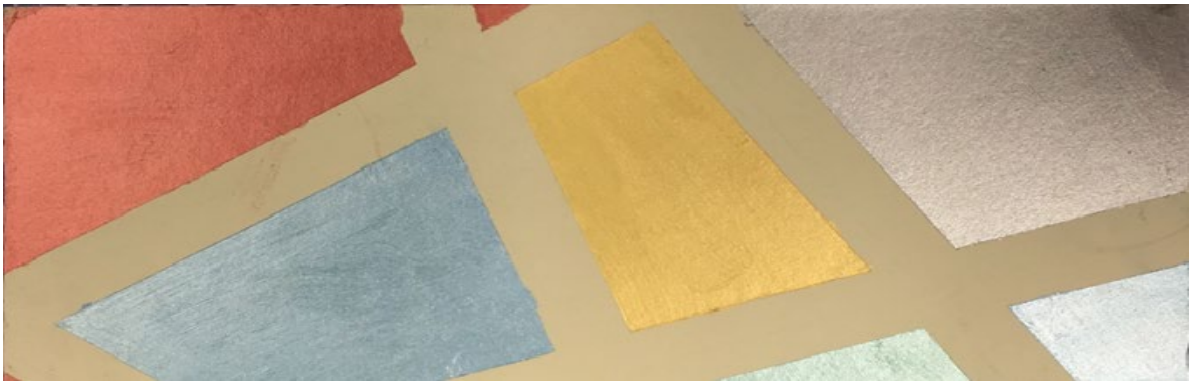

Welcome to the July 2025 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: what to do when an advance decision to refuse treatment may be in play, and the consequences of the gaps between services for those with disordered eating;

(2) In the Property and Affairs Report: capacity in the rear view mirror: how does the presumption work?;

(3) In the Practice and Procedure Report: disclosing position statements to observers; habitual residence, moving jurisdictions and 'lawful authority;' and the impact on P of being assessed;

(4) In the Mental Health Matters Report: progress of the Mental Health Bill and the tort consequences of a finding of Not Guilty by Reason of Insanity;

(5) In the Children's Capacity Report: a depressing snapshot from the national DoL court, human rights of children in the social care system and capacity and gender-affirming treatment;

(6) In the Wider Context Report: the Oliver McGowan statutory learning disability and autism training, and the pitfalls of facilitated communication

(7) In the Scotland Report: joint attorneys in dispute: appropriate remedies and; "If at first you don't succeed …": res judicata in tribunal proceedings.

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.

Contents

A depressing snapshot from the national DoL court

Re N (A Child) (Deprivation of Liberty Orders) [2025] EWHC 1690 (Fam) (03 July 2025) (Family Division) (Henke J)

Article 5 ECHR – children and young persons

Summary

This application related to the deprivation of liberty of N, who was 17 when the application was made; she had since turned 18. N had experienced 'significant insecurity and trauma in her life. As a child in the care of her parents she experienced domestic abuse, physical chastisement and parental substance misuse.' She was made subject to a care order in 2022, and placed first in residential care and then in secure accommodation after she absconded, self-harmed and tried to take her life. She left secure accommodation after about a year, and returned to residential care, where she was made subject to a deprivation of liberty authorisation (with further authorisations at subsequent placements after the first one broke down). N was repeatedly detained under s.136 MHA, but was not detained under ss.2 or 3 MHA.

By winter 2025, N had had noticed served by multiple placements, and found herself in hospital. An urgent application was made to the court to authorise her detention in hospital; after she absconded, she ended up in police custody as she had nowhere else to go. She was then detained in hospital under s.5(2) MHA; when this expired, N was detained in hospital under the inherent jurisdiction on a 2:1 staffing ratio. Henke J noted that this 'was a far from perfect solution but one made in N's best interests to keep her safe in an environment where her physical and medical needs could be met whilst a placement was found for her by the local authority.' [10] A placement was found for N on 3 March, where authorisation was given to supervise her on up to a 3:1 basis.

