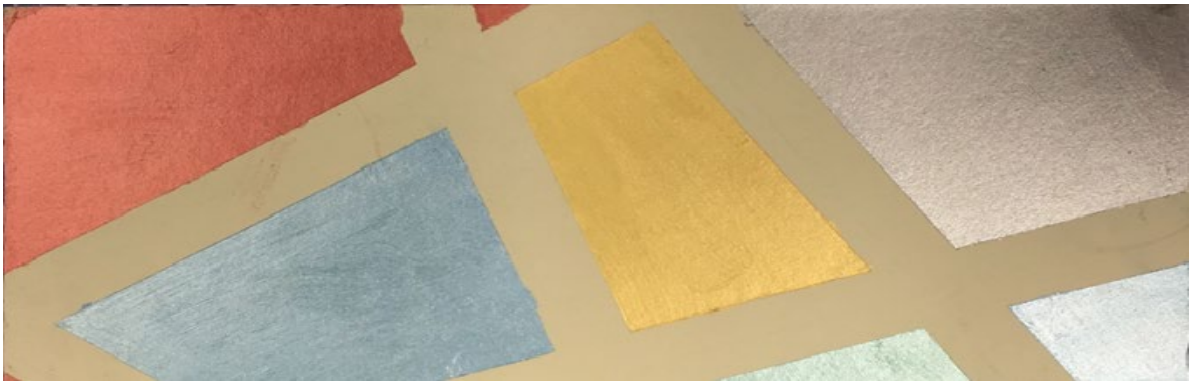
HEALTH, WELFARE AND DEPRIVATION OF LIBERTY
November 2026 | Issue 165



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

(1) In the Health, Welfare and Deprivation of Liberty Report: key themes from post-AGNI caselaw to date, and two medical treatment decisions showing doctors getting it right;

(2) In the Property and Affairs Report: self-dealing in the rearview mirror, dismay at deputy delegation and blithe ignorance of the obligations on a deputy as regards settlement of monies;

(3) In the Practice and Procedure Report: personal welfare orders after HB;

(4) In the Mental Health Matters Report: the Mental health conditions, ADHD and autism prevalence review; and Royal College of Psychiatrists on coercion and human rights;

(5) In the Children's Capacity Report: information-sharing as regards children, and new procedural rules relating to children in ECtHR cases;

(6) In the Wider Context Report: deprivation of liberty before Strasbourg, guidance on eating and drinking at acknowledged risk, and an important change of position relating to Jehovah's Witnesses;

(7) In the Scotland Report: the death of a Bill that never was, and a new appointment for the Mental Welfare Commission.

With huge thanks to Neil Allen, we have set up a running table of post-AGNI cases allowing rapid identification of the types of scenarios being considered, and the results. The case-tracker can be found here, a page where we also host an 'AGNI annex' summarising and commenting on the cases decided in October.

All our other content that you might need – our Reports, our case-law summaries, and our guidance notes – can 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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Senior Judge Hilder

Senior Judge Hilder's term as Senior Judge of the Court of Protection ended on 30 October 2026, having served for nearly 10 years – almost half the life of the new court. All those who use the court owe her an exceptional debt of gratitude for her work in keeping the Cinderella court going on a shoestring and in the most adverse of circumstances – none more so than during COVID-19.

In her judgments, and in her work behind the scenes, Senior Judge Hilder has been vigorous in seeking to ensure that shortcuts are not taken in the interests of others at the expense of P. Her judgments – especially her recent judgments – have shed a sometimes uncomfortable light on how systems have evolved in the interstices of the law and at a tangent to the Court of Protection.

Alongside this, one task Senior Judge Hilder has expended considerable time and energy on is the creation of a Mental Capacity Justice Council, to serve as the equivalent of the Family and Civil Justice Councils; it is characteristic of her to wish to take such steps to establish a body which might well make the life of the court more difficult if it discharges its function of being a critical friend. We will keep working on this whilst Senior Judge Hilder is enjoying a very well-deserved Visiting Fellowship at All Souls College, Oxford, for two terms from January 2027, and we hope that (in whatever guise) it will be a project she can be involved in thereafter.

In the meantime, thank you, Senior Judge Hilder.

