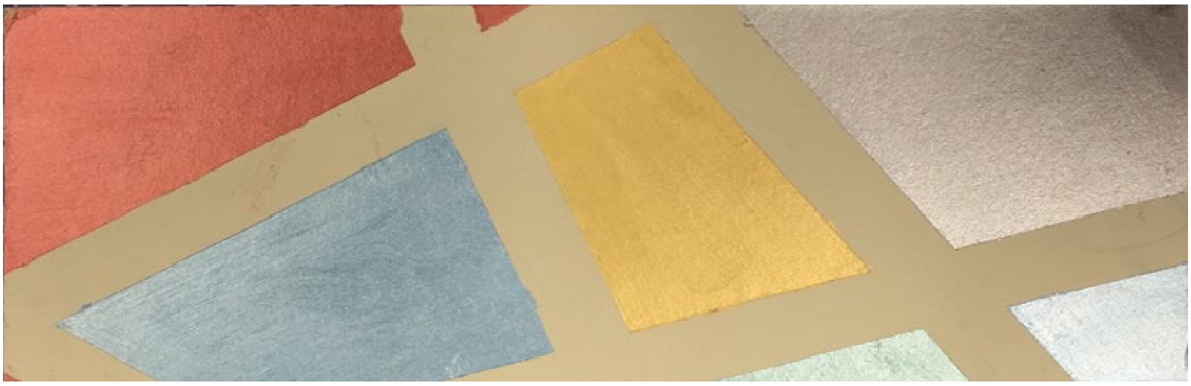
HEALTH, WELFARE AND DEPRIVATION OF LIBERTY
March 2025 | Issue 148



Welcome to the March 2025 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: insight into the proper place of insight, best interests decision-making and good clinical governance, and anorexia and the changing calculus of decision-making;

(2) In the Property and Affairs Report: the Court of Protection's (international) jurisdiction over children;

(3) In the Practice and Procedure Report: fees changes relating to the Court of Protection and the OPG guidance on disclosing visitors' reports;

(4) In the Mental Health Matters Report: the Mental Health Bill progresses and the independent investigation into the care and treatment of Valdo Calocane;

(5) In the Children's Capacity Report: why the report is named as it is, the Court of Appeal confirms that local authorities cannot consent to the confinement of children in care, and guidance for judges writing to children;

(6) In the Wider Context Report: the updated Code of Practice on diagnosing death and restraint in Northern Ireland.

(7) In the Scotland Report: no hard news, but the way ahead for AWI reform becomes clearer, and unhelpful uncertainty about powers of attorney.

The progress of the Terminally Ill Adults (End of Life) Bill can be followed on Alex's resources page here.

You can find our past issues, our case summaries, and more on our dedicated sub-site here, where you can also sign up to the Mental Capacity Report.

Editors
Alex Ruck Keene KC (Hon)
Victoria Butler-Cole KC
Neil Allen
Nicola Kohn
Katie Scott
Arianna Kelly
Nyasha Weinberg

Scottish Contributors
Adrian Ward
Jill Stavert

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

Capacity, insight and professional cultures

CT v London Borough of Lambeth & Anor [2025] EWCOP 6 (T3) (Theis J)

Mental capacity – assessing capacity

Summary[1]

This case is in many ways the companion piece to *Re Thirumalesh (Dec'd)* [2024] EWCA Civ 896). In that earlier case, the Court of Appeal made clear that the fact that a person appeared not to believe information that they were being told could not be used as a shortcut to reach the conclusion that they lacked capacity to make the relevant decision. In *CT*, Theis J has made clear that the same applies in relation to insight. At first instance, HHJ Beckley had concluded that CT

> *25.* […] *cannot use or weigh 'the fact that he has mental impairments and that these lead to specific care needs and impact on his wider decision-making ability' [33], 'his own impulsivity, lack of planning ability and lack of foresight when he is making decisions about his care needs' [34], 'the knowledge of his mental impairments' [35], 'the impact of [CT's] mental impairment [39], that CT is unaware that the impact of his mental impairment 'leads to a lack of foresight when weighing the consequences of refusing treatment' [40] and 'on his impulsivity means he is unable to weigh that impulsivity when making decisions' [40], the inability to weigh the likely outcome of the refusal of care [43] and the impact that 'his mental impairment has on his acceptance of care provision explains the history of admission to and self-discharge from previous placements' [45].*

On appeal, Theis J accepted the submissions of the Official Solicitor in relation to the first ground of her appeal on behalf of CT:

> *53.* […] *that the Judge fell into error when he set the bar too high in considering the relevant information for CT on the facts of this case, in particular that CT's mental impairments are relevant information that he needs to understand and use and weigh.*
>
> *54. The course taken by the Judge conflates the two stage test set out in JB and creates a circular approach that risks leading to the inevitable conclusion that those who have a mental impairment lack capacity. Such an approach undermines the principles and safeguards in the MCA 2005.*
>
> *55. What is required is a careful delineation of the relevant information, relevant to the particular case in question, and then an assessment, in accordance with the statutory*

---

[1] Neil having been involved in the case, he has not contributed to this.