N continued to self-harm and abscond, and was again in police custody within a few days; however, further measures were taken to secure the placement and N was discharged back with monthly reviews. N became more settled over time and by the time of her 18th birthday, the parties:

> *16.* […] *were in agreement that N is now able to make better choices, be independent and to make positive decisions for her own welfare. There was a plan in place for her to move to a more appropriate property that will allow her to progress being fully independent. She will continue to be supported by Adult Social Care and the Leaving Care Team. N had been allocated a personal adviser from the Care Leaver Service and an Adult Social Worker with whom she has started to build positive relationships. I was told that the local authority no longer sought the court's authorisation to deprive N of her liberty. The current application was no longer necessary, and the proceedings could conclude*

Henke J stated that the purpose of the judgment would help "*to provide finality and closure for N' and set out N's 'journey*" (paragraph 17).

The judgment set out some general observations about deprivations of liberty in the inherent jurisdiction:

> *19. N's case was one of the many cases that are issued through the Deprivation of Liberty List each year. According to the Ministry of Justice in 2024 1280 children and young people were the subject of a Deprivation of Liberty order last year. The orders are made under the Inherent Jurisdiction. The applicants are typically local authorities or Hospital Trusts. The inherent jurisdiction is a welfare jurisdiction. The young person's welfare is the paramount consideration. The orders are draconian. They are a significant infringement by the State of the child or young person's right to liberty. They are only made where it is lawful, necessary and proportionate to detain or restrict a child or young person's liberty in order to secure their welfare. The orders must have an educational element - Art 5 (1)(d) ECHR.*
>
> *20. Deprivation of Liberty orders are permissive in nature. The order authorising the deprivations of liberty is not a prescriptive list of restrictions which must be imposed. It is a menu of what may be imposed by the applicants if it is necessary and proportionate to do so to safeguard the young person. The applicants must at all times use the least restrictive option.*

Henke J noted that "*N, like many of the young people who are the subject of a Deprivation of Liberty orders, has suffered trauma. They exhibit challenging behaviours which are often extreme. They put themselves at risk of significant harm and possible death. They are in crisis running from their placements, self-harming and taking steps to commit suicide*" (paragraph 21). She further observed that they do not fall within the MHA, MCA or s.25 Children Act, and:

> *21.* […] *They thus are outside the statutory schemes which would permit their detention. The purpose of exercising the inherent jurisdiction is to fill the statutory lacuna. It grants the applicant permissive powers to detain the young person and restrict their liberty so that they may be safe. Under the orders the children are often kept in unregulated, and sometimes, unsuitable setting to keep them safe in response to a crisis whilst other more suitable placements are found. That can be a protracted process given the paucity of provision and the need often to develop and implement bespoke provision. It means that children and young people are detained or have their liberty restricted for often protracted periods of time.*

Henke J observed that while N was not safe at the time orders were made, she had:

> *22.* […] *permission to N's Guardian and her solicitor to release the papers in N's case to the Official Solicitor to consider whether N has a claim against either the local authority or the Hospital Trusts in this case in relation to (i) the period in the middle of February when N was stuck in a revolving door between the police, the local authority and the Hospital Trust and (ii) in relation to her detention in hospital when the Guardian says the restrictions authorised by the court were imposed rigidly and prescriptively and the least restrictive option was not understood by those trusted to implement them.*

On a more positive note, Henke noted that:

> *23.* […] *the trajectory of N's case changed once there was multi-*

disciplinary working. From the multi-disciplinary meeting on 14 February 2025, there was joined up thinking and a plan began to be formulated that met N's needs. It is not perfect, but it was a plan with which N could and does engage with. Like any good plan, it had an objective and a timeline. The aim was that N should be free from any restrictions other than that which she chose to impose on herself by her eighteenth birthday. It recognised that she was soon to be an autonomous adult with capacity.