DEPRIVATION OF LIBERTY

The floodgates have now firmly opened as regards post-*AGNI* caselaw. Importantly, we are aware of two cases (*AR* and *SM*) which have been leapfrogged to the Court of Appeal. As the former is a judgment of HHJ Simon Burrows, who has delivered the majority of the judgments so far, it will be particularly interesting to see whether the Court of Appeal endorses the general approach that he has been taking.

We are aware that not everyone has time or inclination to read all of the cases being delivered at first instance, especially given that, with one exception, and as a number of judges have made clear, they represent worked examples as opposed to binding decisions in relation to principle. The exception is the decision in *Re B (A Child: Complex Needs: Deprivation of Liberty)* [2026] EWHC 2789 (Fam), which both determines a point of law (namely that the pre-*AGNI* case of *Re J* remains good law, such that

local authorities cannot consent to the confinement of children in their care) and sets out a clear approach that must be followed in relation to approaching the court for authority where a child may be deprived of their liberty.

With huge thanks to Neil Allen, we have therefore set up a running table of cases allowing rapid identification of the types of scenarios being considered, and the results. The case-tracker can be found here, a page where we also host an '*AGNI* annex' summarising and commenting on the cases decided in October.

Drawing together the key messages from the cases in the annex, they might be these:

- That assessments carried out in a pre-*Cheshire West* world are not irrelevant: if a person is not confined applying the old 'acid test,' it is inherently very unlikely that they will be confined under the multi-factorial test. However, satisfying the 'acid test' may be necessary, but is no longer likely to be sufficient;
- The need for a particular focus on the individual's lived experience of restrictions and, in particular, whether they experience those restrictions as coercive;
- That judgments around normality and participation in 'ordinary life' as part of the multi-factorial test need to take into account what is normal for that person;
- That it will be an unusual situation in which a person is confined but is seen to be able to (and does) give valid consent to that confinement. Either they will not be confined at all, or they will be confined but are not consenting;
- That there is a need to consider alternative safeguards under Article 8 where Article 5 is not engaged – but that care needs to be taken to identify a proper basis upon which it can be said that the appointment of "rights protection" advocates under the Care Act 2014 (or Social Services and Well-Being (Wales) Act 2014) is something that a local authority can actually lawfully do (if it is falling to the local authority to secure the individual's Article 8 rights.

We also draw attention to the decision of the ECtHR in *Kaganovskyy v Ukraine (No. 2)*, discussed in the Wider Context section of this report.

In other developments, the Joint Committee has written again to the Secretary of State for Health and Social Care to identify that they remain concerned about what concrete steps the Government is taking after *AGNI* to secure rights protection.

HEALTH AND WELFARE

Giving the court the benefit of clinical judgement in the most difficult of circumstances

St George's University Hospitals NHS Foundation Trust v UJ & Ors [2026] EWCOP 39 (T3) (Theis J)

Best interests – medical treatment

Summary

This very sad case, decided in the summer, has only recently come to our attention. A 45 year old man attempted to take his own life by shooting himself in the head with a crossbow arrow. As a result, he was taken to A&E at the Trust, and underwent emergency surgery to remove the arrow and the insertion of an external ventricular drain. His body was then unable to drain the fluid his brain was producing. This had been managed by a combination of procedures including lumbar punctures, a lumbar drain, and an external ventricular drain, but this was no longer

sustainable, and he therefore required surgery to insert a shunt as a permanent solution to draining the fluid; not carrying out the surgery would (as Theis J put it) "negatively impact his long term recovery," and was likely to lead to his death. The Trust made an urgent application to authorise the surgery. Theis J recorded the family's position thus:

> *18. The evidence from the family has been given in statements and oral evidence. There are detailed and moving written statement from his aunts and cousin. They speak as one voice, about how much UJ valued his independence, especially walks with his dog and his adventurous spirit. They explain that to be trapped in a body which cannot move or function independently is a fate that he would consider a living torment. The shunt cannot remove the original damage caused. That act of self-harm was a tragic expression of the deep pain he was experiencing. To undergo further surgical procedures is something he would not want, as interventions to maintain a minimal, highly compromised existence is described in the statements as a "violation of his dignity and who he was as a person". His maternal cousin describes how close they area, that he loves art in all its forms. His biggest passion is solo travel, and she describes him in her statement as adventurous. She brings to life his wanderlust, his phrase of choice.*
>
> *19. The family have nothing but praise for the medical team, however, they consider that the medical best interests for this course of action and UJ's best interests are being conflated.*
>
> *20. His cousin, EM, said that to take away his autonomy and add to his disabilities would be truly devastating to him. She considers UJ would not align with this treatment and would fight against it. In her statement she says: "To take away his autonomy, his independence and any to add of the disabilities that have been touched upon would be truly devastating to him. I say with conviction, UJ would not align with this treatment and would fight against it. I'm sure that in most cases, for most patients, this this treatment could be the best course of action. However, UJ's outlook on his own life along with his views on the world, do not necessarily align with the masses. I would like it to be considered how UJ will live out the remainder of his years beyond the proposed treatment and rehabilitation. Whilst the prognosis spectrum is exceptionally broad, I can say with confidence, that's even with the best case scenario that the medical team can predict UJ would be deeply unhappy. Subjected to lifelong disabilities, stripping him of his dignity, reliant on others for his day to day care. We cannot yet predict whether he will see, walk, talk or even have the capacity for basic human functions of feeding and toileting independently. But beyond this, my main concern is the mental load that will take its toll on UJ when, if ever, his condition allows him to become conscious enough to be aware of his state, and the immense pain and suffering that will cause him for the rest of his days. Let it be known, I understand that without the procedure, UJ will not pass away imminently, I am clear that without the procedure, UJ will live, for an unknown amount of time. A burden that we, his immediate family, will happily take on as his carer; but he will live without the awareness of his condition. At peace that before the incident, he fulfilled his goal in life. He lived it fully, independently, without apology. He*

lived a life less ordinary, a life that most can only dream of."

21. In her powerful oral evidence, UJ's mother recognised that her position has changed. As she set out, she initially supported the treatment proposed, but as she thought about it more, she knew in her heart that this would not be what UJ wanted. Her initial view was as a mother, not expressing UJ's wishes. She was clear in her oral evidence that UJ wouldn't want to live with a disability. Being dependent on others was not the way he lived his life, and she was sure he would want to die.

The final position of the parties at the conclusion of the evidence was set out at paragraph 5:

The position of the parties at the conclusion of the evidence was that the Trust still maintained its application, but they maintained it in a neutral way. They wanted to bring this matter before the court, and it was still their clinical judgement that this procedure should be undertaken. The family have listened to the evidence with great care, and maintained their position that they do not support the application. Simply put, they do not think it accords with UJ's best interests, including his wishes and feelings and beliefs and values if he was able to be here today. The Official Solicitor reserved her position until the evidence had been heard. Ms Hearnden has specifically taken instructions from the Official Solicitor herself, and on a fine balance, she supports the position of the family in opposing the application being granted.

Theis J's conclusion was as follows:

32. Standing back as I have to do, this is a finely balanced decision. I have to factor in a number of matters. The importance of the sanctity of life is a powerful and compelling force. Dr A's evidence is that this procedure is the best opportunity for rehabilitation, whatever it may be, though that is largely unknown within the range indicated. Dr A's evidence highlighted the disability paradox, in that sometimes those who one would not expect to be able to gain enjoyment out of life in such circumstances in fact do. The court needs to be very cautious about any unquestioning acceptance in relation to what may be said to be UJ's views. All of those views need to be weighed in the balance. There is no dispute in reality about the evidence from the family about wishes and feelings and beliefs and values. Their written evidence is thoughtful, considered and reasoned. They have known UJ over many years, in many different and difficult circumstances. They should be given considerable weight. They speak with one voice that he wouldn't want the procedure. I have to recognise that this is not from UJ himself, and what he would think now, following three months in hospital is still unknown. They are reporting a position prior to the incident in April, and one has to be cautious as to what Ms Hearnden describes as the 'detective position' in trying to second guess what his view was on 24 April 2026, and whether he really did intend to end his life. It is right to record that the attempt was of a different nature to his previous attempts, with UJ having taken the additional steps to write 'DNR' on his chest and arms to make it clear on what he thought.