> *framework, whether the individual can understand, retain, use/weigh that relevant information and communicate the decision. It is only when that process concludes that the individual is unable to make a decision within that statutory framework that the court then has to consider whether the inability is 'because of, an impairment of, or a disturbance in the functioning of, the mind or brain'. In the Judge's judgment that important delineation was not present or clear.*

The Official Solicitor also appealed on the basis that:

> 39. [...] *the intention of the MCA 2005, as explained in the JB case, is to focus on the functional assessment in the first instance, without considering the individual's mental impairment. This is an important safeguard for those with mental impairments. The Judge's approach in this case of including in the list of relevant information insight into mental impairment had the effect that he did not conduct the functional test in accordance with the MCA 2005, separately as set out by Lord Stephens in JB. Ms Bicarregui submits the Judge's approach in the judgment had the effect of conflating and blurring the two stage test. There was no effective analysis of the relevant information, the Judge's assessment of whether CT could use or weigh the information or engage with the differences in outcome between the assessments undertaken by the social workers and the clinicians. It is submitted the judge erred in carrying out the functional test with reference to CT's mental impairment and in not resolving the key evidential dispute regarding the functional test with those who had assessed CT's capacity.*
>
> *40. The focus of the third ground of appeal is that assessments of capacity are time and decision specific. The assessments of the clinicians that CT lacked capacity dated from CT's time in hospital, around the time the proceedings were started. The more recent assessments considered CT had capacity. It is submitted whilst this difference is referred to by the Judge at paragraphs [20] and [22], he does not explain why the more recent assessments should not be preferred.*

Although not necessary for the purposes of the outcome of the appeal, Theis J also accepted that both of these grounds were made out:

> *57. The two stage test in JB is clear. The approach in this case of including insight into his mental impairment had the effect that the Judge did not conduct the functional test in accordance with the requirements of the MCA 2005. By taking that into account the Judge conflated and risked blurring the two distinct tests. This was caused by not taking the structured approach of going through the list of information identified as being relevant, resolving the relevant issues in the written and oral evidence and setting out the Judge's assessment of whether CT can use/weigh the information. In effect, the Judge's conclusion on the first stage was determined by CT's mental impairment and not by resolving the key evidential dispute in respect of the functional test.*
>
> *58. In relation to ground three there was evidence from the social work assessments, in particular the more recent ones, that CT had capacity to take decisions about his residence and care. Whilst the Judge refers to these assessments he did not properly take into account the evidence that pointed towards CT having a better understanding that his physical state had changed progressively and had insight into his increasing frailty. Whilst*

> *it is accepted that this experienced Judge had the benefit of hearing the oral evidence it was nevertheless important that he explained why the later assessments fell into error and were not capable of being relied upon.*
>
> *59. It is a striking feature of this case that the evidential divide on capacity was largely between the clinicians and the social workers. The form used by the local authority in their capacity assessment promoted a structured approach to the assessment in accordance with the statutory framework. It identifies the decision, sets out the relevant information the person must understand, retain, use or weigh in regard to the decision, includes what has been done to enhance the capacity of the person to maximise their ability to make the decision for themselves, and then cross checks the person's ability to communicate. It then requests a summary of the options that have been discussed with the person. The form then structures each stage of the requirements in s3 MCA 2005 (understand, retain, use, weigh, communicate). In terms of structure the capacity assessment of Ms G, the allocated social worker, in May 2024 was an excellent example of providing both relevant detail at each stage, with clear reasoning to underpin conclusions. This high standard was replicated in the management scrutiny of that assessment by Ms M, the interim Team Manager. In comparison some of the assessments by the clinicians were in a less structured format. I recognise this may have been due to the particular circumstances at the time, but future assessments will benefit from more closely following the statutory framework in the way Dr M detailed in her witness statement in May 2024. As capacity assessments are time and decision specific, the relevant dates when the individual was assessed should always be clearly set out and borne in mind.*

Counsel for CT and for Mind (who had intervened in writing) had provided checklists to assist those assessing capacity. "Whilst not wanting to add to the growing industry of checklists," Theis J "recognise[d] they may be useful and have adapted them as follows:

> *(1) The first three statutory principles in s 1 MCA 2005 must be applied in a non-discriminatory manner to ensure those with mental impairments are not deprived of their equal right to make decisions where they can be supported to do so.*
>
> *(2) In respect of the third principle regarding unwise decisions, particular care must be taken to avoid the protection imperative and the risk of pathologising disagreements.*
>
> *(3) As set out in A Local Authority v JB [2021] UKSC 52, whether the person is able to make the decisions must first be addressed. Only if it is proven that one or more of the statutory criteria are not satisfied should the assessor them proceed to consider whether such inability is because of a mental impairment.*
>
> *(4) Those assessing capacity must vigilantly ensure that the assessment is evidence-based, person-centred, criteria-focussed and non-judgmental, and not made to depend, implicitly or explicitly, upon the identification of a so-called unwise outcome.*
>
> *(5) Insight is a clinical concept, whereas decision making capacity is a legal concept. Capacity assessors must be aware of the conceptual distinction and that, depending on the evidence, a person may be able to make a particular decision even if they are described as*