Henke J noted lessons learned in N's case at paragraph 24:

a. Working together between the statutory agencies is key. Once the statutory agencies came together at a multi-disciplinary meeting, a plan began to be formulated to meet N's current needs and her anticipated needs in adulthood. The multidisciplinary process ran in parallel to the court proceedings with the court being updated on its progress.

b. N participated by speaking to me. She was listened to and her wishes and feelings were factored into decision making whilst her welfare remained my paramount consideration. She wanted to be free of restriction when she turned eighteen. That provided a focus for her and for the agencies. It influenced and shaped a step-down plan.

c. Within the court proceedings, a step-down plan (a route-map out of restrictions) was drafted by the applicant. It was considered at each interim hearing. At each interim hearing, only those restrictions which were likely to be necessary and proportionate were permitted.

d. The case was timetabled and a final hearing listed.

e. The applicant local authority was reminded of its obligations under the Care Leaver legislative scheme (see ss.23A-E of the Children Act 1989 and the Care Leavers Regulations 2010) and went on to fulfil its statutory obligations. N now has a Pathway plan, a key worker and a personal adviser. The effective implementation of the Care Leavers legislative scheme should run alongside the court proceedings. Sadly, this court's experience is that sometimes that scheme is not observed or not fully observed as it should be.

f. N was referred to adult social services which enabled the seamless transition N deserved. As an obviously vulnerable young person whose need for care and support was unlikely to end on her eighteenth birthday, a seamless transition between adult and children's social services was properly anticipated and acted on. Section 17ZH of the Children Act 1989 is an often-overlooked provision. It deals with the transition of assessments of children under s.17 Children Act 1989 and adults under the Care Act. The spirit of the policy which underpins that section was observed in this case.

Summary

The judgment reflects a very 'normal' case in the National Deprivation of Liberty list for children, to the extent that one exists. The children who are the subject of these urgent applications are often in crisis, and have nowhere to go – that is typically a temporary situation, and a place is eventually found for them. As in N's case, placements will often break down, and the child may find themselves in a 'rolling' period of crisis for some time. Happily, some stability was found in N's case, but this does not always align with the child turning 18 and these inherent jurisdiction applications sometimes proceed on

as complex Court of Protection matters, where a diagnosis may be elusive.

We would, though, respectfully disagree with the statement at paragraph 19 that "*The orders must have an educational element - Art 5 (1)(d) ECHR*." Many children subject to these orders are out of education, and that may not be a feasible goal for a child in severe crisis. On a proper analysis many of these orders are in fact made under Article 5(1)(e) ECHR and turn on the child's putative 'unsoundness of mind.'

Human rights of children in the social care system

The Joint Committee on Human Rights has announced an inquiry into the human rights of children in the social care system.

It will have a particular focus on children in care but wider aspects of the system will also be relevant, for example in regard to kinship care, to the availability of additional support to families with disabled children, or to the efficacy of early intervention measures.

The Joint Committee has launched a call for written evidence asking questions on issues such as the adequacy of the legal framework and the availability of complaints mechanisms.

The Committee has also launched an online survey to better understand the views of those who have experience of the children's social care system in England.

More information and how to respond can all be found here.

Unsurprisingly, the Committee is interested in how Article 5 rights are being upheld. Rather pointedly given the apparently endless trailing of changes to EHCPs, the Committee is also expressly interested in understanding:

> *To what extent is there a clear understanding by organisations, individuals, and public authorities, about statutory duties owed to children in the social care system, as well as the individual entitlements of these children? Do social workers, as well as others involved in providing support to children in care, receive adequate human rights training?*

Capacity and gender-affirming treatment

N v N (Expert Evidence on Gender Affirming Treatment) [2025] EWHC 1325 (Fam) (Family Division (MacDonald J))

Mental capacity – assessing capacity

Summary

In this case, MacDonald J was concerned with applications by the parents of a 17 year old for orders under the Children Act 1989 and / or the inherent jurisdiction of the High Court. The parents principally sought a declaration that B lacked capacity to consent to "cross-sex hormone" gender affirming treatment. At the case management stage, the court was concerned with whether permission should be given, pursuant to s. 13 of the Children and Families Act 2014 (hereafter "the 2014 Act") for the instruction of expert evidence. As MacDonald J noted at paragraph 4:

> *All parties submit that it is necessary for permission to be given to instruct an expert endocrinologist to assist the court, although there is a dispute as to the identity of the appropriate expert. The applicants also apply for permission to instruct an expert psychiatrist to assess whether B has capacity to take decisions with respect to HRT and with respect to the psychiatric impact of continuing such treatment. In addition to the applications for permission to instruct an expert psychiatrist and an*

expert endocrinologist, on behalf of the applicants, Mr Sachdeva and Mr Hadden contend that, in circumstances where this is what they characterise as a "medical treatment case", the parties should each be permitted to instruct their own experts in those respective fields.

