to be made to the court, or not.

70. In addition to the decision whether an application needs to be made, or not, there must be careful consideration given as to whether any application should be made in the Court of Protection or the High Court, involving the Inherent Jurisdiction, or both.

71. Any application issued in these circumstances needs to very clearly set out why that particular procedural route has been taken, what declarations are being sought and, if required, address the applicability, or not, of ss16A, 28 and Schedule 1A MCA.

A more thorny issue was as to what "finely balanced" meant:

72. In their document submitted after the hearing the parties invited me to give guidance on 'what 'finely balanced' means where there is unanimity as to the treatment plan'. As this issue was not addressed in the written or oral submissions of the parties I do not consider it would be appropriate to accept this invitation. If required, it can be considered in a case where that is an issue between the parties.

73. All I can do is set out what is stated in Epsom at [61] - [62] and [65] - [69] and draw attention to the reference in that judgment to the Royal College of Physicians and British Medical Association guidance regarding clinically assisted nutrition and hydration (CANH) for adults who lack capacity to consent. This guidance suggests that a decision may be considered finely balanced if there remains 'on going uncertainty'. Baker LJ recognised in [67] that such guidance could have wider application to other life-sustaining treatment other than CANH. As Ms Butler-Cole astutely observed in her written submissions 'Sensitive decisions with serious implications for P are not necessarily finely balanced and Trusts making applications such as the present need to focus on whether the decision is truly arguable either way, or whether they are in reality seeking a court declaration for defensive purposes".

74. Permission has been given to both parties in Epsom to appeal to the Supreme Court.

Comment

There are four implications arising from these three judgments.

The first is that the decision of Peel J can be read as implicit confirmation that the fact that person lacks capacity to make a decision about their medical treatment for mental disorder does not mean that *Epsom* applies so as to require clinicians applying the MHA 1983 to take 'best

interests' as their yardstick, but rather the provisions of Part 4 MHA 1983.[6]

The second, linked, is that in due course Part 4 MHA 1983 will be brought much close to the provisions of the MCA 2005 by the Mental Health Act 2025 so as to make the factors to be considered by a clinician determining what treatment to give under Part 4 very similar to those which are taken into account on a 'best interests' basis (they cannot be identical, and the term 'best interests' cannot be used because Part 4 can apply to those who have capacity)

The third is that it might be thought rather optimistic of Peel J to consider that Patricia could bring a challenge by way of judicial review. The MHA Review expressly recommended that there be a route of challenge within the MH Tribunal in relation to medical treatment decisions precisely because judicial review is (in reality) very close to a non-starter. That recommendation was not taken up, and, whilst the changes to be brought about the MHA 2025 will enable a closer scrutiny of medical treatment decisions by the Tribunal as part of the overall 'package,' they do not ultimately provide the direct counterpart to the scrutiny available before the Court of Protection. Whilst there are treatment safeguards available under Part 4 (most obviously the SOAD procedure) which are being strengthened by the MHA 2025 changes, safeguards which do not apply when the MCA is in play and reliance is therefore placed solely on s.5 MCA 2005, it is perhaps not immediately obvious why – as regards judicial oversight – there should be such a difference between those under Part 4 MHA and those falling under the MCA.

The fourth implication is that the *Cumbria* case reinforces the need for there to be a Practice Direction under the CPR for inherent jurisdiction applications, both such as the (relatively niche) ones in contemplation here, and the rather more extensive number of cases brought to seek relief in cases involving coercive control. The CPR is not well-suited to these sorts of cases, and a Practice Direction would make navigation of its provisions as painless as possible.

Short note: "detainability" and the courts

In *Blackburn With Darwen Borough Council v AD* [2026] EWHC 2148 (Fam), HHJ Burrows undertook a very creditable impersonation of the late Sir James Munby in deploying barely-controlled fury in relation to "a deeply vulnerable child who has, for years, been oscillating between crisis and temporary stabilisation, whilst professionals struggle to identify a regime capable of meeting his extraordinary needs." The judgment is sufficiently short, and sufficiently punchy, as to merit reproduction in near full (we have placed it here; it could equally go in the Children's Capacity section).

> *8. This case raises once again an issue with which judges of the Family Division have become depressingly familiar. It is the phenomenon of the child who is plainly unwell, highly vulnerable, and at immediate risk of grave harm, but who falls between legal and organisational frameworks. Such children often become the subject of repeated court applications because the Court is the only institution left to whom desperate professionals can turn when every other system has reached the limits of its response.*

[6] The subsequent observations made by Theis J about *Epsom* in the *Birmingham* case were expressly made in relation to patients who are not detained under the MHA 1983: see paragraph 67.

9. AD's present circumstances illustrate that problem starkly.

10. The evidence before me records recent ingestion of glass, repeated ligaturing, overdoses, significant self-harm, numerous physical interventions, police involvement, ambulance involvement, hospital admission, and behaviour so dangerous that concerns have been raised regarding potentially fatal consequences. As I understand the position, AD's current placement has now terminated because it considers itself unable safely to continue caring for him. He remains in hospital because there is presently no safe discharge plan. That hospital is a general hospital which has cleared an entire children's ward to enable AD to reside there with security. The hospital needs those beds for other sick children. However, it is to their credit that they are not placing undue pressure on the council to remove AD. That is because they share the concern all of us have for his safety.

