



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

- (1) In the Health, Welfare and Deprivation of Liberty Report: the court is not a rubber stamp for clinicians and what does it mean to represent P's interests;
- (2) In the Property and Affairs Report: Professional Deputy Costs, and paying drug debts for P;
- (3) In the Practice and Procedure Report: capacity to conduct proceedings and the costs of inadequate disclosure;
- (4) In the Mental Health Matters Report: capacity to conduct Tribunal proceeding, and the independent investigation into the care and treatment of Valdo Calocane;
- (5) In the Children's Capacity Report: looking at other options before using the inherent jurisdiction to authorize a deprivation of liberty;
- (6) In the Wider Context Report: what happens if you never had litigation capacity and new books;
- (7) In the Scotland Report: AWI reform and the UK Protocol on Judicial Cooperation.

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.

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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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Capacity in Tribunal proceedings

KH -v- Nottinghamshire Healthcare NHS Foundation Trust; AH -v- Avon & Wiltshire Mental Health Partnership NHS Trust (HM) [2025] UKUT 128 (AAC) (UTJ Church)¹

The Upper Tribunal has given guidance on what a mental health tribunal must do when faced with a patient for whom a representative has been appointed under rule 11(7) but where there is a conflict on whether or not the patient has regained capacity to appoint a representative or there is a dispute/refusal of engagement with the said representative.

In both KH and AH’s cases, a legal representative had been appointed but there was an issue regarding capacity or engagement. KH, a restricted patient with convictions of manslaughter and attempted murder, refused to engage with the representative but the representative continued to act in his best interests. AH, also a restricted patient, was also found to lack capacity to “make the decisions required of him in the context of his involvement in the proceedings” [37] but the tribunal considered the involvement of a representative against his will would be contrary to his best interests such that the representative was discharged. In light of the far-reaching nature of the issues, the Law Society was joined into proceedings as an Interested Party.

Summing up the law, UTJ Church recorded that ‘[t]he proper approach to assessing mental capacity as established at common law and confirmed in the MCA 2005 is set out by the Supreme Court in *Dunhill v Burgin (Nos 1 and 2)* [2014] UKSC 18, [2014] 1 WLR

933 at §13).’ [44] In the context of assessing capacity to conduct proceedings before a mental health tribunal, the test is that set out by Charles J in *YA v Central and North West London NHS Trust* [2015] UKUT 37: “The identification of the specific decision, issue or activity that is the subject of the capacity assessment is important because it identifies the matters that have to be sufficiently understood, taken into account and weighed by the decision maker.”

47...there are three principal matters that are relevant to patients involved in mental health proceedings:

- a. the initial decision of whether to make an application to the tribunal;
- b. once an application or referral has been made, the decision whether to appoint a representative, or to conduct their own case; and
- c. conducting the proceedings, whether in person or through a representative...

51. The power to appoint a representative under rule 11(7) Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008 is discretionary (“the Tribunal may”, not “shall” or “must”). Whenever a tribunal considers exercising its discretion under rule 11(7) it must ask itself three questions:

- a. whether the patient lacks capacity to appoint a representative (the first limb of rule 11(7)(b));
- b. the second question depends on the answer to the first question in a. above:

¹ Neil Allen, having acted in this case, has not been involved in writing this report.

- i. if the answer to a. is “yes”, it must then ask whether it is in the patient’s best interests to be represented (the second limb of rule 11(7)(b)).
- ii. if the answer is “no”, then the tribunal must consider instead whether to make an appointment under rule 11(7)(a), which is available only if the patient has stated that they do not wish to conduct their own case or they wish to be represented; and
- c. whether the discretion should be exercised in favour of the appointment (the first sentence in rule 11(7))

As per Charles J in *YA*, capacity “to appoint” a representative and capacity to conduct proceedings are “inextricably linked” and the distinction between them can be “theoretical rather than real” (see *YA* §57-60). When assessing capacity to appoint a representative (and to conduct proceedings), the nature of the proceedings and the demands they make on participants must be considered: “Capacity to appoint a representative” may, therefore, include “capacity to conduct proceedings” [55].

