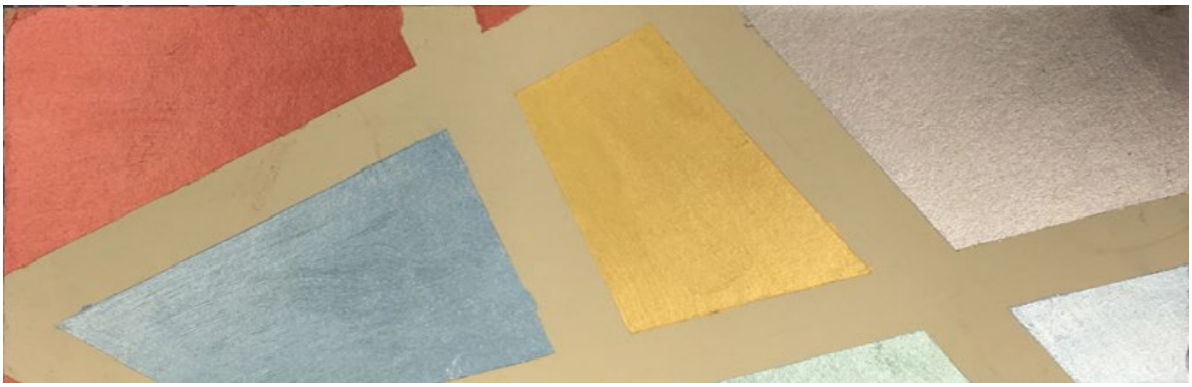


Welcome to the July 2025 Mental Capacity Report. Highlights this month include:

(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.

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

## HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

### Advance decisions to refuse treatment – what (not) to do when it appears one may be in play

*Re AB (ADRT: Validity and Applicability)* [2025] EWCOP 20 (T3) (Poole J)

*Medical treatment – advance decisions*

#### Summary

This is a (rare) example of a court having to grapple with advance decisions to refuse medical treatment. It is rare largely because ADRTs are rare, and also because (in our experience at least), issues relating to ADRTs are usually resolved outside court. The case has a very tangled and complex history, and important issues relating to whether the ADRT in question in fact ever existed in legal terms are still to be resolved. However, for wider and immediate purposes, the judgment is very important for the wider guidance given by Poole J at paragraph 53, in which he notes that:

> *There are few reported judgments concerning ADRTs and none have the unfortunate history of this case. The Trust has rightly accepted responsibility for failing to address the apparent ADRT in a proper and timely manner once it was brought to light. This case provides some important lessons for individuals who have made an ADRT or are contemplating doing so, for their families and friends, and for clinicians and NHS Trusts. They include:*
>
> *53.1 The MCA 2005 Code of Practice, paragraph 9.38 states:*
>
> > *"It is the responsibility of the person making the advance decision to make sure their decision will be drawn to the attention of healthcare professionals when it is needed. Some people will want their decision to be recorded on their healthcare records. Those who do not will need to find other ways of alerting people that they have made an advance decision and where somebody will find any written document and supporting evidence. Some people carry a card or wear a bracelet. It is also useful to share this information with family and friends, who may alert healthcare professionals to the existence of an advance decision. But it is not compulsory. Providing their GP with a copy of the written document will allow them to record the decision in the person's healthcare records."*
>
> *An ADRT will not be effective if the relevant people do not know it exists. In the present case the ADRT had not been placed in AB's medical records or provided to his GP before he sustained his*

*brain injury. AB relied on friends to alert healthcare professionals of the ADRT but they did not do so for nearly four months after his brain damage was sustained. Any individual wanting to make an ADRT would be well-advised both to (i) provide a copy to their GP, and (ii) give clear instructions to anyone else to whom they provide a copy to bring it to the immediate attention of healthcare professionals in the event that the individual is unable to make decisions for themselves about their medical treatment.*

*53.2. Disputes about the authenticity of an ADRT may be rare but provision of the document to the individual's GP would avoid any later allegations that the document was made at a later date than appears on its face.*

*53.3. A signed, written ADRT that is valid and applicable to the clinical situation is legally binding on clinicians. There is no need for a best interests discussion because the patient has made their decision and it is to be treated as if it is their decision at the time when a question of treatment arises. The wishes of the family cannot override a valid and applicable ADRT nor can clinicians' views of the wisdom of the ADRT.*