MacDonald J gave a helpful summary of the principles applicable to medical treatment of older children, which merits reproduction in full:

13. With respect to the wider legal context within which the current case management decision falls to be taken, B is over the age of 16 years. Within this context, s. 8(1) of the Family Reform Act 1969 (hereafter "the 1969 Act") provides as follows:

"The consent of a minor who has attained the age of sixteen years to any surgical, medical or dental treatment which, in the absence of consent, would constitute a trespass to his person, shall be as effective as it would be if he were of full age; and where a minor has by virtue of this section given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his parent or guardian."

14. No party seeks to dispute, in the present context, that the prescription of spironolactone and oestrogen to children and young people who seek gender affirming treatment constitutes medical treatment for the purposes of s.8(1) of the 1969 Act. Pursuant to s.8(1) of the 1969 Act, as a 17-year-old young person B is competent to provide effective consent to that medical treatment as if she were an adult and in the absence of consent by her parents (see In Re W (A Minor) (Medical Treatment: Court's Jurisdiction) [1993] 1 FLR 1 at [16]).

15. As with an adult, those medical professionals providing B with medical treatment must decide whether or not she has capacity within the meaning of the Mental Capacity Act 2005 (hereafter "the 2005 Act"). Section 1(2) of the 2005 Act contains a presumption of capacity and s.1(4) provides that B is not to be treated as unable to make a decision merely because she makes an unwise decision. In PC & NC v City of York [2013] EWCA Civ 478, the Court of Appeal noted at [54] that:

"...there is a space between an unwise decision and one which an individual does not have the mental capacity to take.... it is important to respect that space and to ensure that it is preserved, for it is within that space that an individual's autonomy operates."

16. In the foregoing circumstances, and relying on An NHS Trust v X [2021] EWHC 65 (Fam) at [55], this court summarised the effect of the wider legal framework in the context of which the best interests decision before the court falls in GK v EE [2023] EWCOP 49 at [49], a case in which the parents of a young person sought to prevent gender affirming treatment to a young person over the age of 16:

"Accordingly, unless the presumption of capacity from which EE benefits under s.1(2) of the 2005 Act is rebutted, whilst under the age of 18 EE is able to give effective consent to lawful gender affirming medical treatment pursuant to s.8 of the Family Law Reform Act 1986 in

> *circumstances where they are over the age of 16...Once over the age of 18, unless the presumption of capacity under s.1(2) of the 2005 Act is rebutted, EE is able to give effective consent to lawful gender affirming medical treatment as a capacitous adult."*

17. Finally, and crucially in the context of deciding whether it is necessary to give permission to instruct an expert consultant psychiatrist and / or an expert consultant endocrinologist, the ability of a young person over the age of 16 to give effective consent as to medical treatment is not absolute, as court retains a welfare jurisdiction to override that consent in certain circumstances (Re R (A Minor) (Wardship: Consent to Treatment) [1992] Fam 11 and Re W (A Minor) (Medical Treatment: Court's Jurisdiction) [1993] Fam 64. The circumstances in which a court may override consent were expressed by Nolan LJ in Re W (A Minor) (Medical Treatment: Court's Jurisdiction) to be, specifically, where it is necessary for the court to intervene to protect the child or young person from "grave and irreversible mental or physical harm". Thus, as made clear by the President of the Family Division in O v P [2024] EWCA Civ 1577 at [46], the court's best interests jurisdiction is not, in this context, a general welfare jurisdiction. In deciding whether it is in the child or young person's best interests to override their consent, it was further made clear in Re W (A Minor) (Medical Treatment: Court's Jurisdiction) that in determining whether to exercise its jurisdiction to do so, the court will take particular account of the child or young person's wishes, the importance of which will increase with his or her age and maturity.