> *lacking insight into their general condition.*
>
> *(6) In some cases, a lack of insight may be relevant to, but not determinative of, whether the person has a mental impairment for the purposes of s2 MCA 2005.*
>
> *(7) When assessing and determining the legal test for mental capacity, all that is required is the application of the statutory words in ss2-3 MCA 2005 without any gloss; having 'insight' into mental impairment is not part of that test.*
>
> *(8) Relevant information will be different in each case but will include the nature of the decisions, the reason why the decision is needed, and the likely effects of deciding one way or another, or making no decision at all.*
>
> *(9) The relevant information is to be shared with the individual and the individual should be supported to understand the relevant information. The individual is not required to identify relevant information him/herself.*
>
> *(10) If a lack of insight is considered to be relevant to the assessment of capacity, the assessor must clearly record what they mean by a lack of insight in this context and how they believe it affects, or does not affect, the person's ability to make the decision as defined by the statutory criteria, for example to use/weigh relevant information.*

Comment

For those wanting to think more about the apparent lack of insight of a person into their own situation, and how to translate such a situation into the language of the MCA, this may help.

Four other observations about this case:

1. Theis J was clearly taken by the structured approach to capacity prompted by the relevant forms used by the local authority. Such a structure is undoubtedly very helpful, but it is vital that it follows the correct ordering of the capacity test – as is sadly still not often the case (a situation not helped by the fact that the Code of Practice directs people incorrectly).

2. The flashpoint in this case was around discharge from hospital (in particular in a situation where one potential option had been discharge to be street homeless). Capacity in the context of homelessness is a notoriously difficult area, not least because it is so often loaded with assumptions about individuals, and also capacity being used as a gatekeeper by organisations with stretched resources: see further here.

3. Capacity in the context of discharge from hospital is frequently a flashpoint because of (1) confusion about what decision is actually in issue (as to which, see here); and (2) because of professional cultural differences between the professions involved, of which distinct traces appear in this case. Frequently in our experience, these can be papered over by people talking about "fluctuating capacity," when the reality is that there is a disagreement about the person's capacity which requires identification and resolution.

4. We would not consider that this judgment should be taken as a general finding that a person's insight into any mental disorders is *irrelevant* to whether a person has decision-making capacity. While

> insight and capacity are distinct concepts, a person's ability or inability to recognise the impact of a mental impairment or illness may be relevant to their ability to keep themselves safe in a living situation, or problem-solve during times of difficulty. For example, if a person with a brain injury and executive functioning impairments is asserting that their condition does not pose challenges and will be able to look after themselves if they are street homeless, but is unable to use and weigh that they have historically not been able to cope, the person's understanding of the condition and how it impacts them may be not only relevant but central to the issue of whether the person has capacity to decide where to live. The question of what information is and is not relevant will depend on the nature of the decision to be taken, and as per *B v A Local Authority* [2019] EWCA Civ 913, a person's insight is not necessarily in a separate 'silo' to the relevant information to make a particular decision.

Consultation, (rotten) compromises and challenging complacency – Hayden J on the warpath

NHS South East London Integrated Care Board v JP & Ors [2025] EWCOP 4 T3 and [2025] EWCOP 8 (T3) (Hayden J)

Best interests – medical treatment – practice and procedure

Summary[2]

This pair of cases concern governance failures in best interests decision-making in relation to a man, JP, in a Prolonged Disorder of Consciousness. They concern the Royal Hospital for Neuro-disability, and follow other recent decisions of Theis J. For present purposes, it is the second judgment which is of most wider relevance. In it, Hayden J made a number of observations about the operation of s.4(7) MCA 2005, and of the role of ICBs in such cases.

Section 4(7) MCA

One of the issues concerning Hayden J was as to the approach that had been taken to involving JP's family and taking into account their views.

> *18. It is important to say something of the relevance and weight to be afforded to the views of family members, when evaluating best interests. Grief, which does not await death, frequently ambushes families in these challenging circumstances. Sometimes, their own sense of loss can become the prevailing emotion. This is of course entirely normal and natural. Those charged with the task of identifying what P would likely have wanted must be alert to the reality and focus of their enquiry. The views of family members, their own wishes, feelings, religious and cultural beliefs, are, in themselves, of little, if any, relevance.* ***I emphasise that their views are being sought solely to illuminate the likely wishes and feelings of P.*** *Their evidence is garnered to assert P's autonomy, not to subjugate it. This case is, as my earlier judgment seeks to demonstrate, a striking example of this point. To some extent, many of the family members here identify as Pentecostalists, certainly many have strong Christian faith. Their views, however, on these difficult ethical issues*

---

[2] Note, Arianna and Katie both having been involved in these cases, they have not contributed to this.