*53.4. The RCP PDOC Gudelines 2020 state:*

> *"Where there is genuine doubt about the capacity of the patient at the time to make the ADRT or about its validity or applicability, legal advice should be sought and, if necessary, an application made to the Court of Protection." (paragraph 4.5.1)."*

*The Trust's previous internal guidance did not follow the RCP PDOC Guidelines 2020 in this respect. Furthermore, the Guidelines emphasise that clinical teams should request a copy of the ADRT and not rely upon a report of what it says. These documents require careful consideration as Hayden J said in NHS Cumbria CCG v Rushton (above):*

> *"25. Mrs Rushton's circumstances do however provide an opportunity for this Court to emphasise the importance of compliance both with the statutory provisions and the Codes of Practice, when preparing an Advance Decision. Manifestly, these are documents of the utmost importance; the statute and the codes provide essential safeguards. They are intending to strike a balance between giving proper respect and recognition to the autonomy of a competent adult and identifying the risk that a person might find himself locked into an advance refusal which he or she might wish to resile from but can no longer do so. The balance is pivoted on the emphasis, in the case of life-sustaining treatment, given to compliance with the form specified by statute and codes. The Court has highlighted the profound consequences of non-compliance with the requirements: W v M and S and A NHS Primary Care Trust [2012] COPLR 222; Re D [2012] COPLR 493.*
>
> *26. It perhaps requires to be said, though in my view it should be regarded as axiomatic, that the medical profession must give these advanced decisions the utmost care, attention and scrutiny. I am confident the profession does but I regret to say that I do not think sufficient care and scrutiny took place here. The lesson is an obvious one and needs no amplification. Where advanced decisions have been drawn up and placed with GP records there is an onerous burden on the GP to ensure, wherever possible, that they are made available to clinicians in hospital. By this I mean a copy of the decision should be made available and placed within the hospital records with the objective that the document should follow the patient. It need hardly be said that it will rarely, if ever, be sufficient to summarise an advance decision in a telephone conversation."*

*AB's apparent ADRT demanded careful scrutiny as soon as it was brought to light. That ought to have involved some immediate enquiries to ascertain its validity and consideration of its applicability. Once doubts were raised about its authenticity there was a need for an application to the Court of Protection.*

*53.5. A prolonged disorder of consciousness is one in which the patient is unconscious for more than four weeks (RCP PDOC Guidelines 2020, paragraph 1.1). For a patient in a PDOC, in the absence of a known ADRT, those responsible for treating P will need to follow the best interests guidance within the RCP PDOC Guidelines 2020 and within caselaw such as NW London CCG v GU [2021] EWCOP 59. The emergence of a patient from PDOC is of considerable importance and should be recorded only when the criteria for emergence are met and recorded. The importance of a finding of emergence can hardly be understated. It is relevant to decision-making about treatment and best interests, as well as to communications with the family and long-term planning. In the present case it was also crucial to the applicability of the ADRT which the Trust had at the time when it recorded emergence. Accepting Professor Wade's opinion, it is regrettable that professional rigour was not applied at the time when it was wrongly noted that AB had emerged from his PDOC when under the care of the Trust. That error has contributed significantly to delay in identifying and then resolving the issues in this case.*
*53.6. MCA 2005 s25(2) sets out when an ADRT is not valid. A clinician is unlikely to know simply by looking at the document whether it has been subsequently withdrawn, whether it has been rendered invalid by the making of an LPA, or whether P has done anything else clearly inconsistent with the ADRT remaining their fixed decision. The Trust's new internal guidance enjoins a clinician presented with an ADRT to assume that it is valid unless they have doubts about its validity. However, it would be wise for clinicians presented with an apparent ADRT pro-actively to make enquiries - with the family or friends of P if possible - to discover whether there is any evidence that might call into question the validity of the ADRT under MCA 2005 s25(2).*

*53.7. Unless the ADRT is clear, questions as to its applicability under MCA 2005 ss25(3) and (4) and, if the treatment under consideration is life sustaining treatment, s25(5), require careful consideration and may require legal advice to be sought, as the RCP PDOC Guidelines 2020 recommend. If there is unresolved doubt or an ongoing dispute about the validity, applicability and/or authenticity of an ADRT, then it is likely that an application to the Court of Protection will be required. The Trust accepts that it should have made such an application in this case. Instead, CD made the application but her primary concern at the time of the application was not the ADRT but the parts of the Living Will and Letter to Presiding Judge dealing with contact with members of AB's family. Hence the issues concerning the ADRT itself were not promptly brought to the Court's attention until January 2025. The Trust had the resources and experience to make a prompt application for a determination of the validity and applicability of the ADRT and it should have done so. The need to make a prompt application when the validity, admissibility or authenticity of an ADRT are in doubt or dispute is clear: administering a treatment to a person who has refused it through an authentic, valid and applicable ADRT is as unlawful as is providing treatment to a person with capacity who refuses consent to it. MCA 2005 s26(5) allows treatment to be given "while a decision as respects of any relevant issue [relating to an apparent advance decision] is sought from the court" but that is not a reason to delay seeking a decision from the court.*