18. In the foregoing context, in O v P at [2], the Master of the Rolls summarised the overall legal position as follows (emphasis in the original):

> *"It is useful at the outset to distinguish between three possible issues with which the courts have to deal. First, there is the issue of whether a child under 16 is **competent** to consent or to refuse medical treatment (see Gillick v West Norfolk and Wisbech AHA [1986] AC 112 (Gillick), and more recently R(Bell) v Tavistock and Portman NHS Foundation Trust [2021] EWCA Civ 1363, [2022] 1 All ER 416 (Bell v Tavistock). Second, there is the issue of whether a child (but also an adult) has mental **capacity** to consent to or to refuse medical treatment (see sections 1-6 of the Mental Capacity Act 2005). Thirdly, there is the issue of what is in the child's **best interests**. This issue arises once the presumption as to **competence** of a child over 16 to consent or refuse medical treatment is engaged (see section 8 of the Family Law Reform Act 1969 (FLRA 1969), which provides that a child over 16 can give consent in the same way as an adult, and not further consent is required from parents or guardians). Despite section 8, the court still retains the right to override consent given or withheld by a child over 16 on welfare or **best interests** grounds in very limited and well defined circumstances (see Re W (A Minor)(Medical Treatment: Court's Jurisdiction) [1993] Fam 64 (Re W)."*

As regards the instruction of experts, MacDonald J noted that:

> *21. Pursuant to FPR 2010 r.25.11(1), where two or more parties wish to put expert evidence before the court on a particular issue, the court may direct that the evidence on that issue be given by a single joint expert in accordance with the provisions of r.25.12, FPR 2010. Paragraph 2.1 of FPR 2010 PD 25C identifies that, wherever possible, expert evidence should be obtained from an expert jointly instructed by both or all the parties. Mr Sachdeva and Mr Hadden submit that in cases concerning the medical treatment of children it is the practice to allow a second opinion as a matter of course. They cite a number of cases where this has occurred on the facts of the case in question.*

MacDonald J first considered whether an instruction of an expert psychiatrist – sought by the parents – was justified.

> *23. Having considered carefully the written and oral submissions, I am satisfied that it is necessary for the court to give permission to instruct an expert endocrinologist, and that the expert instructed should be Dr Cotterill. I am further satisfied that the endocrinologist should be instructed by way of a single joint instruction on the basis of the questions I set out below. I am not satisfied that it is necessary to instruct an expert psychiatrist on either the issue of capacity or the issue of best interests. My reasons for so deciding are as follows.*
>
> *24. In determining whether it is necessary for this court to give permission to instruct a consultant psychiatrist and / or a consultant endocrinologist in order to resolve the proceedings justly, it is important to maintain a careful focus on the issue that this court is required to decide.*
>
> *25. It is readily apparent from the material before the court that the applicants wish the court to examine wider questions of policy with respect to gender affirming treatment, including those they contend arise from the Cass Review and the "implementation" of the recommendations in that Review. That is not the role of this court. As confirmed by the Court of Appeal in O v P, matters of policy concerning gender affirming treatment are the province of the NHS, the medical profession, the regulators and Parliament. This case is not a forum for determining wider political, social or philosophical questions arising from such treatment, nor will it be permitted to become such a forum. This court is concerned only with the best interests of B, in so far as they are engaged by the applications made by the parents.*
>
> *26. The issue that this court is required to decide is whether it is in B's best interests to continue, or to stop, receiving the HRT treatment currently prescribed to her by her General Practitioner, the latter decision involving overriding B's consent to such treatment given under s.8 of the 1969 Act. In determining the issues before it, the court will ask itself whether B's best interests require the court to intervene to protect B from "grave and irreversible mental or physical harm". It is this question that informs the extent to which it is necessary to instruct a consultant psychiatrist and / or a consultant endocrinologist in order to resolve the proceedings justly.*

Expert psychiatrist

MacDonald J first considered whether to grant the parents permission to instruct an expert psychiatrist.