> *vary widely. I have placed emphasis on the evidence of those family members who have eschewed their own religious and cultural views and concentrated on the views and beliefs of JP.* (emphasis added)

In the instant case:

> *19. It is clear that the RHN recognised these different views within the family. The immediate family, to use Ms Paterson's helpful term, all held clear views that continuing treatment was entirely contrary to what JP would have found tolerable. For the reasons set out in the earlier judgment, those views were expressed cogently and were supported by substantial and choate evidence. Those family members, believing that their father was beyond any experience of his surroundings, eventually drifted away from the hospital and turned, as they had to, to their own lives and young families. VP (JP's daughter) told me, expressly, that she stopped attending the hospital with any frequency because her father was "no longer there". The wider family, perhaps in part driven by moral and religious obligation, as well as love, continued to attend. I suspect, and I say this without any criticism at all, that their views became heard most clearly and consistently. I have found that those views were not JP's.*
>
> *20. With no apology for further repetition, because the point needs to be crystal clear, the objective of the discussions with family members is **not** to ascertain their views and beliefs but to ascertain if what they have to say can illuminate P's wishes and beliefs. There has been some discussion as to the need to be sensitive to "the family's views". This referred to JP's sisters' and mother's strict religious beliefs. Of course, I would expect all concerned to be respectful and polite, and I have no doubt they were. However, delaying decision-making for JP in consequence of a heightened sensitivity to the religious views of some of his family would be to neglect him and to lose focus on the central question of what is in JP's best interests. The incapacitous individual, with no awareness of the outside world, is uniquely vulnerable and requires vigilantly to be protected.*
>
> *21. It was clear from Dr Hanrahan's evidence that he was convinced from the beginning, and particularly after his conversation with JP's partner, that JP would not have wished to languish as he now has done. There was strong and convincing evidence as to what JP would have wanted from the outset. I have struggled to understand why there was not a timely application to the Court. I have not discovered any satisfactory explanation. Dr Hanrahan did not seek to proffer one. It is important to say that when there is disagreement within a family as to where P's best interests lie, that is a signal to bring the matter to Court. It most certainly is not a reason to spend months or, as here, years in hand-wringing procrastination. Moreover, the divide in the family really lay between those who had drilled deeply into the beliefs and codes by which JP led his life, and those who advanced doctrinal objections. Keeping JP at the front of the process and applying the best interests test in the manner required, has, on a proper analysis, indicated throughout, that the evidence of the former is qualitatively strongest. A failure to act when confronted by a family disagreement is to elevate that dispute above the best interests of the patient. It is also necessary to say that where the focus is, as it must be, on what P would most likely have wanted, and where there is a reliable foundation (as here) to establish what those views are, it is not helpful or in P's best interests to spend*

> *months tracking down family members whose addresses are difficult to find. The exercise is a proportional one, predicated on the quality of the available evidence and the undesirability of delay.* (emphasis in the original)

The systemic problem

It is important to note that Hayden J had his attention drawn to the Parliamentary Office of Science and Technology POSTNote (July 2022) identifying that, as at that point, there were *"between 4,000 and 16,000 patients in VS in nursing homes in England and Wales, with three times as many in MCS and an unknown number of people with PDOC care in other settings*." In light of the very modest number of applications relating to PDOC patients, the Official Solicitor inferred that “*"there may well be significant numbers of PDOC patients in nursing homes across England and Wales in respect of whom a full consideration of their best interests has not taken place and that the delays seen in this case may well be far from unique to the RHN*.” Further, Hayden J endorsed the observations that

> *that the relatively early discharge of PDOC patients from both an acute hospital or a brain rehabilitation service to a General Practitioner or nurse led community-based service may be a significant feature. As Ms Paterson says, the reality is that P is moved from an environment in which they have been reviewed regularly by a clinician with specialist knowledge (e.g. neurology or neuro-rehabilitation) to an environment in which medical reviews are performed by a General Practitioner review most frequently generated by symptoms or medical problems separate from the prolonged disorder of consciousness.*

The role of ICBs

Hayden J was, as had been Theis J in the previous cases, very concerned about the apparently passive stance of the ICB, which was responsible for commissioning the care being delivered to JP.

> *31. In analysing the delay that has occurred, the ICB acknowledges that JP's case should have been identified and referred to the Court of Protection sooner. They have apologised for their part in that delay. It is important that I record their response:*
>
> *"Avoiding delays of this nature in the future*
>
> > *6. The ICB recognises that as a commissioner of care, it must give active consideration to whether the 'care package includes an effective system being in place for best interest decisions to be made in these difficult cases so that drift and delay is avoided,' as stated in XR. NHS CHC reviews are conducted on at least annual basis per the national framework, and the ICB did review [JP] annually during this period save for one year during the pandemic. The ICB has reflected on the lessons in [JP]'s sad case, and recognises the need to be proactive in exploring if there are other patients within the South East London population living in similar circumstances. The ICB will, as a priority, work with system partners across to identify and review patients on a case-by-case basis to determine whether care of this nature is agreed to be in the patient's best interests, or agreed not to be in the patient's best*

interests, or whether there is a need for the Court of Protection to determine any relevant dispute. The ICB is conscious that this would be needed both for patients in a hospital setting and for those patients who may be residing in nursing homes or in the community.