As UTJ Church observes at [55], given the equivalence of capacity to appoint a representative and capacity to conduct proceedings, “the Tribunal Procedure Committee may wish to consider amending the HESC Rules to make this explicit” [55]. At paragraphs [56] to [82], UTJ Church gives detailed guidance on (a) when to assess capacity (ideally at an early case management stage but ultimately this may be done on the day of the hearing), (b) the implications for a Rule 11(7)(b) appointment of fluctuating capacity – “the appointment continues unless and until the representative is discharged from the appointment by the tribunal” [61]; where possible, a decision may be delayed until capacity is regained [62]; (c) the duties of the representative, (d) the nature of the capacity assessment to be undertaken and (e) the duties of the rule 11(7)(b) representative who considers their appointment not to be in the patient’s best interests or to be otherwise inappropriate. Particular interest should be given to UTJ’s observations at paragraph 80-82:

80....In principle, a patient would benefit from being represented at a tribunal hearing. In practice, however, if the patient has no trust in a representative imposed on him or her by the tribunal and is not willing to co-operate or engage with the representative, the theoretical advantages of representation will clearly not be realised. The situation risks resulting in a representative unable to represent and a patient who is unable to participate. That is inimical to the objective of rule 11(7)(b), and inimical to the overriding objective of the tribunal.

81. If the representative considers that their continued appointment is not in the best interests of the patient, they should make submissions to the tribunal, identifying their reasons why. If, conversely, the representative considers that their appointment is in the patient’s best interests, despite the patient’s objecting to it, the representative should set out why they take that view and also set out the patient’s reasons for taking the contrary view.

82. In any case where a tribunal is making a determination of capacity to appoint a representative or to conduct proceedings, or is deciding whether the continued appointment of a representative is in the best interests of an incapacitous patient, it must give clear reasons for what it decides. These should address each of the three preconditional decisions required for exercise of the rule 11(7)(b) discretion identified in paragraph 51 above.

As UTJ Church observed at [98], a finding of a lack of capacity to appoint a rule 11(7)(b) does not lead inevitably to a conclusion that one should be appointed in the patient’s best interests in any event:

98. The discretion under rule 11(7)(b) about whether the patient should be represented applies even where the tribunal has concluded that representation would be in the patient’s best interests. That might seem like an odd provision to anyone not familiar with mental health tribunals, but not to those who have participated in them. Those who have participated in hearings before the

mental health tribunal will appreciate that hearings are not just about whether the patient will achieve discharge or a statutory or extra-statutory recommendation: often it is more about being seen and heard, and being afforded an opportunity of agency. That right might be less obvious than the right to liberty, but its importance should not be underestimated to someone who finds him or herself detained, especially if they are thought to have a delusional disorder, and especially if they do not agree with their diagnosis.

Comment

We consider that the wording of paragraph 98 could be, respectfully, better formulated. Clearly, the jurisdiction of the MHT is different from that of the COP so that it is not bound to act only in a patient's best interests. That said, the implications of paragraph 98 are clear and, self-evidently, correct: whether or not it might be in a patient's best interests to have representation generally, the case management decision must include a broader reflection on whether or not it is in their best interests to have representation forced upon them in circumstances where they are vehemently opposed to it.

Calocane inquiry: Questions to be asked

The questions to be asked by the Calocane Inquiry have been published, which include a set around capacity. The questions are non-exhaustive, and include consideration of:

- Information-sharing between public bodies which encountered Valdo Calocane, including the police;
- Valdo Calocane's discharges from primary and secondary mental health services and consideration of risk;
- Missed opportunities for action, both in the long-term and on the night of the murders;
- Data breaches on sharing of sensitive information;
- Consideration of detaining Valdo Calocane under the MHA;
- Whether 'lack of compliance on medication taken into account and the potential for a Community Treatment Order ("CTO") considered' and '[w]hat aftercare services were provided?'
- Whether Valdo Calocane's 'capacity to make decisions about his care and medicine regime considered? Was insight or lack of insight considered in relation to capacity to make such decisions? If so, when and what criteria were used? Would assessment of capacity under the regime of the Mental Capacity Act 2005 have provided alternative approaches to ensuring compliance with medication?'
- The adequacy and appropriateness of Valdo Calocane's care and treatment;
- Further measures which could be taken to improve multi-agency working, including any legal barriers to improvement.

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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](#).

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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.

Neil is running the following courses, with tickets available [here](#):

- BIA/DoLS refresher training: 26 June 2025, 16 July 2025.
- DoLS Authoriser Training: 4 July 2025
- AMHP/MHA 1983 Legal Update: 10 July 2025

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 July. 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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