*53.8. Even if the ADRT is not valid and/or is inapplicable, it may yet be taken into account in a best interests decision. Furthermore, clinicians and P's family may agree that P's best interests coincide with their expressed wishes, even if those wishes were contained in an invalid or inapplicable ADRT. Even if there are disputes about the provision of some treatments, such as CANH, there may be*

> *agreement about others, such as CPR. Hence, ongoing consideration of best interests should not be put on hold whilst the validity and applicability (and indeed, authenticity) of an ADRT is being scrutinised. These are processes that should be followed in parallel with each other.*
>
> *53.9. Any person who questions the authenticity of an ADRT which is ostensibly valid and applicable, or who is concerned that it was made under undue influence, must provide some reasonable grounds for raising those issues. The Courts will not sanction significant delays in resolving disputes about an ADRT without good cause.*

In addition, it is worth noting that Poole J, in considering whether the ADRT in question was svalid and applicable, returned to his analysis in *PW (Jehovah's Witness: Validity of Advance Decision)* [2021] EWCOP 52, and noted that:

> *42. No party has taken any issue with that analysis. In particular, no party suggested that, as a matter of principle, for the purposes of s25(2)(c) the Court should disregard what AB has done after he lost capacity to make decisions about his treatment. Whilst the Courts have to make binary decisions about whether P has or has not lost capacity to make decisions about their treatment, it does not follow that everything P says and does after losing capacity should be disregarded. In a different case a person might lose capacity but still be able to vocalise a desire not to be bound by the ADRT they had previously made. It would be troubling if that was to be wholly disregarded.*

### Comment

Even advance decisions that clearly exist (i.e. where there is no doubt that the person had the relevant decision-making capacity, and was not under coercion) pose ethical dilemmas, as identified in *PW* (and see further here). However, even more problematic is the situation where those involved do not know what questions to ask, or actions to take, in the face of knowledge of a potential ADRT being in play. Poole J's guidance is therefore particularly useful for setting out so clearly what needs to happen.

## Disordered eating and the gaps between services – the consequences for the Court of Protection

*Cwm Taf Morgannwg Health Board v AB & Anor* [2025] EWCOP 24 (T3) (McKendrick J)

*Mental capacity – assessing capacity*

### Summary[1]

This is a judgment about case management in a very difficult case involving a 17 year old with profoundly disordered eating. As the child, AB's mother put it:

> *She is beautiful (inside and out), she is highly intelligent and extremely articulate, with her whole future ahead of her. She is brilliant at art, studies hard at school, and dreams of one day being a paediatric nurse. She is a 17 year old CHILD currently fighting the most horrendous battle of her life that no child should have to face.*

It is of note for two reasons. The first is the intense concern of the judge, McKendrick J, to get to the

[1] Arianna having been involved in this case, she has not contributed to this note.

bottom of whether or not AB had capacity to make the decisions in question. As he noted (in a footnote to the first paragraph of his judgment):

> *The application was issued within the Court of Protection's jurisdiction. Given AB is a child, I have been alive to the possibility of providing clinicians with consent to treat under the High Court's Inherent Jurisdiction in the absence of consent from AB herself. See the succinct expression of the court's protective power at paragraph 2 of Sir James Munby's magisterial judgment in A NHS Trust v X [2021] EWHC 65 (Fam); [2021] WLR 4 WLR 11: "It is conventional wisdom that no child (that is, someone who has not reached the age of 18) has such an absolute right, and that even if the child is Gillick competent (see Gillick v West Norfolk and Wisbech Area Health Authority [1986] AC 112) or, having reached the age of 16, comes within the ambit of section 8 of the Family Law Reform Act 1969, the court, in the exercise of its inherent parens patriae or wardship jurisdiction, can in an appropriate case – typically thought of as being a case where the consequence of the child's decision is likely to be serious risk to health or death – overrule the child's decision, either, as the case may be, vetoing some procedure to which the child has consented or directing that the child should undergo some procedure to which the child is objecting." The fact that this powerful, residual, protective power is available to me, has added to the anxiety that has clouded these proceedings.*