7. *Since its formation in July 2022, the ICB has worked on developing the governance, escalation and oversight mechanisms for complex and high-risk patients that the ICB funds care for. This includes any patient where there is an element of safeguarding concern or mental capacity that should be considered. There is currently a suite of refreshed policies and procedures (most likely the Clinical Quality Assurance and Safety framework and protocols) going through the ICB internal governance processes to ensure greater alignment and standardisation across the ICB.*

8. *The ICB is aware that some of its system partners have already taken proactive action in relation to the identification and review of any patient who may lack capacity based on profound brain injury and prolonged disorders of consciousness. The ICB will continue to collaborate and assure that this work has been undertaken using a consistent approach across South East London.*

9. *Following the escalation of [JP]'s case to the ICB's Chief Nursing Officer we will also be undertaking An After Action Review to identify areas of improvement and gaps in policy, procedure and approach across the system and the wider regional health economy that will need to be addressed.*

10. *The ICB anticipates that relevant training based on its findings will be delivered to all partners across the South East London System."*

I have re-read these passages several times. I should very much have preferred plain language, an unambiguous recognition of the extent of the delay, and acknowledgment of the avoidable pain caused to the family by it. I am prepared, however, to take the assurance that "there is currently a suite of refreshed policies and procedures (most likely the Clinical Quality Assurance and Safety framework and protocols) going through the ICB internal governance processes to ensure greater alignment and standardisation across the ICB" as an expression of a real determination to ensure that the ICB will not in future be a "passive bystander", to use Theis J's apposite phrase. The obligation is to be a proactive participant in promoting the patient's best interests. I note, as has the Official Solicitor, that the review of the ICB's working practices would appear to be at a relatively early stage. For all the reasons set out, and which I am bound to say strike me as obvious, this review requires to be given priority. What has occurred with JP is entirely unacceptable.

32. Ms Paterson submits that in deferring their obligations to the RHN, the ICB may have leant too heavily on the status of the RHN as an

> *internationally recognised centre for neuro-rehabilitation. I have some sympathy with that but, to use the famous aphorism of human fallibility, 'even Homer sometimes nods'. The checks and balances required to ensure that these crucially important decisions are taken effectively and timeously are predicated on robust collaborative relationships. The law relating to decisions to discontinue the provision of artificial nutrition and hydration in PDOC cases is now well settled. Neither is there any lack of clarity in ascertaining what procedural steps need to be taken by the parties, collectively to ensure that an application is ready for a hearing when one is required.*

Recognising when cases need to go court

Hayden J, finally, reiterated the need to recognise when cases need to go court.

> *33. Ms Paterson has also highlighted what she describes as the RHN's drift "into a well-meant attempt to mediate the family dispute about [JP]'s best interests, which resulted in yet further delay". She makes the following submission:*
>
> > *"The Official Solicitor suggests that a clear signal needs to be sent through the judgment that there is no onus on either ICBs or healthcare providers to broker an agreement between family members, even if that would be desirable. The terms of section 4(6) of the Mental Capacity Act 2005 only place an obligation on a decision-maker to take "reasonable" steps to "ascertain" P's wishes and feelings; and, s4(7), to "take into account, if it is practicable and appropriate to consult them, the views of anyone engaged in caring for the person or interested in his welfare". In light of this, in the present case, it would have been better to file an application, once the immediate family had been consulted and the family tree obtained from [TP]. That said, the need for an application definitely crystallised once either the RHN and/or the ICB had been met with the absence of a response from a family member(s) as there was then "a lack of agreement as to a proposed cause of action" in relation to "the provision of life-sustaining treatment."*
>
> *34. I would endorse this submission. There is no onus on the ICB or healthcare providers to broker an agreement between family members. Ms Paterson moots that it might be desirable if there were. On that point, I take a stronger view. That approach risks occluding the nature of the enquiry, which as I have been at pains to identify, is directed towards understanding what P's wishes and feelings might have been in these circumstances. It is difficult to see how a disagreement amongst those consulted is capable of mediation. The question is ultimately a binary one: would P have been likely to prefer to remain artificially nourished and hydrated or would he have preferred it to be discontinued in circumstances where treatment was ascertainably futile. Mediation in these circumstances risks conflating the family's views of best interests with the authentic views of P himself.*
>
> *35. Perhaps the loudest signal emerging from this troubling raft of cases is a failure to understand the*

> *crucial significance of issuing proceedings promptly. The Official Solicitor suggests that it is better for an application to be filed early, with an accompanying report by a General Practitioner and, if necessary, stayed for a short period while a second opinion from a Consultant in Neuro-rehabilitation is obtained. The reasoning underpinning this is to ensure the Court is seized of P's best interests as early as possible. Equally importantly, P's voice will be given the priority it requires by the provision of representation that this would confer. This, it is said, ensures that "in effect, the court proceedings and the ICB's and/or the healthcare providers' compliance with the guidelines can be progressed in tandem, but P's best interests remain at the forefront of any "time-tabling"." I find this an attractive submission, but I would not wish to be quite as prescriptive. It seems to me that the spirit of this could or ought easily to facilitate a timely application with both the General Practitioner report and one from a Consultant in Neuro-rehabilitation.*