> *27. The applicants advance their argument that a report from an expert psychiatrist is necessary on two bases. First, that B lacks capacity in the relevant decision making domains. Second, that in determining whether it is in B's best interests to continue or to cease HRT, the court needs to understand the psychological and / or psychiatric impact on B of one or other of those steps being taken, in circumstances where the court's jurisdiction to override her consent is narrowly founded on the question of whether an order is necessary to protect B from grave and irreversible mental or physical harm.*
>
> *28. With respect to the question of capacity, at the last hearing the court made clear to the applicants that they needed to set out the evidence on which they rely in order to demonstrate that B lacks capacity in the relevant decision-making domains. Beyond an assertion in the father's statement that conversations with B raise in the father "concerns" about B's mental health and "doubts" as to whether B: (i) has been provided with all relevant information, including all material risks and alternative treatment; (ii) her ability to understand, use or weigh that information considering a "fixed viewpoint" on the issue, no such evidence has been forthcoming.*
>
> *29. Against such assertions, in these proceedings B now directly instructs her solicitor, who is satisfied that she has litigation capacity. As I have noted, B also has the benefit of a CAFCASS Guardian. Ahead of this hearing, her solicitor and Children's Guardian met with B. Whilst I did not hear evidence on the point from the Children's Guardian, in their Position Statement Ms Fottrell and Ms Baker set out the view of the solicitor and of the Children's Guardian that B is eloquent, articulate, well-presented and sensible and does not resemble the father's description of her in the evidence filed to-date. During the course of her oral submissions, which the applicants did not attempt to gainsay, Ms Fottrell relayed that B is committed to her education and is taking A levels in chemistry, biology and French. Within this context, B wished the court to know that she finds it insulting that her ability to investigate treatments, understand them and act responsibly with the assistance of her General Practitioner in relation to her medical treatment is being questioned by a small group of individuals, including her parents, who have taken her to court in an effort to stop her treatment. B further emphasises that the law gives her permission to make her own decision and that is what she has done. Ms Fottrell informed the court that it is difficult to convey B's strength of feeling that her personal story has become highly politicised. B told the Children's Guardian that "I live in two opposite worlds, one in my household where I am seen as less than and the other outside the home where I am calm and grounded."*
>
> *30. Within the foregoing context, the overall assessment of the Children's Guardian is that B is a mature and measured young person who has thought deeply about her situation and want she wants from life, and did not start taking HRT lightly. As I have noted, B has been assessed by Mr McGovern as competent to instruct her own solicitor in these proceedings. Ms Demery entirely concurs with that assessment and does not consider it necessary to seek a capacity assessment of B. Whilst this case turns*

on its own facts, I note the observation of the Master of the Rolls in O v P at [3] that in circumstances where, in that case, the young person in question was agreed to be "impressive, hardworking and intelligent" with no mental health problems, questions as to the young person's mental capacity were unlikely to arise.

31. I acknowledge that the documents before the court evidence B as having had some involvement with CAMHS due to depression and possible ASD. However, the letter of 14 March 2025 from CAMHS confirms, for present purposes, that a consultant psychiatrist is of the view that B experiences gender incongruence with bodily related distress and has recommended intervention from the National Gender Incongruence Service. There is no cogent evidence that B has mental health difficulties to an extent that would impact on her capacity.

Importantly, MacDonald J emphasised that:

32. On the face of it, whenever a parent brings an application before the court asserting that a young person lacks capacity in the context of s.8(1) of the 1969 Act, there will be an "issue" as to capacity. That is not however, by itself, sufficient to meet the test of necessity. In the context of the presumption of capacity in s.1(2) of the 2005 Act, for an expert report to be considered necessary for the purposes of s.13 of the 2014 Act there must be at least some prima facie evidence that the young person in question may lack capacity in the relevant decision-making domains before the court will consider an expert report as to capacity to be necessary to determine the proceedings justly. To hold otherwise would be to undermine the presumption of capacity in s.1(2) of the 2005 Act. There is no such prima facie evidence in this case.