The second was the judge's intense concern as to the gaps that AB appeared to be falling through – and the court was being confronted with – given the intersecting powers, obligations and stances of the multiple public bodies involved, leading to these observations:

> 33. *This application was issued urgently on 27 June 2025. It was heard by the court within hours, out of hours. Orders were made. Further orders were made by Henke J over the weekend. It took up considerable court time in the urgent applications list on 30 June 2025. Further orders were made. It required two further hearings on 9 July 2025. All this judicial time recognised the gravity of AB's condition and the need to have in place a lawful framework to treat her.*
>
> 34. *One can understand the reasoning behind each public bodies' position, to some extent. Wye Valley's role largely ended when AB was discharged from its acute ward. Herefordshire and Worcestershire Health and Care NHS Trust made a good faith attempt to file a witness statement of events rather than a capacity assessment. One can understand there may be a limited role for a community psychiatric team if AB is sectioned and therefore Powys may have a limited role. I accept Powys County Council's limited role until discharge from section. I can also understand the logic of Cwm Taf's position that whilst under 1983 Act detention, the role of this court may be limited.*
>
> 35. *However there are a number of concerning features of this litigation which are individually and collectively caused by the public bodies (although I recognise the very limited role played by Powys County Council). These are:*
>
>  a. *A failure to appreciate these proceedings began as an urgent out of hours application and the hearings and orders made without hearings have all had to be fitted into already very busy court lists. It is especially disappointing to note that orders made have been routinely ignored. Nor have the Court of Protection rules been followed.*
>
>  b. *Whilst AB is currently detained under section 2 of the 1983 Act, she requires an urgent capacity assessment. The chronology seems clear: her capacity appears to have*

*fluctuated and there have been questions over capacity and liability to be detained. There is repeated reference to voluntary admission. She has a complex presentation. Thought needs to be given now, as to whether she lacks capacity in circumstances where her section 2 1983 Act liability to be detained and treated is discharged. Will there be the framework to keep her safe or will there be a further urgent out of hours application?*

c. *It is surprising that two orders from this court to two different public bodies which were made to ascertain this court's jurisdiction, have not been followed. It is concerning that Powys felt the appropriate response was to email the parties letting them know the order would not be complied with, without considering a formal COP 9 to vary the order, as the original section 49 order provided for.*

d. *It is a matter of concern that Cwm Taf are detaining and treating AB and knew of this hearing and had sufficient understanding of the issues involved, yet they did not write to the court to update it or instruct representatives to attend. Nor does it appear to me they adopted a constructive approach to Wye Valley's legitimate attempt to be discharged as applicant and replaced by another public body.*

e. *All in all, the failure of these public bodies to work together is perplexing. They each appear to operate in silos having only regard to their own duties, without any common sense approach to the life of a child, who requires them to work together to protect her.*

f. *Overall, the approach taken by the public bodies has failed to properly respect Mrs CD* [AB's mother] *and AB herself. The lack of common sense thinking appears to have permitted a disregard for the humanity of those involved. Mrs CD's powerful, maternal plea (above) should be re-read by those treating AB and those advising and representing the public bodies.*

36. *The court had anticipated that the Court of Protection proceedings might end. This is clear from orders set out above. However, I unhesitatingly agree with the submissions of the Official Solicitor that AB's capacity is complex. It needs to be assessed. It may provide a life sustaining framework to enable her treatment, should she lack capacity. Aside from post 1983 Act detention issues, it seems to me that whether AB has capacity to consent or not to forced treatment is a fundamental issue which should be properly taken into account when considering her regime under detention and any treatment without her consent pursuant to section 63 of the 1983 Act. Likewise it is also relevant should the court exercise its parens patriae jurisdiction.*

37. *The communication between the relevant public bodies has been sufficiently poor that in the exercise of my quasi-inquisitorial jurisdiction, I cannot accede to Cwm Taf's submission that I stay or conclude these proceedings at the hearing. I do not have the necessary confidence to do so. Furthermore, such an approach would be unfair to Mrs CD. I shall adjourn the matter for the limited evidence as set out above. I add that experience suggests Court of Protection practitioners generally adopt a collaborative approach and the missteps in this matter may have been caused by the urgent nature of the application for variety of very busy professionals.*

## Comment

The problem of silos is one that causes impossible problems and heartache outside the courtroom (one of the reasons why the interface between health and social care has troubled the Law Commission greatly in its disabled children's social care project, and also why the work of the SPROCKET project is potentially so important). It is deeply depressing that resolution – even if only partial resolution so far in this case – sometimes then has to involve the time and resources of a judge being deployed not to resolve questions of capacity and best interests, but rather to act, in effect, as an armed care coordinator.