Comment

The systemic problems identified by Hayden J in relation to people in PDOC outside facilities such as the RHN are very challenging. The RHN has been the subject of repeated criticism before the Court of Protection because it has recognised its previous failings in best interests decision-making and brought cases to court in consequence (and hence Hayden J was at pains to seek to emphasise that, despite these failings, the actual care being delivered by the staff there is of very high quality). What is much more concerning, arguably, are all the cases in facilities where no-one has even recognised that there may be an issue. Hence the importance of ICBs recognising their strategic responsibilities for securing good governance as regards best interests decision-making.

Hayden J's observations on s.4(7) are striking, and go beyond Lady Hale's observations in *Aintree* (at paragraph 39):

> *The most that can be said, therefore, is that in considering the best interests of this particular patient at this particular time, decision-makers must look at his welfare in the widest sense, not just medical but social and psychological; they must consider the nature of the medical treatment in question, what it involves and its prospects of success; they must consider what the outcome of that treatment for the patient is likely to be; they must try and put themselves in the place of the individual patient and ask what his attitude to the treatment is or would be likely to be; and they must consult others who are looking after him or interested in his welfare,* ***in particular for their view of what his attitude would be.*** (emphasis added)

Whilst it is undoubtedly correct that the primary purpose of consulting with family (and – very often just as, if not more, important friends) is to understand what the person themselves might have wanted, it is arguably to go too far to say that their views of what the right outcome is are irrelevant. For better or worse, the best interests jurisdiction of the Court of Protection remains a jurisdiction where the decision is ultimately intended to be a subjectively-informed 'objective' one, rather than one of a pure exercise in substituted judgment – that must mean that it is legitimate to take account of the family's views as part of considering all the relevant circumstances (as is required by s.4(2)).

Finally, in relation to the (very) vexed question of when to go to court, it is undoubtedly the case that treating bodies should not pursue what might well be seen as a rotten compromise[3] for the sake of satisfying others at the expense of P, and, as Cobb J has previously identified, the perfect can be the enemy of the good in terms of preparing material for consideration by the court. But it is perhaps important that Hayden J did not descend to prescription in the way invited to by the Official Solicitor, as that could equally well lead to situations where the court simply does not have the material before it to make the relevant decision, and the clinicians have become so embroiled in the court process that they are not able to do the work that is required of them under the PDOC guidelines. Arguably of much greater importance is that clinicians recognise at an early stage that they are in a situation which may need to go court, so that they can start the twin-tracking of working with the relevant lawyers to prepare the application, whilst at the same time continuing the necessary diagnostic and prognostic testing.

Anorexia, the Court of Protection and the changing calculus of decision-making

St George's University Hospitals NHS Foundation Trust & Anor v LV [2025] EWCOP 9 (T3) (Morgan J)

Best interests – medical treatment – practice and procedure

Summary

When and under what circumstances it is legitimate not to treat those with anorexia is a very contentious topic, and is under particular scrutiny at the moment in the context of the Terminally Ill Adults (End of Life) Bill, with very heated arguments as to whether anorexia does, or does not, fall within the scope of the Bill. In the context of the Bill Committee's debates, there has been much discussion of whether and under what circumstances the Court of Protection will endorse compulsory feeding.

This is the most recent case to be determined concerning such issues. As Morgan J described the position of a 20 year old woman, LV:

> 3. *LV is currently an inpatient on a ward in an eating disorder unit of a university teaching hospital. She has been a patient on that ward for more than 2 years since January 2023. Prior to that she had been an inpatient on a different ward in the same hospital since August 2022. That date coincides with her reaching the age of 18. Before that she had been an inpatient since February 2022 on the Paediatric intensive care unit at another hospital, also a centre of excellence in the South London area. So it is that as the case comes before me LV has been an inpatient in hospital wards of one sort or another for the last 3 years. That is the environment in which this intelligent, academically ambitious young woman has spent the last months of her childhood and the early years of her adulthood. She is detained under section 3 of the Mental Health Act 1983.*
>
> *4. LV has been diagnosed with Anorexia Nervosa; Autism Spectrum Disorder; Severe Depression; and Anxiety. Whilst there are interrelating consequences and presentations arising from those conditions, it is those which arise from the anorexia which lead to the application I have to determine. LV is now extremely unwell. She is presently being fed twice a day using a Naso Gastric Tube. She has to be restrained for this. The process requires seven staff members. Since December of last*

---

[3] A phrase for which we thank Jordan Parsons, who is doing some very interesting thinking in this area.

