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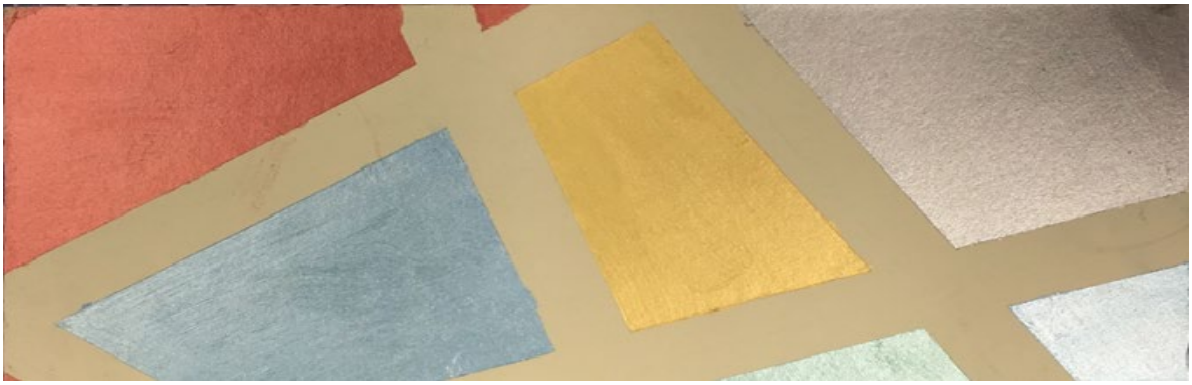

Welcome to the September 2026 Mental Capacity Report. Highlights this month include:

(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.

Contents

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.[1]

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*

[1] 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.

only institution left to whom desperate professionals can turn when every other system has reached the limits of its response.

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.

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

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

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

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

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Nicola appears regularly in the Court of Protection in health and welfare matters. She is frequently instructed by the Official Solicitor as well as by local authorities, ICBs and care homes. She is a contributor to the 5th edition of the *Assessment of Mental Capacity: A Practical Guide for Doctors and Lawyers* (BMA/Law Society 2022). To view full CV click here.

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

Annabel Lee: annabel.lee@39essex.com

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

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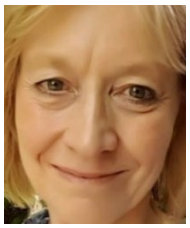
Alex regularly appears in health and welfare and property and affairs cases in the Court of Protection. He has appeared in leading cases to do with deputyship and published a textbook about LPAs. His recent doctoral thesis explores the impact of changes to mental capacity law in England and Wales. To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

Adrian Ward: adrian@adward.co.uk

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



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Conferences

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

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

Advertising conferences and training events

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

Our next edition will be out in 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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