## Short note: medical treatment, medical advice and capacity (and the inherent jurisdiction)

At points in the very detailed judgment of Theis J in *Blackpool Teaching Hospitals NHS Foundation Trust v GWS & Ors (Capacity)* [2025] EWCOP 23 (T3), the prospect that the court might be invited to make declarations about medical treatment under the inherent jurisdiction loomed. Ultimately, however, the Vice-President found that the 18 year old in question lacked capacity to make the medical treatment decisions in question, leaving tantalisingly open (as other judgments have done) the question of whether and under what circumstances it could ever be appropriate for a court to find a person to have capacity to make the decision, but nonetheless to override that decision by deploying the inherent jurisdiction.[2]

The Vice-President's reasoning in relation to her conclusion that the man, in fact, lacked capacity merits setting out in full as a worked example of the resolution of a complex case:

> *125. I recognise that failure to take on board medical advice per se cannot be sufficient to establish an inability to use and weigh that information but here the decision to ignore medical advice carries clear and high risk of long term disability or death. This needs to be considered in the context of GWS's clear wish to survive and improve his situation in life. The inconsistency between his words and actions also support the conclusion that he is unable to use and weigh the risks he is told about. This is not GWS choosing not to give weight to the harsh realities of his situation, namely acute kidney failure and the risks of discharge when he has nowhere to go. I agree with Ms Roper this is an inability to use and weigh the most critical pieces of information in reaching a decision about treatment and a decision on discharge.*
>
> *126. In reaching this conclusion I am acutely aware of the presumption of capacity, to consider whether any further support can be made available to GWS, the need to avoid the protection imperative or for any conclusion to be outcome led. The evidence demonstrates GWS has continued to be given support with his advocate and there being more consistency in those who speak to him. I do not consider at this stage any further support can be provided. In my judgment, taking the evidence as a whole, I have reached the conclusion, on the balance of probabilities, that GWS is unable to use and weigh the relevant information in relation to the decisions set out above. Even making allowance for the fact that it is not necessary for him to understand all the detail of the information there are salient factors here which involve serious and long-term implications for GWS that he is not using and weighing in reaching his decision.*
>
> *127. Turning to consider the reason for this inability there is, in my judgment, considerable evidence*

[2] Spoiler alert – we think that it is highly doubtful: see paragraphs 27 and 28 of our guidance note on the inherent jurisdiction.

*that GWS is suffering from multiple impairments of his mind or brain within the meaning of s2(1) MCA 2005. He has a confirmed diagnosis of ADHD, clear evidence of PTSD, an ongoing dependency syndrome in relation to ketamine and, possibly, elements of autism although there has been no formal diagnosis in relation to the latter. I agree with Ms Roper that it is the combination of those matters taken together with his current circumstances that creates what she calls the 'perfect storm'. Dr Glover's addendum report made clear he considered there was stronger evidence of PTSD, that the symptoms of that are likely to influence GWS towards misuse of drugs and his relentless determination to access ketamine despite understanding the harm it causes. His conclusion that GWS retained capacity on a fine balance was based on his assessment that he detected little impact of those conditions on his pattern of thinking. However, Dr Glover accepted he did not discuss in any detail the decision about whether or not to have the stent procedure so was not fully able to consider that in the context of the particular decision in question. In the light of what MacDonald J set out in North Bristol NHS Trust v R Ms Roper submits, and I agree, there is not a requirement for a formal diagnosis. The MCA does not require the 'impairment of, or disturbance in' to be tied to a specific diagnosis. The court is not precluded from reaching a conclusion on the question in the absence of a formal diagnosis or the court being able to formulate precisely the underlying condition or conditions. As MacDonald J stated in North Bristol NHS Trust at [48] 'the question for the court remains whether, on the evidence available to it, the inability to make a decision in relation to the matter is because of an impairment of, or a disturbance in the functioning of, the mind or brain.'*