> *year, this process has been largely ineffective in providing her with nutrition since she has developed the ability, at will, to regurgitate feed whilst it is being delivered and to purge by vomiting most, nearly all, of the remainder after delivery. In that time she has lost a further 15% of her body weight. Her body mass index is slightly over 11. The likelihood is that, absent effective intervention, she will die soon. It is difficult to predict when that may be, but the evidence before me is that a timescale of days or weeks is what is contemplated rather than one of months.*

On an urgent application, the two Trusts sought orders providing for LV to be admitted to an ICU for a period of feeding under sedation. The Official Solicitor, on LV's behalf, ultimately agreed.

Morgan J was satisfied on the evidence before her that LV lacked the capacity to make decisions about the treatment and to conduct the proceedings:

> 51. […] *In combination both the anorexic cognition and the effects of starvation on her brain are such that LV is affected by an impairment of her mind. Dr A (with whom Dr Kern in her second opinion agrees) in his report dated 21st February gave the following opinion: "I assessed P's capacity on 18 February 2025 and concluded that she lacks capacity to: Make a decision between the options for life-saving treatment, as she was not able to weigh the information for the decision that needed to be made, based on the merits of the options. His view was unchanged in his oral evidence and is not challenged." I have read carefully the basis on which he arrives at that conclusion and accept it.*

The question was therefore as to what was in LV's best interests. As Morgan J noted:

> *56. The proposed course of action is most unusual and there is good reason why it is regarded as an option of last resort. There are the risks which have been outlined in the medical evidence. Those risks include starkly that she may die as a result of the treatment contemplated. A long period of deep sedation or anaesthesia is not a benign experience. The well documented phenomenon of ICU delirium is prominent amongst the risks not to be taken lightly. It is a reasonable inference to draw that for someone with an established history of serious psychiatric illness it may, if experienced, add to the mental health burdens which LV already struggles to bear. There is so much that is unknown: perhaps, so the intensivist tells me, she will not remember very much about the process when awoken. Amnesia is not an uncommon sequela in part attributable to the medication – but one cannot know. Perhaps she will remember all or much of it. If she does, the possible risks psychologically from the experience of having been treated and fed against her will have been highlighted by Dr A . In a sense most troublingly of all it may be that she goes through this risky, invasive and perhaps frightening process in which all control is taken from her - a person for whom control is of enormous importance - and at the end it all, it may be for nothing. It may still be that she cannot break the cycle and move on to the next therapeutic stage and start to recover.*
>
> *57. I have thought long and hard about all of those risks and detriments as I weigh the balance. The point about the balance however is to look at what it is that falls on the other side. Here when I look at the other side, at what lies in the balance against all that is risky; all that which in other circumstances would be an intolerable affront to her autonomy, what I contemplate is her imminent*

> *death. At the moment twice a day, LV is subject to what, in other times and contexts, was called 'force-feeding'. The means by which it is achieved, for all the empathetic approach and skill of the staff, is not so very far removed from the images which that phrase conjures up. Yet for all the pain distress and indignity of it (during all of which she is emotionally and physically present) it is achieving nothing. LV is starving to death. An exchange between Ms Paterson and Dr C encapsulated the situation when exploring on behalf of the Official Solicitor the imminence and likelihood of death.*
>
> > *'Is she at risk of collapse by heart attack and death if she walks from one end of the ward to the other briskly '*
> > *'yes'.*
> >
> > *'Could that happen this afternoon'*
> >
> > *'yes'*
> >
> > *Is that a remote or appreciable risk ?*
> >
> > *I'm not sure I can answer that*
>
> *58. I am satisfied that it is, in all the circumstances of this most unusual and troubling case, in LV's best interests to undergo the proposed course of treatment. I make it clear that influential to the decision which I reach on this has been my careful consideration albeit that she lacks capacity, as to how I should factor in her own wishes and how to regard the well documented occasions on which she has said she would like to die. I am acutely conscious that I lack the assistance I would ordinarily have from the Official Solicitor's visit to LV. It is right that LV should be able to have an explanation of how what she has said has factored into but not determined my conclusions on best interests. Setting as I have those expression of her wishes in the context of all the other evidence, including her own other words and behaviour, I have concluded that the wider picture informs me that her wishes or feelings, forming as they do a part of my decision making, are more nuanced and less consistent than might appear the case at first glance and before detailed consideration.*

Finally, at paragraph 59, Morgan J agreed with the submission made by the Official Solicitor that:

> *given the highly unusual circumstances of this case and the time critical way in which it has been necessary to make decisions in the short period between the issue of proceedings and the conclusion of this hearing, the matter should come back for further review hearing.*

Comment

Over and above the challenges of this very difficult individual case, it is important to draw out a number of features of wider importance.