11. It became clear during the hearing, in fact, that AD is no longer receiving any treatment for his physical problems that cannot be administered outside a hospital. He is, however, on 24/7 3:1 supervision. There is also evidence that he has received sedative medication from the general hospital clinicians designed simply to address his challenging behaviour.

12. In other words, AD is presently in hospital but receiving no active treatment of his core mental disorder. He is being confined. Nothing else.

13. Those facts are extraordinary.

14. Yet simultaneously the Court is told that AD does not meet the criteria for detention under the Mental Health Act. Not once, but repeatedly.

15. I entirely accept that courts must not substitute themselves for psychiatrists. The Mental Health Act establishes a legal and clinical framework which Parliament has entrusted to appropriately qualified professionals.

16. The question whether statutory criteria are met is not one for me.

17. However, whilst I cannot direct a Mental Health Act assessment to reach a particular conclusion, I can identify the consequences of the evidence before me.

18. The consequence is that a child who repeatedly self-harms, attempts overdose, ingests glass, ligatures, presents a risk of death by misadventure, requires constant supervision and has exhausted one highly specialised placement after another is nevertheless to be regarded as suitable for management in the community.

[…]

23. Reading this material as a whole, one is left with the uncomfortable impression that mental health services have been rather more successful in explaining why they cannot help than in explaining how they will help.

24. That is not, in my judgment, a satisfactory position.

25. Of particular concern is the repeated emphasis placed upon questions of consent, engagement and willingness to participate in services. The Court has before it evidence from one part of the system asserting that AD lacks Gillick competence in relation to these issues, whilst other evidence concludes the opposite.

26. Whatever the correct answer to that question, this child has plainly not been making decisions free from overwhelming vulnerabilities and risks. Repeated reliance upon a lack of engagement as an explanation for limited intervention sits uneasily alongside the extraordinarily serious risks documented by multiple professionals over an extended period.

27. I wish to make something else clear.

28. This Court's powers are limited. I cannot compel psychiatrists to reach clinical conclusions they do feel able to reach.

29. I cannot direct detention under the Mental Health Act.

30. I cannot create resources which do not exist.

31. I cannot require a public authority to conjure into existence a therapeutic placement, treatment programme or specialist service which it says is unavailable.

32. The inherent jurisdiction is not a magical source of solutions. It authorises this Court to scrutinise, to question, to require explanations and, where necessary, to authorise restrictions which interfere with Article 5 rights. Or, indeed to refuse to authorise them. It does not permit the Court to redesign the health and social care system.

33. That limitation creates a profound frustration.

34. That being said, my role in evaluating AD's Article 5 rights does require me to consider the justification for his deprivation of liberty. In this case the justification is that he is "of unsound mind" (Article 5(1)(e)). I have no doubt that is correct. The problem is that his deprivation of liberty does not appear to be for the purpose of treating the underlying or core disorder. At the present time, he is being confined so that decisions can be made about what happens next.

35. Once again, this Court finds itself confronted by a case in which every professional agrees that a child faces extraordinary risks, every professional agrees he requires intensive support, yet there is no coherent agreement regarding who bears ultimate responsibility for ensuring that such support is delivered.

[…]

40. AD is not an isolated problem to be solved.

41. AD is a child.

42. He is a child with serious needs, a frightened family, exhausted professionals and a future which remains alarmingly uncertain.

43. It would be easy to lose sight of the human being beneath the paperwork. The Court must not do so, and it will not do so.

44. Whatever frustrations may properly be directed towards systems and agencies, none should be directed towards AD himself. The evidence reveals a child overwhelmed by needs which he is presently incapable of managing and which adults have repeatedly struggled to understand.

45. The central question remains the same as it has throughout these proceedings: how can this young person be kept safe whilst receiving meaningful therapeutic help?

> *46. Disturbingly, despite many months of intervention and many hundreds of pages of evidence, the Court is still unable confidently to answer that question.*
>
> *47. That, ultimately, is the tragedy of this case.*

As HHJ Burrows very correctly observed in the penultimate paragraph of the judgment.

> *50. This case raises issues extending well beyond the circumstances of one child and concerns the ability of public services collectively to respond to highly vulnerable children who do not fit neatly within existing statutory frameworks.*

AGNI and restricted patients

In July 2026, the Mental Health Casework Section (MHCS) of HMPPS published a short guidance note on how the *AGNI* judgment affects detained mental health inpatients. It is caveated that this is the 'current' position, and that the MHCS *intends to update its published guidance on discharge under s42 of the Mental Health Act 1983 and its guidance on supervised discharge.* The current note draws on the published DHSC interim guidance on the effect of the *AGNI* judgment, and applies that interim guidance to restricted patients.