*128. I agree with Ms Roper that on a day to day basis there is much force in Dr Glover's conclusions. The Trust has carried out multiple assessments of GWS's capacity and has reached the same conclusion, that he has capacity. However, having considered all the evidence that position has changed and the evidence supports a conclusion, on a fine balance, that GWS's underlying impairments compounded by his current circumstances are currently preventing GWS from using and weighing the information relevant to decisions about his treatment and discharge. It is acknowledged that a capacitous individual may make a decision in the face of advice even where the outcome is catastrophic. Here there is evidence that GWS is not using and weighing relevant information about the outcome of his decision, such as any stent blockage being symptomless and the life changing consequences of that in circumstances where he expresses a clear wish to live and improve his life. This conclusion is also supported by GWS's approach to the question of surgery, imposing conditions that do not properly use and weigh the medical evidence about the consequences of that. If GWS has such a compulsion to exert control despite those significant risks that, on a balance of probabilities, can only be explicable in the context of and because of his impairments.*

*129. I agree with the Trust that the evidence rebuts the presumption of capacity and GWS does not currently have the capacity to make decisions about his treatment, particularly the treatment to replace his stents, and does not have capacity to decide to discharge himself from hospital prior to that surgery being undertaken. I agree this decision is time specific and should be kept under active and close review.*

## Short note: capacity, best interests and birth arrangements

*Oxford University & Ors v AX* [2025] EWCOP 21 (T3)[3] breaks no new legal ground, but is a decision which is notable for its careful *JB*-compliant analysis of the capacity of the woman in question to make

[3] Tor having been involved in the case, she has not contributed to this note.

decisions about her birth arrangements, and (it being found that she lacked that capacity) of her best interests, taking into account all of the factors required by s.4 MCA 2025.

## Calling medico-legally curious intensivists

An opportunity has arisen for new clinical members to join the Legal and Ethical Policy Unit of the Faculty of Intensive Care Medicine. LEPU (on which Alex has sat since the outset) was founded as an expert panel to advise the FICM on legal and ethical matters. It is comprised of legal professionals from all four UK home nations and ICM clinicians with medicolegal expertise. The Unit falls under the remit of the FICM Professional Affairs and Safety Committee (FICMPAS) but acts autonomously. Its main aims are to identify, review, analyse and act upon legal and ethical matters relevant to the specialty.

The positions are open to any medical professional who has an affiliation with FICM, provided they have relevant medicolegal expertise.

For more details, and to apply (closing date 11 August) see here.

# PROPERTY AND AFFAIRS

## Capacity in the rear view mirror – how does the presumption work?

*Furley Page LLP v KFL* [2025] EWHC 1703 (SCCO) (Senior Court Costs Office) (Costs Judge Whalan))

*Other proceedings – civil*

### Summary

The problem of the retrospective consideration of capacity troubled Costs Judge Whalan in *Furley Page LLP v KFL* [2025] EWHC 1703 (SCCO). The question arose in relation to the detailed assessment of costs due by the defendant (a distinguished – unnamed – barrister who is now living with dementia) to those solicitors acting for him in complex proceedings ultimately leading to the appointment of a property and affairs deputy and the execution of a statutory will (see for a summary: *T & Anor v L & Ors (Inherent Jurisdiction: Costs)* [2021] EWHC 2147 (Fam).

As a preliminary point on the detailed assessment, the point was taken on behalf of the barrister that:

> *At the time of the Claimant's instruction, the Defendant did not have contractual capacity to enter into a contract to retain the Defendant. The Claimant took no steps to establish if the Defendant had contractual capacity prior to acting for him in circumstances where the Claimant knew, or ought to have known that the Defendant lacked contractual capacity. Consequently, the alleged retainer between the Claimant and the Defendant is unenforceable and no costs are payable by the Defendant.*

The solicitors asserted that the barrister had had the capacity at the material time. This meant that Costs Judge Whalan had to engage in a detailed reconstruction exercise both as to the Defendant's contractual capacity at the relevant item, and the solicitors' knowledge of his contractual capacity.