33. Each case is fact-specific, by definition, and the court has to weigh very carefully in the balance the importance of the sanctity of life and wishes and feelings, with no direct evidence from UJ. The court also needs to look at the quality of the evidence it does have about what his wishes would be.

> *34. I have reached the very sad conclusion that the application for the Trust should be refused. I recognise the sanctity of life and consider that even though it does give him some prospect of recovery, it is a recovery with a wide spectrum, which I have to view in the context of the evidence from the family, which I accept, about what his wishes and feelings and beliefs and values are likely to be.*
>
> *35. My conclusion is that this is not a procedure he would support or want to take place. For those reasons, with very great sadness, I refuse the application.*

Conclusion

It is hardly surprising that, as Theis J made a point of recording, Counsel for the Official Solicitor sought specific instructions from the Official Solicitor herself before advancing the proposition that it was not in UJ's best interests to undergo the surgery proposed by the Trust, given the sensitivities around a situation which could by some – but wrongly – be characterised as "suicide by doctor."

It is also hardly surprising that Theis J also expressed the need for caution before simply accepting unquestioningly what might be said about UJ's views.

However, it is difficult when reading the (admittedly short) judgment not to feel that the approach in this case entirely captured the point of the best interests exercise. And one reason that this might have been is that this is a case in which the doctors did exactly what we would hope: i.e. to deploy their clinical judgement to set out what the right course of action clinically would be, enabling (in this instance) Theis J to stand in the shoes of UJ to make an informed decision as to whether or not to accept that advice, taking account not just the clinical input but also the wider picture. It therefore stands in interesting contrast to the decision in the *MSP* case where (as Alex has discussed here) a strong case could be made that the doctors abdicated their responsibility to set out the full clinical picture, disabling the court from making a truly informed decision as to whether life-sustaining treatment should continue. The decision in the *Epsom* case has not helped the cause of trying to ensure that doctors do not simply short-circuit the exercise of their clinical judgment in pursuit solely of trying to identify the patient's presumed wishes. We would find that unacceptable (and indeed potentially negligent) in respect of a capacitous patient; it is not obvious why the incapacitous patient should not equally be required to benefit from the exercise of that clinical judgement.

Short note: responding appropriately to the physical health needs of those with mental health conditions – a case study

Barts Health NHS Trust v CG [2026] EWCOP 55 (T3) is a relatively 'routine' serious medical treatment case, which Theis J identified was rightly brought because of the level of proposed restraint required both pre-operatively and post-operatively to secure the safe carrying out of keyhole surgery (an endoscopic transsphenoidal resection) on a 59 year old man, CG, suffering from a large pituitary macroadenoma. CG, who had a diagnosis of paranoid schizophrenia, consistently refused the procedure "aris[ing] from his fixed belief that he does not have a tumour and that his difficulties can be cured by obtaining a new pair of glasses." That fixed belief meant that he lacked the capacity to make the decision whether or not to undergo surgery.

One passage in the judgment stood out for us. At paragraph 28, Theis J held that:

> *Having considered the evidence I am clear that CG's best interests are served by making the necessary declarations to permit the procedure to take place. This procedure is the standard treatment option,* ***and CG should be placed in no worse position due to his lack of capacity than anybody else requiring this procedure****.* (emphasis added).

The plan advanced by the Trust would – potentially – mean that CG's experience in undergoing that 'standard treatment option' might be very different to anyone else. However, in the face of so many cases in which 'freezing' has taken place in the context of those with mental health conditions, leading to them suffering serious harm, if not death, in consequence of their comorbidities because of failures to take forward the standard assessment / treatment protocols for such comorbidities, it is refreshing to see the discrimination inherent in such situations identified and, in this case (we hope) avoided.

For help in avoiding these situations more broadly, we strongly recommend this guidance from SCIE: Get me to hospital.

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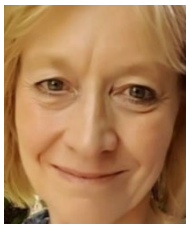
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Conferences

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

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

Advertising conferences and training events

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

Our next edition will be out in December. 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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