Until further guidance is issued, where those applying the MHCS guidance in relation to patients who have been discharged are advised who consider a deprivation of liberty authorisation is no longer required are advised to consider:

> *whether the multifactorial assessment, with an assessment of the patient's views and whether they validly consent, suggest a deprivation of liberty is taking place?*
>
> - *If no it is likely that renewing the DoLS is inappropriate; the community team must inform MHCS in advance of the order lapsing.*
>
> - *The team must set out how they have established that there is no restriction / confinement against the patient's will, detailing the multifactorial circumstances of the confinement including what can be ascertained about the patient's views.*
>
> - *MHCS will deal with this via a change of conditions, and an updated conditional discharge warrant will be issued with the revised conditions listed.*
>
> - *If yes, it is likely a DoLS will require renewal*
>
> - *The team should advise MHCS of their proposed approach prior to the DoLS lapsing.*
>
> *When considering if there is an element of a patient being confined against their will, including whether the patient consents, we encourage stakeholders to refer to the DHSC guidance which deals with the difference between compliance and consent and the need for authorities to document their approach to reviewing authorisations.'*

For patients who have a previously agreed supervised discharge, warrants remain valid. The cases should be reviewed by care teams to determine whether they are deprived of their liberty. If they are not deprived of their liberty, the MHCS should be contacted before a referral to the Tribunal, and the community RC should

consider "*if the criteria for a conditional discharge amounting to a DoL continues to be met*." Where the conditions are necessary to protect the public from serious harm, "*it may be appropriate to move the patient to a conditional discharge under s42(2) of the MHA 1983 with an appropriate supervision condition*."

For patients who have not yet been discharged, "[f]*uture discharges where a constant supervision requirement is considered necessary for the safe management of the patient in the community will still be via conditional discharge (either s 42(2) or section 42(2A) MHA83)*." Consideration will be given the patient's views, and whether this amounts to a deprivation of liberty. "*Where the patient does give valid consent to discharge with strict supervisory conditions, conditional discharge under s 42(2) may be appropriate. For all cases of this nature the SoS will want to clearly document the decision and how the patient's consent (or lack of) was understood*."

Short note: challenging MHA detention in the civil courts

Appiah & Anor v Leeds and York Partnership NHS Foundation Trust [2026] EWHC 2135 (KB) related to a claim for damages (against the detaining NHS Trust) arising from the First Claimant's detention under the MHA for a four-month period in 2019, and a claim by the Second Claimant that his Article 8 rights had been unlawfully breached by the First Claimant's unlawful detention. Liability and quantum were both in dispute, and the claim was heard in a three-day trial in the High Court. An attempt had also been made to bring a claim against Leeds City Council, but such a claim requires permission under s.139 MHA, which had been refused at an earlier stage.

The First Claimant, Ms Appiah, had been convicted of several offences in 2017, and was detained first in relation to the criminal matter, and then under immigration detention. While in prison, she had been observed as having psychotic symptoms, and was eventually transferred to a psychiatric hospital in 2018 under ss.48/49 MHA, where she was treated with anti-psychotics. Her ss.48/49 detention came to an end on 26 April 2019, and a new process was undertaken in the days prior to conduct a fresh MHA assessment, as her treating clinicians considered that she would need to remain in hospital. The MHA assessment recommended her continuing detention; however, her nearest relative (her husband, and the second Claimant) objected to this. An application was made to displace the nearest relative, which was granted on an interim basis on 26 April 2019 (this was unsuccessfully appealed in June 2019). Leeds City Council was appointed as her nearest relative and the s.3 MHA detention proceeded.

On 23 August 2019, the First Claimant was discharged by the First-Tier Tribunal, with immediate effect, on the basis that she did not have a mental disorder. As a result of the discharge, there was no final hearing on the application to displace the Second Claimant as nearest relative.

The claim brought was one for false imprisonment (both at common law and in breach of Article 5 ECHR) and breach of the Claimants' Article 8 rights; and the treatment received whilst detained was alleged to have breached Article 3 ECHR. The First Claimant originally sought damages of £1.5 million from the Trust (which were overwhelmingly Special Damages). After what appears to have been a long and tortured five-year procedural history on the way to the trial, the matter was heard before Tom Little KC sitting as a DHCJ in May 2026. The Claimant's case was that she had never been mentally unwell (despite her own expert evidence stating that she had likely been mentally unwell at the time of detention, and what appears to have been very substantial evidence from a

range of clinicians from the period from 2018-2019 stating that she was demonstrating clear psychotic symptoms). In her oral evidence, "[i]*t was clear that on a number of occasions during her evidence rather than answer the question she was asked she implied that there was a Home Office driven conspiracy, involving a number of Doctors and others not employed by the Home Office, to deport her and that her mental health was used as the means to do that*" (paragraph 90).