Costs Judge Whalan's judgment is commendably succinct on the key points, reproduced below:

> *40. Capacity is presumed under the MCA 2005 until the party challenging the presumption discharges the burden of proving otherwise. Although the Claimant has referred to a "high burden of proof", the standard of proof is the balance of probabilities. For a party to avoid a contract due to lack of capacity, it is clear, following the Supreme Court judgment in Dunhill v. Burgin (ibid), that the other party must have actual or constructive knowledge of the incapacity. I reject the Claimant's narrow construction purporting to limit the test to actual knowledge only.*
>
> *41. In the extended chronology of this matter, two propositions are tolerably clear. First, that on 15th October 2019, when the Defendant executed a Lasting Power of Attorney for health and welfare, and property and finance, he had the capacity to do so. Second, that by June 2021, when Dr Warner and Professor Howard (experts in the High Court proceedings) conducted a joint meeting, the Defendant no longer had capacity as a result of his dementia. Although the High Court proceedings concentrated necessarily on the Defendant's testamentary capacity, it seems to me that the Defendant's capacity to contract certainly followed a similar trajectory. The Defendant's condition, in other words, deteriorated to the extent that he effectively lost capacity to contract sometime between October 2019 and June 2021. All the evidence I have seen suggests that his downturn was characterised by a gradual, steady deterioration, rather than a precipitous bright-line*

*moment when his status notably changed.*

*42. I am not satisfied that the Defendant has discharged the burden of proving that the Defendant had lost capacity to enter into a contract by October 2020. Indeed, I find as a fact that he had such capacity when the retainer with the Claimant was concluded on 4th October 2020. I am satisfied that the reports of Peterkin Ofori of Mental Capacity Consults in October and November 2020, accurately recorded and assessed the Defendant's capacity as it was at that time. Whatever Mr Ofori's precise status as an expert, he was instructed properly and carefully by the Claimant, who was aware of the Defendant's dementia diagnosis and keen to ensure that he had capacity, and his reports suggest a structured, informed and accurate analysis. The Office of the Public Guardian, moreover, recorded in late January 2021, that it was ending it's investigation, having 'received mental capacity assessments' which found that the Defendant had capacity 'to make their own decisions about their lasting power of attorney (sic)'.*

*43. Insofar as I have noted that the Defendant had lost capacity by June 2021, it seems to me that this represented the first point in time when this conclusion could be justified and stated with any confidence. Although the High Court had made a number of interlocutory orders in April and May 2021 which appear to have been predicated on the Defendant's lack of capacity, a joint experts meeting (Dr Warner and Professor Howard) on 10th May 2021 'failed to yield any clear consensus on key issues relevant to a determination of capacity' (Cobb J, JB 92, para. 16). Accordingly, and doing the best I can on the available evidence, I find as a fact that the Defendant had no capacity to contract from 22nd June 2021.*

*44. It would be hard for the Claimant to argue that it was not affixed with actual knowledge of the Defendant's lack of capacity from, at the very latest, 29th July 2021, when Cobb J delivered his judgment in Re K: T (& Another) v. L (& others) (Inherent Jurisdiction: Costs) (ibid). Indeed, while the Claimant was not instructed in the High Court claim, it seems clear from the parties' respective submissions in this case, that the material produced in the High Court, specifically the medical evidence, was available contemporaneously. To be cautiously clear, however, I find as a fact that the Claimant had actual knowledge of the Defendant's lack of capacity as a contracting party on 29th July 2021. I have seen no persuasive evidence to suggest that the Claimant had constructive knowledge of the Defendant's condition prior to that date. As ever, reaching such absolute conclusions in a case in which bright-line certainty is characteristically absent, is a challenging process. But my conclusions accord with the expert findings and the manner in which this evidence was construed in the High Court proceedings.*

*45. In summary, therefore, the Defendant had capacity to enter into the contractual retainer agreed with the Claimant on 4th October 2020. He maintained such capacity until 22nd June 2021 when, on the balance of probabilities, his dementia had deteriorated to the extent that he no longer had the capacity to contract. The Claimant's solicitors had actual and/or constructive knowledge of this from 29th July 2021.*

## Comment

We would respectfully suggest that it would have assisted Costs Judge Whalan considerably had he been addressed on whether his assumption that "[c]apacity is presumed under the MCA 2005 until the party challenging the presumption discharges the burden of proving otherwise" is correct when considering matters retrospectively. For the reason that Alex has discussed in greater detail in this

paper (which is framed around testamentary capacity, although the principles are the same[4]), he at least would suggest that:

1. The statutory presumption[5] of capacity is 'real time' – i.e. it applies when considering whether the person currently has capacity to make the relevant decision.

2. When assessing the position in retrospect, the question is whether proper doubts have been raised that the person lacked the relevant capacity. The evidential burden then shifts to those person(s) seeking to establish that the relevant capacity was present.

Looking through this lens, the question for Costs Judge Whalan was whether the barrister had adduced evidence sufficient to give rise to proper doubts as to his lack of capacity at the material time. It may well have been that he would have reached the same conclusion, but he would have done so by an analytically different route.