The first is that both Trusts involved clearly took the view that this was not a situation which could be encompassed within the four walls of the MHA 1983. Many treatment options relating to anorexia – including, for instance, nasogastric feeding under restraint – can, and often are, deployed entirely appropriately under Part 4 MHA. In other words, the fact of the coming into force of the MCA 2005 has not transferred the treatment of anorexia from the MHA 1983 to the MCA 2005. Further, a patient such as LV, who would be on s.17 leave to the ICU in the acute trust, would still notionally be subject to the provisions of Part 4 MHA 1983. An argument could be made that the treatment plan fell within the definition of medical treatment for the (manifestation) of mental disorder, such that it could be delivered under Part 4 MHA 1983. But we would suggest that this precisely the sort of situation in which, even if this **could** be the case, it was entirely right for the treating Trusts to come to court to ask whether it **should** be the case. They could have come to the High Court for a declaration under Part 8 CPR as to the lawfulness of their proposed course of action (by analogy, see *Re RC*, where that course of action was taken to confirm that **non** treatment was lawful). But it is arguably much better that they came to the Court of Protection, as a court equipped to undertake the substantive, inquisitorial, consideration of the position.[4]

The second is that this is a case in which the court was being asked, and was prepared to, endorse very 'high end' steps in relation to a person with anorexia. There appears to be something of an urban myth building up that the Court of Protection will both never take such steps, and indeed actively takes the view that such steps should not be taken. This is simply untrue. What the Court of Protection is doing is deciding upon courses of action proposed by treating clinicians in individual cases – it is therefore important to ask why clinicians take the view that they do in those cases as to whether they want to pursue particular courses of action. This line of thought is developed in these slides, which also set out the cases decided by the Court of Protection prior to *LV*.

The third point arises out of the second. Morgan J in the case before her was at pains to identify that the situation had to be kept under review, and provided expressly for this. In other cases, the decision appears to be a final one. In many such cases, the clinicians have come to court for decisions that either continuation or escalation of treatment is not in the person's best interests. It is vitally important to understand that if and when the court makes such a decision, it is not concluding that the clinicians must stop thinking at that point. In particular, there may well be situations in which the person's circumstances change – at that point, the clinicians must consider whether they should bring the matter back to court. In many cases, careful drafting of the relief sought can make clear that the court is not closing the door on treatment if the person wishes it, but rather making clear that it does not have to be imposed upon them against their will: for a very clear example of such a case, see the decision of Cobb J *in A NHS Foundation Trust v Ms X* [2014] EWCOP 35. But even where the relief drafted in a way which appears more definitive, a failure to reconsider where the person's circumstances change would be both legally and ethically indefensible: if the person's situation changes, so must the calculus of their best interests.

---

[4] Some complex issues do arise in such situations, not addressed in this judgment, about the operation of s.28 MCA 2005. They may need to fall for consideration in due course.

Editors and Contributors

Alex Ruck Keene KC (Hon): alex.ruckkeene@39essex.com
Alex has been in cases involving the MCA 2005 at all levels up to and including the Supreme Court. He also writes extensively, has numerous academic affiliations, including as Visiting Professor at King's College London, and created the website www.mentalcapacitylawandpolicy.org.uk. To view full CV click here.

Victoria Butler-Cole KC: vb@39essex.com
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 Vice-Chair of the Court of Protection Bar Association and a member of the Nuffield Council on Bioethics. To view full CV click here.

Neil Allen: neil.allen@39essex.com
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. Also a Senior Lecturer at Manchester University and Clinical Lead of its Legal Advice Centre, he teaches students in these fields, and trains health, social care and legal professionals. When time permits, Neil publishes in academic books and journals and created the website www.lpslaw.co.uk. To view full CV click here.

Arianna Kelly: Arianna.kelly@39essex.com
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 Court of Protection Practice (LexisNexis). To view a full CV, click here.

Nicola Kohn: nicola.kohn@39essex.com

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, CCGs 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.

Katie Scott: katie.scott@39essex.com

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.

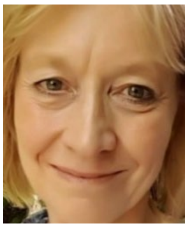
Nyasha Weinberg: Nyasha.Weinberg@39essex.com

Nyasha has a practice across public and private law, has appeared in the Court of Protection and has a particular interest in health and human rights issues. 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.



Jill Stavert: j.stavert@napier.ac.uk

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

Sheraton Doyle
Senior Practice Manager
sheraton.doyle@39essex.com

Peter Campbell
Senior Practice Manager
peter.campbell@39essex.com

Chambers UK Bar
Court of Protection:
Health & Welfare
Leading Set

The Legal 500 UK
Court of Protection and
Community Care
Top Tier Set

clerks@39essex.com • DX: London/Chancery Lane 298 • 39essex.com

LONDON
81 Chancery Lane,
London WC2A 1DD
Tel: +44 (0)20 7832 1111
Fax: +44 (0)20 7353 3978

MANCHESTER
82 King Street,
Manchester M2 4WQ
Tel: +44 (0)16 1870 0333
Fax: +44 (0)20 7353 3978

SINGAPORE
Maxwell Chambers,
#02-16 32, Maxwell Road
Singapore 069115
Tel: +(65) 6634 1336

KUALA LUMPUR
#02-9, Bangunan Sulaiman,
Jalan Sultan Hishamuddin
50000 Kuala Lumpur,
Malaysia: +(60)32 271 1085