DHCJ Little KC found that the Trust had established that the First Claimant was lawfully detained on 26 April 2019. He found "*without hesitation that the Defendant has established that the First Claimant did have* [a mental] disorder *and that it required detention*" (paragraph 142), noting the range of evidence from clinicians who considered that she had a mental disorder, and the improvement in the First Claimant's condition on treatment. The Claimants had produced no expert evidence to counter the opinions of the treating doctor and the Defendant's expert. The Claimants themselves had been unpersuasive witnesses, as was the external evidence they sought to rely upon. In what is likely the most notable part of the judgment for our readers, the court did find the Tribunal's finding that the First Claimant did not have a mental disorder in August 2019 either binding or persuasive. The Tribunal were not "*making any finding about detention since April 2019. But even if I am wrong about that and the Tribunal did consider itself to be determining the question of whether the whole of the detention was lawful, and purported to do so, that determination would be ultra vires of section 72 of the MHA and unlawful. In any event if it was not unlawful, that determination does not bind the High Court or determine the issues in a civil action for damages and in which I have received far more evidence than the Tribunal had*" (paragraph 153).

The court additionally found that the entirety of the detention was lawful for the following reasons (relying on the Defendant's expert):

> *On the basis that the position of the First Claimant gradually improved as a result of the medication and that that is consistent with the transfer summary in July 2019, then it is my judgement that the timing of the Tribunal hearing came at the earliest point in time where it was no longer necessary to detain the First Claimant. On that basis it follows that the entirety of her detention was lawful and that the Defendant has persuaded me, on a balance of probabilities, of that. Such a conclusion is supported by the evidence of [the Defendant's expert] who has considered the position globally. It follows that the First Claimant has no common law claim for false imprisonment for any part of the First Claimant's 120 day detention in 2019. For reasons set out below the same applies to Article 5 of the ECHR* […]

The Claimant was also unsuccessful in arguing that her detention was unlawful due to alleged 'procedural flaws' of (1) not first detaining her under s.2 MHA and (2) breaching s.5 MHA. Both were considered "*unarguable as a matter of statutory construction*" (paragraph 167) Ss. 2 and 3 are self-contained provisions, and there is no obligation to use s.2 MHA where the criteria of s.3 MHA are made out (particularly where the patient had already been a long-term inpatient under ss.48/49 MHA). Similarly, there is no obligation to use the maximum period of s.5 MHA detention before detaining a patient under s.3 MHA – there is plainly no minimum period in the statute, and it is a holding power to facilitate assessment.

The Claimant did not come close to demonstrating an Article 3 ECHR breach arising out of administering her depot medication under restraint. The court found her claims of how she

was treated on the ward were 'grossly exaggerated,' and not credible.

The Second Claimant did not have any parasitic Article 8 claim where the First Claimant had not been unlawfully detained.

The judgment stands (in part) as a convenient summary of the operation of the MHA 1983 and a (relatively rare) insight into how it is operated in practice. It also stands as a reminder of the challenges that stand in the way of someone seeking to establish in the civil courts that detention under the MHA 1983 has been substantively unjustified.

CHILDREN'S CAPACITY

AGNI and children

The decision in *Re Mustafa (A Child)* [2026] 2159 (Fam) represents the first reported consideration of *AGNI* in relation to children. The child in question was 15 and subject (at that point) to an order authorising of liberty. The local authority sought to withdraw an application for an extension of the order; an application opposed by the Guardian on the basis that he should still be seen to be deprived of his liberty even after *AGNI*.

Mr Recorder Adrian Jack (sitting as a High Court Judge) considered that it was possible for consent can only be given by a Gillick competent child: "[a] *child who is not Gillick competent may nonetheless have sufficient understanding for their views to be relevant as to whether they consent to aspects of deprivation of their liberty*" (paragraph 39). However,

> *40. This, however, still leaves the issue as to whether Mustafa's apparent consent is, as the Guardian submits, "compliance by Mustafa rather than valid consent" and whether his apparent consent "is likely to be insecure, not of an enduring nature and likely to be revised and retracted." The Guardian is in my judgment right to point out that Mustafa may seek to withdraw any consent he has given, if he does not like particular restraints placed on him. Moreover in principle he can do this at any time, even (or indeed especially) whilst physical restraint is being used on him. This observation, however, overlooks the fact that in some cases schools are entitled to use physical restraint on children regardless of the child's wishes.*

Directing himself by reference to the analysis of the powers of schools to restrain children (both at common law and in statute) analysed in *Re FXS v Mulberry Bush Organisation Ltd* [2026] EWCA Civ 415, Mr Recorder Adrian Jack considered that:

> *14.*[7] *When I stand back at look at all the factors relevant to the assessment as to whether there is a deprivation of liberty, in my judgment there is no deprivation of liberty. Mustafa is, as the Guardian sets out at length, generally happy in his placement. Where the school uses physical restraint, it either has Mustafa's consent or it is entitled to use restraint under its common law powers. Either way, there is no deprivation of liberty such as to give rise to a violation of Article 5(1). An extension of the DOLs order is therefore neither necessary nor proportionate and I refuse to grant one.*

The judgment indicates that the Guardian was contemplating an appeal. If no appeal is forthcoming, we lay down a marker that we consider that it is likely that both of the core points set out above will be examined further in due course. There remains (to use a technical term) significant amount of 'fuzz' around whether *Gillick* has now in some way mutated to be the functional aspect of the MCA test. If it has, then the approach taken by the court in this case would appear to track the logic of *AGNI* impeccably. If it has not, but represents some rather more nebulous conception of the child's developmental abilities, it is perhaps not so obvious that the logic applies.