MacDonald J then turned to the basis upon which the application was being made:

33. In support of the parents' application for permission to instruct an expert psychiatrist, Mr Sachdeva and Mr Hadden further submit it would be a too narrow approach to exclusively focus on the physical impact of any hormone treatment via the assessment of an endocrinologist and that, in determining the question of best interests, and whether it is necessary in this case to override B's consent to protect her from grave and permanent harm, the court will need expert assistance on the psychiatric consequences of continuing with gender affirming treatment or withdrawing it, which are an essential component of the Court deciding what course of action is in B's best interests. I am not persuaded by that submission.

34. The parents' argument that the psychiatric consequences of, as they put it, "continuing with an inappropriate, negligently given, life altering treatment or withdrawing it" are an essential component of the Court deciding what is in B's best interests, is based solely on their view that the fact of B's gender incongruence (as now assessed by CAMHS) and the "bridging prescription" she receives, amount to prima facie evidence of grave and permanent psychiatric harm necessitating an expert psychiatric report. However, beyond the parents' strongly held view of what they see as the inevitable result of the treatment B is receiving, there is currently no cogent evidence before the court suggesting that B is suffering, or is likely to suffer, grave and irreversible psychiatric harm such that the court needs an expert psychiatric assessment of her in order to determine her best interests. Indeed, the letter of 14 March 2025 from CAMHS confirms that a consultant psychiatrist is of the view that B experiences gender incongruence

> *with bodily related distress and has recommended intervention from the National Gender Incongruence Service. The assessment of Children's Guardian is that, save for the stress caused by the litigation of these proceedings, B is generally happy and doing well in school. She does not have a forensic history of significant mental health issues and has had limited and appropriate interactions with CAMHS.*
>
> *35. In these circumstances, the parents' submission regarding the need for psychiatric evidence to inform the best interests decision amounts to contending that expert evidence is necessary to assist the court to determine whether B has been misdiagnosed and / or whether gender affirming treatment is psychiatrically harmful generally. There is no evidence to support the former contention. Once again, the evidence in the form of the recent communication from CAMHS reinforces the basis on which her current prescription of HRT is said by her General Practitioner to be justified. With respect to the latter contention, the court is concerned with impact on B of continuing or ceasing gender affirming treatment and not with the psychiatric or psychological consequences of gender affirming treatment generally. B herself does not seek permission for expert psychiatric evidence on the impact on her mental health of ceasing HRT treatment, and I am satisfied that the court can take judicial notice of the fact that, on the evidence before the court, such impact is likely to be a negative one when viewed from B's perspective.*

The Children and Families Act 2014 (we note, in contrast to the MCA 2005 / Part 15 of the Court of Protection Rules) requires:

> *36. Finally, s. 13 of the 2014 Act requires the Court to consider the permission for expert evidence with regard to the impact on the welfare of the subject child. I accept the submission of Ms Fottrell that it would have an adverse impact on B's welfare to direct an assessment that she is vehemently against, and for her to know that there is a psychiatrist considering deeply personal elements of her life before writing a report to be sent to the court in circumstances where there is no evidence that she suffers from a psychiatric illness or lacks capacity in the relevant decision-making domains.*
> *In the foregoing circumstances, I am not satisfied that it is necessary for the court to give permission to instruct an expert psychiatrist in order to resolve these proceedings justly and I decline to do so.*

Endocrinologist

All the parties agreed that an expert endocrinologist required – the dispute in relation to this issue was as to the identity of the expert. For reasons immaterial for these purposes, MacDonald J preferred the expert proposed by the child and the guardian. He also then refused the application by the parents to instruct their own endocrinologist:

> *42. I am not satisfied that it is appropriate in this case also to give permission to the parents to instruct their own expert endocrinologist. Pursuant to FPR 2010 r.25.11(1), where two or more parties wish to submit expert evidence on a particular issue the court may direct that the evidence on that issue be given by a single joint expert in accordance with the provisions of r.25.12, FPR 2010. Whilst FPR 2010 r.25.11(1) is permissive in its terms, Paragraph 2.1 of FPR 2010 PD 25C emphasises the desirability of the court hearing from a single joint expert by stipulating that, wherever possible, expert evidence should be obtained from an expert jointly instructed by both or all the parties.*

> *43. I am not able to accept the submission of Mr Sachdeva and Mr Hadden that cases concerning the medical treatment of children form a special category in which it is the practice to allow a second opinion as a matter of course. Whilst they are able to identify a number of cases which, on the facts of those cases, have resulted in the court acceding to a second expert, there is no provision in the rules mandating such an approach in specified categories of case and no authority was cited to the court in support of such a general principle. In the circumstances, the test for a second expert on the same area of expertise remains that of necessity for the purposes of s.13 of the 2014 Act. It is almost axiomatic that such a test falls properly to be applied after the receipt of the relevant jointly instructed expert report. Accordingly, if following the receipt of the report of Dr Cotterill, the parents can demonstrate that a second opinion is necessary having regard to the issue the court is required to decide, it is open to them to make an application to that end.*

MacDonald J determined the scope of the questions to be asked of the endocrinologist, with a clear eye to:

> *44* […] *the parents tendency to seek to examine wider questions of policy and principle arising from gender affirming treatment, including those they contend arise from the Cass Review and the "implementation" of the recommendations in that report, the questions as drafted by the parents go somewhat wider than I consider is necessary to enable the court to resolve the issue before it justly. To repeat, the issue before the court is the impact on B of continuing or ceasing gender affirming treatment and not the merits and consequences of gender affirming treatment generally.*

Comment

The summary by MacDonald J of the case-law relating to decision-making by older children is clear and very helpful well beyond the confines of this particular case, as are his observations as to the extent to which an assertion of incapacity is (or is not) sufficient to warrant the instruction of an expert psychiatrist.

It is interesting to note that the court in the context of children has to consider the impact of instructing an expert on the welfare of the child – it might be thought that similar provision could usefully be made express in the Court of Protection Rules 2017. Assessment of capacity is not, itself, a neutral matters, a matter that courts have increasingly recognised: see *Re SB (Capacity Assessment)* [2020] EWCOP 43 at paragraph 17, where HHJ Anderson recognised the:

> *real risk to SB's emotional well-being if I allow such an assessment to proceed. SB now says to me that she is content to see another doctor. Therefore, I can assume that if I allow such an assessment she would cooperate. However, I note the evidence of both the social worker and SB's solicitor that SB has engaged less with them since the further work was ordered. She has told her solicitor that she finds questions from professionals distressing. I also take into account the evidence of the social worker that the involvement of a new professional is likely to cause SB distress, as all contact with professionals appears to do. The introduction of a new professional and therefore going over very difficult matters in SB's past, which she has perhaps covered with others, will be likely to cause SB anxiety and distress and increase the risk of emotional harm to SB. It cannot be said that the process will have a therapeutic element. It is purely discussion for assessment*

> *purposes and will not necessarily have any intrinsic benefit to SB.*

And, as a social worker very pertinently put it in *Re RK (Capacity; Contact; Inherent Jurisdiction)* [2023] EWCOP 37 at paragraph 84:

> *This independent spirit, this determination to set her own store has been continuously undermined and undervalued time and time again. R has been assessed, questioned and interviewed repeatedly over the same issues which have left her feeling that her words and feelings count for little. That her views have been ignored or diminished, her experiences, her feelings and more importantly her own decisions, disregarded".*

Making the Court of Protection expressly consider the question of the impact on P of expert assessment (whether in relation to capacity or otherwise) might well be thought to be something which could be a salutary discipline.

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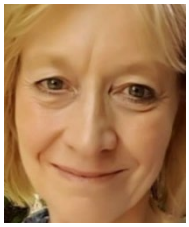

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Conferences

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 September. 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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