Whilst it is undoubtedly relevant that there are powers to restrain children at school that do not exist in relation to either those in other situations or to adults, it is perhaps not entirely obvious that

[7] Note, the paragraph numbering in the judgment has gone somewhat awry; this paragraph comes later than those set out above.

the existence of a power to restrain gives the answer to the question before the court, which is whether the child is in a situation where (in legal terms) a power is required to serve as a defence to unlawfulness.

Shortly before the decision was handed down, the Nuffield Family Justice Observatory published a helpful blog by Camilla Parker KC (Hon) and Emma Smale on *Deprivation of Liberty and Children after AGNI*, available here.

The Joint Committee on Human Rights and children in care

The JCHR has published a detailed and wide-ranging report on the human rights of children in care (which includes mention of *AGNI*). It includes detailed examination of and endorsement of the Law Commission's proposals for reform of disabled children's social care, to which we still await the Government's final response.

THE WIDER CONTEXT

The courts and litigation capacity

Two cases concerning this issue, one before the family courts, and one before the civil courts, merit noting.

In *RT v DW* [2026] EWFC 183 (B), HHJ Muzaffer gave a characteristically thoughtful – and rightly 'bothered' – judgment about the problems he faced in a financial remedies hearing in the Family Court with two litigants in person, one of lacked the capacity to conduct the proceedings. The Official Solicitor at one stage had been involved, but then for reasons which clearly frustrated HHJ Muzzafer, but which he could not properly criticise her in relation to, ceased to do so. As he noted:

> *25. The systemic difficulty is that vulnerable individuals such as the husband do not have automatic recourse to legal aid in cases of this kind. The husband has been left to navigate matters alone and without representation, while the wife has had to endure the continuing financial and emotional burden arising from the protracted litigation. The reality is that both parties have, in a very real sense, been impeded in their access to justice and have suffered hardship as a result. This is a matter that ought to give rise to real concern.*
>
> *26. I note that other possibilities were considered by the court, including pro bono assistance or the involvement of the Court of Protection. In terms of the former, advocates and charitable organisations understandably will not agree to act when there is a risk of being liable for costs. In respect of the latter, any application to the Court of Protection for the appointment of a professional deputy, who might then assist as a litigation friend, would be a lengthy and costly process. There is also no clear avenue as to who or how such application would be made in the circumstances of this case. Finally, there are no family or friends willing to take on the role.*

HHJ Muzzafer was therefore left to navigate through as best he could to do justice to the parties, and, for reasons he set out in his judgment, held that he could properly proceed notwithstanding the lack of a litigation friend to represent the husband. He did manage to involve an intermediary, and, at their recommendation, prepared a simplified explanation of the judgment appended to the end.

The issues identified by HHJ Muzzafer, although they arose in the Family Court, are equally problematic in the civil courts. They were the subject of a detailed report and recommendations by the Civil Justice Council in 2024, recommendations which have yet, sadly, to bear fruit.

In *TLA v Chelsea and Westminster Hospital NHS Foundation Trust* [2026] EWHC 1751 (KB), HHJ Carmel Wall, sitting as a Judge of the High Court, had to consider whether the litigant in person claimant had capacity to conduct relatively complex personal injury proceedings arising out of asserted breaches of confidence and other matters. The issue had been put in play by the defendant's expert, who had been instructed to report on causation, condition and prognosis. Whilst HHJ Carmel Wall found that the defendant had been entirely right to raise the issue before the court in light of the expert's suggestion that the claimant lacked the capacity to conduct the proceedings, she found that, in fact, he had it. Of particular interest is the extent to which HHJ Carmel Wall was concerned about the expert's pre-JB approach of analysing the so-called diagnostic limb first, noting that:

> *66.* […] *Dr Bradbury's assessment of capacity is substantially undermined by the error she made in the way in which she approached the questions that had to be considered in making the assessment. She frankly accepted that she believed that the diagnostic criterion had to be addressed as the first stage of analysis and was not aware of more recent authority that mandated consideration of the functional criteria as the first stage. Her error had the result that she viewed the Claimant's functional decision-making through the lens of the diagnosis she had arrived at rather than making an openminded assessment of his ability to weigh or use information to make a decision.*
>
> *67. When asked in her oral evidence to approach the assessment from the correct starting point, she accepted that she found it very difficult to untangle her functional assessment from her diagnosis. She was not able to explain convincingly the areas in which she believed the Claimant was unable to use or weigh information without straying into a value judgment about how he did so. Her opinion on this issue seemed to me to be unduly influenced by her own view of the wisdom and reasonableness of the position he had taken in relation to the Defendant.*

The expert also found herself drawn to protect the claimant:

> *68. It also appeared from her evidence that another factor influencing her view on capacity was her clinical opinion that the litigation was causing damage and distress to the Claimant such that pursuing it was to the detriment of his mental health. She did not see any positive outcome for the Claimant was at all likely. She saw his determined pursuit of the claim in those circumstances as unreasonable and unwise. She recognised that as a clinician, her instinct was "to protect people from themselves".*
>
> *69. Time will tell whether she is correct in her assessment of the merits of the claim and/or its ultimate impact on the Claimant. But in my judgment, she has conflated her view of the wisdom of pursuing the claim with issues of capacity. It is undoubtedly the case that the Claimant has strong views about this litigation, and his priorities are influenced by those views. When making decisions about the conduct of the claim, he has and no doubt will continue to put those strong views at the forefront of his decision-making process. But he is not shown to lack capacity simply because he weighs factors differently from others. Nor is he shown to lack capacity because he makes decisions that may be seen as unwise by others, or which are not considered by others to be in his own best interests.*

Another – not uncommon – feature was the strong feelings held by the claimant:

> *70. I have considered Dr Bradbury's particular concern with the Claimant's antipathetical approach towards the Defendant and towards evidence with which he does not agree. In the context of functional decision-making, she may well be right that he lacks objectivity. Many capacitous litigants lack objectivity when conducting a claim in which they passionately believe. They may lack an objective view of the defence to their claim, the motives of a defendant, the evidence that is against them or the motivation of a witness giving that evidence. A lack of objectivity may be expressed strongly. But it does not equate with incapacity. I am not persuaded by Dr Bradbury's evidence that the Claimant is unable to make the*

> *relevant decisions necessary in this case.*

The decision stands, with respect, as an extremely good 'worked example' of how to analyse and resolve doubt about capacity whilst steering an appropriate path between the Scylla of over reliance on the presumption, and the Charybdis of paternalism.

The challenge of respecting end of life wishes

A new report from the charity Compassion in Dying, Bridging the Gap, examines why it appears to be so difficult for those at the end of life to have their plans respected. As the report notes, there have been many conversations and initiatives around end of life care, which have "*in common is their potential to deliver care at the end of people's lives that is driven by their priorities and underpinned by their own informed decisions. Existing policy has long emphasised the importance of this too – of people being seen as individuals, with the opportunity to have honest and timely conversations about what matters most.*" However, the report asks, "*if this is what people want, and where policy aims to go, why are so many people still experiencing care that is not aligned with their decisions and preferences?*"

> *To understand this, we spoke with health and care professionals across levels and specialisms about their experiences of decision making at the end of people's lives. This report brings together both perspectives – health and care professionals and dying people and those who love them. It shines a light on how sometimes, delivering care aligned with people's preferences is the hardest thing for a clinician to do. This should be a wake-up call to everyone working to improve the experiences of people at the end of their lives.*

Protection of vulnerable adults

In a relatively rare criminal case before the Supreme Court, important clarification has been given as to the scope of the offence of under s.5 of Domestic Violence, Crime and Victims Act 2004 "allowing a child or vulnerable adult to die or suffer serious physical harm." In *R v Sheikh* [2026] UKSC 28, the Supreme Court made clear that the relevant question was not whether the defendant foresaw, or ought to have foreseen, the precise unlawful act that caused serious physical harm to the victim, but whether the act occurred in circumstances of the kind that the defendant foresaw or ought to have foreseen. The provision required a broad and purposive interpretation. Where an act causing serious physical harm to a vulnerable adult was "utterly different" from the antecedent violence inflicted on the victim, that was not necessarily fatal to the requirement of foresight in s.5(1)(d)(iii).

Consent to anaesthesia, and medical treatment frameworks around the British Isles

The Association of Anaesthetists have published an updated version of their guidelines available here [8] The supporting material also includes a table setting out the main differences in the legal framework for decision-making and consent, including in relation to those lacking capacity, in the nations of the UK and Ireland.

Caring for patients who elect to voluntarily stop eating and drinking to hasten death

The BMA Medical Ethics Committee [9] has published guidance about the law and ethics of

[8] Full disclosure, Alex was on the working group along with, amongst others, Nadine Montgomery.

[9] Alex is on the BMA Medical Ethics Committee.

voluntarily stop eating and drinking (VSED), seeking to set out a legal and ethical framework to enable doctors to engage in patient-centred care and provide the best possible support and care to patients electing to VSED, whilst acting in accordance with the law. This guidance does not provide clinical information about VSED or symptom management.

Patients with severe eating disorders and critical care

A framework document has been developed by members of the College of Intensive Care Medicine's Legal and Ethical Policy Unit, [10] *Referring patients with severe eating disorders to critical care to facilitate assisted nutrition under restraint: a framework to support decision making in life-threatening situations,* working with critical care consultants, psychiatrists, legal professionals, and patient and lay representatives. It is endorsed by the Intensive Care Society and the Northern Irish, Scottish and Welsh Intensive Care Societies.

The document sets out a framework to care for people who are under the care of eating disorders/liaison psychiatry teams and who have been referred to critical care, following a multidisciplinary team decision, so that they can receive nutrition to sustain life.

Assisted dying

Lauren Edwards MP has now published the Bill that she intends to bring forward to the Westminster Parliament in September (with second reading due on 11 September) to 'finish the task' of Kim Leadbeater MP. It is essentially identical to that earlier Bill. Alex and colleagues from the KCL-based Complex Life and Death Decisions Group has prepared a briefing above the Bil.

If Parliamentarians in Westminster do want to seek to move forward in a considered fashion, they may well wish to look to Jersey, where the (Government-drafted) legislation received Royal Assent on 7 July 2026.

[10] On which (with apologies for sounding like a stuck record) Alex sits.

SCOTLAND

Legal Director for Mental Welfare Commission

The Mental Welfare Commission for Scotland is to be commended for creating a new post of Executive Director (Legal & Policy). The Commission is of course an authoritative source of law and best practice across the many areas of skill and expertise relevant to its remit and available in-house, and it is notable that Colin McKay (now a professor at Edinburgh Napier University) was the first and – so far – only lawyer to be appointed as Chief Executive of the Commission. The creation of this new post is the right thing at the right time, as is clear from the following statement kindly provided for this Report by Colin's successor, Julie Paterson:

> *"The Mental Welfare Commission for Scotland is delighted to introduce the new role of Executive Director (Legal & Policy), a senior leadership position created to strengthen legal expertise and policy capability across our organisation.*
>
> *"This is a key executive level role which will influence national thinking on mental health and incapacity law, and provide expert leadership on human rights issues. The role is being established as Scotland's mental health and incapacity legislation undergoes significant reform and provides an opportunity to help drive and shape that change, supporting the development and implementation of a modern legal framework that better protects the rights of people with mental illness, learning disability, dementia and other conditions within the broad remit of the Commission."*

Adrian D Ward

New Practice Note – a case for review and re-issue?

When guardianship and related procedures were transferred from the Outer House of the Court of Session to the sheriff courts in 2002, it was foreseen that there would be a risk of divergence in interpretations and practices among different sheriff courts.

> *"The convenience and lesser expense of the sheriff court was never available for appointment of tutors, which may have been a disadvantage for individual petitioners. Nevertheless, during the period of revival 1986 – 2002, which paved the way for the new régime, this area of law benefited from being developed with the coherence and authority which resulted from all petitions being heard by the Court of Session, rather than being scattered across Scotland's sheriffdoms." (Adult Incapacity, Ward, 2003, para 10-13).*

Practice has certainly diverged across different sheriff courts. Where sheriffdoms have adults with incapacity ("AWI") practice notes, they vary. That Scotland's sheriffs principal have collaborated to produce a uniform practice note is thus to be welcomed – a welcome tinged with regret that it has taken a quarter of a century for it to appear. It is nevertheless worrying that one already hears complaints from practitioners that they are still experiencing significant divergences in practice, even after the coming into force on 13 July 2026 of the new All-Scotland Sheriff Court Civil Practice Note No 1 of 2026: "Applications under the Adults with Incapacity (Scotland) Act 2000".

Of much greater concern are the complaints, also to be heard from practitioners, that the new practice note appears to have been prepared and issued without any consultation of which they are aware. It seems unlikely that if the

consultation that has generally preceded developments in AWI law and practice had been carried out, the notable omissions and errors in the new practice note would have been spotted and corrected. As it is, one must hope that the present Practice Note will soon be superseded with a corrected and updated version.

The present Practice Note fails at the first hurdle. All AWI applications customarily commence with averments along the lines of: "*The adult is habitually resident at xx, which is within the territory of this court. This court accordingly has jurisdiction.*" See for example the styles offered in *Adult Incapacity*. The Practice Note omits any requirement to aver and demonstrate which of the grounds of jurisdiction in Schedule 3, paragraphs 1 and 2, apply. (All statutory references are to the Adults with Incapacity (Scotland) Act 2000; and hereafter all references to paragraphs are to the new Practice Note.)

Curiously, the Practice Note seems to require that only the current address of the adult be specified. That will not necessarily be the adult's habitual residence, and of course habitual residence is only one of the grounds of jurisdiction. In the cases of *Aberdeenshire Council v SF* [2024] EWCOP 10 and *Argyll and Bute Council v RF* [2025] EWCOP 12 (T3), so far as one can deduce from the Court of Practice judgments, the original Scottish guardianship orders would appear to have been granted on the basis of habitual residence in the relevant sheriff court district, but the adult having no current address there, being resident in England. It is also good practice to specify the ordinary residence of the adult, and thus "the local authority" in terms of the relevant provisions of the 2000 Act. Again taking a cross-border example, in *Milton Keynes Council v Scottish Ministers* [2015] CSOH 156 the Scottish court proceeded on the basis that it had jurisdiction, but the adult's ordinary residence would appear to have remained in England when she was removed to Scotland, and thus Milton Keynes Council was held still to be responsible for her care costs.

A further apparent omission, in relation to guardianship applications, is the requirement to aver and demonstrate that all proposed guardians consent to being appointed (section 59(1)(a)). That may be presumed only in relation to an applicant who is proposed as guardian.

Some of the omissions may not have seemed to be such a quarter of a century ago, prior to the whole development since then of the human rights dimension that must underlie all AWI practice. However, while paragraph 3(t) refers to deprivation of liberty, it does need to require clear specification of whether proposed powers would, if granted, lead to interference with rights assured by Articles 5 or 8 of the European Convention on Human Rights. The measures proposed should specify how such powers will be operated lawfully, having regard to the exceptions in each of those Articles, and related provisions and jurisprudence, including in particular under Article 6 of the Convention. These should include the proposed mechanisms to give the adult a real right to seek review.

Provisions are required to ensure real participation of the adult in the proceedings. Is it anticipated that the adult will be unable to attend the proceedings, despite provision of reasonable accommodations? If not present, will the adult be independently represented? The appointment of a safeguarder may not achieve that, as the safeguarder's responsibilities are to the court, rather than primarily to the adult.

The only reference to the UN Convention on the Rights of Persons with Disabilities in paragraph 3(i) seems to imply that the Disability Convention is accepted by the sheriffs principal as fully applicable: but if so, then other requirements of

that Convention should be incorporated, and read along with the provisions of the European Convention to ensure a coherent human rights-compliant regime. In paragraph 5(i), which refers to duration of orders, such a coherent approach would require limitation of any order relating to Article 5 rights to the general norm of six months.

It is apparent that the present text has not been check-read. Paragraph 4(b) seems to have conflated two quite separate intended requirements. As it appears, it suggests that a crave for appointment of a substitute guardian should: "specify whether the application is made due to the death, incapacity or resignation of the original guardian". That, as it appears in the Practice Note, obviously makes no sense. A substitute guardian is appointed "to act as guardian in the event of the [original] guardian … becoming unable to act" (section 63(1)). One cannot predict at that point in time what might render the individual guardian unable to act.

Some editing points are minor, but nevertheless ought to have been corrected in a document of this status. Thus, "even" in the second line of item 22(iii) of the checklist in Appendix 2 to the Practice Note should be "ever", and the reference in paragraph 4(s) to section 60(4)(A) should be to section 60(4A).

Further editing points are more significant. The structure of the Practice Note is to deal with "all proceedings" in paragraph 3, and with "all proceedings under Part 6 of the 2000 Act" in paragraph 4. However, some of the provisions in paragraph 3 would appear properly to belong in paragraph 4, examples being paragraphs 3(i), (k) and (r).

Strangely, one has to look in four different places to ascertain whether, for example, a continuing attorney must receive intimation of an application seeking welfare powers only. There should at least be consistency among provisions (4) and (5) of paragraph 3(b), paragraph 4(g), and question 7 of the checklist.

Section 1(4)(a) requires ascertainment of the present and past wishes and feelings of the adult. Paragraph 3(c) adds the qualification "about any order sought". This seems to make the fundamental error of viewing matters from the position of the lawyers involved, rather than that of the adult, who should be central to the proceedings, not peripheral. Adults who might struggle to understand any full explanation of an order sought, and its implications, may well have significant wishes and feelings which must be taken into account.

Paragraph 4(c) and question 25 perpetuate the over-simplification that appointments can be characterised as either "joint" or "joint and several". Is the intention to disapply the scheme of section 62(6) – (9)? If not, stating "severally" or "jointly and severally" would seem to add nothing but confusion. If so, then the nature of the disapplication and the basis on which it is competent, and why it would better accord with the section 1 principles, should be specified.

In paragraph 4(i) and elsewhere, the situation of adults having assets or other interests furth of Scotland appears to be disregarded. Good practice where there is a fixed asset overseas is to ask the court to use its power under section 58(3) to grant an intervention order in respect of that property only, so that only the intervention order, and not the whole guardianship order, need be transmitted to the other jurisdiction, and – often – translated. Also, where an applicant believes that an intervention order should be granted, but believes that the court may take the view that there should be a guardianship order, best practice is to seek a guardianship order with a motion asking the court nevertheless to grant an intervention order, because of the "one-way" nature of section 58(3). In either of these situations, I personally (while in practice) never

had a case where it was not most helpful, verging on essential, to provide the court with a draft of the resulting order(s) sought. One wonders whether there was a reason for not formalising that practice in the new Practice Note.

Adrian D Ward

Cross-border cases involving England & Wales

Editorial note: practitioners who are involved in situations where a Scottish Guardianship Order may be in play in England & Wales are strongly advised to read the Practice and Procedure section of this Report and the discussion thereof of the recent flurry of cases involving such orders.

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Alex regularly appears in health and welfare and property and affairs cases in the Court of Protection. He has appeared in leading cases to do with deputyship and published a textbook about LPAs. His recent doctoral thesis explores the impact of changes to mental capacity law in England and Wales. To view a full CV, click here.

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

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

Conferences

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

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

Advertising conferences and training events

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

Our next edition will be out in October. 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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