## The forfeiture rule and Dignitas

In an unreported case helpfully the subject of a note prepared by the Counsel involved (the order being here), Deputy Master Bowles confirmed that, where all potential beneficiaries are adult and have capacity and agree to abide by the deceased's wishes in the will notwithstanding the potential application of the forfeiture rule following assistance in enabling a person to travel to Dignitas, their agreement is not contrary to public policy, but will be binding on, and can safely be actioned by, the personal representative, avoiding the need for costly and distressing court proceedings.

## Short note: undue influence and the Supreme Court

In *Waller-Edwards v One Savings Bank Plc* [2025] UKSC 22, Lady Simler (giving judgment for the Supreme Court) made some interesting observations about undue influence. Although they were given in the context of decision-making by a bank about lending, they have wider resonance – in circumstances where it should be remembered that financial abuse can constitute coercive or controlling behaviour as well as domestic abuse.

As she put it in the first paragraph:

> *The law recognises that there are certain (non-commercial) relationships where there is a heightened risk that one party has an undue influence over the other: the husband-and-wife relationship is an obvious example but there are others too. In certain circumstances the vulnerable party to such a relationship (say, a wife) who has been induced to enter into a financial transaction by the undue influence of her husband, is entitled to have it set aside as against the husband. The question that can then arise is whether the undue influence as between husband and wife affects the lender with whom the husband has been dealing, even where the lender has entered into the transaction in good faith and without actual knowledge of the undue influence.*

[4] Not least because the capacity to make a will is, at present, a common law test, in the same way as capacity to enter into a contract.
[5] Technically, of course, it is not a "presumption" but an "assumption" in s.1(2) MCA 2005, but we have it on good authority that the two words are intended to mean the same: Lady Hale when at the Law Commission thought that the latter was easier to understand.

[…]

*6. I should make clear at this stage that, in the discussion below, I refer to the non-commercial relationship of husband and wife, and to the wife as the vulnerable party since that is the fact pattern in this appeal, and an all too common one. However, the same points apply equally to other non-commercial relationships open to abuse and men can also be abused or exploited by their intimate partners.*

She also emphasised that, whilst:

*38.* [i]*t might have been thought that the increased participation of women in the labour market over the decades since O'Brien coupled with an increase in their levels of financial and other independence would mean that the prevalence of economic abuse between women and their spouses or intimate partners has reduced. But the evidence shown to the court in the form of reports and regulatory activity suggests that is wrong. Indeed, a report published by the Financial Conduct Authority suggests that as many as one in six women in the UK has experienced financial abuse by a current or former intimate partner: see "The hidden cost of domestic financial abuse: working together to improve outcomes" by Joanna Legg, 17 May 2024. Legislation and greater regulation in this area suggest an increasing awareness and understanding of economic abuse as a form of domestic abuse (see for example section 1(3) of the Domestic Abuse Act 2021) and its damaging effects.*

## Testamentary capacity – how to identify an unhelpful report

Time may be running out for *Banks v Goodfellow* if the Law Commission's proposals are adopted, but for the moment it remains alive and well. It featured in *Parfitt v Jones & Anor* [2025] EWHC 1552 (Ch). The case is of interest for the fact that, notwithstanding there had been an expert report prepared for purposes of Court of Protection proceedings considering the testator's testamentary capacity in 2024, HHJ Keyser KC found that the challenge to her capacity at the point of making the contested Will in 2008 to have been without merit, such that he suggested that it was "rather unsavoury and disrespectful to the dead to advance what I regard as a groundless case that a clearly capable testatrix lacked testamentary capacity" (paragraph 81). This conclusion was reached, in part, on the basis of HHJ Keyser's analysis of the factual evidence that was before the court about matters in 2008, but his observations about the expert report from the 2024 proceedings merit setting out in full as the issues raised are ones we see too often:

*80.1 I accept that Dr Thompson had expertise to qualify him to give an opinion in the case. However, I do regard his expertise as limited and consider that this lessens the weight to be placed on it. Dr Thompson has a very impressive array of academic credentials, including (among many others) an MPhil in Clinical Psychology and a PhD in dementia assessment. However, it appears that his experience is entirely academic and that he has no experience as a treating psychologist. He certainly has no medical qualification, as was envisaged by the order giving permission for expert evidence. When the question of his professional, as distinct from academic, credentials was raised by those acting for Carolyne, Vicky's solicitor wrote to him as follows:*

> *"It has been suggested that they can find no record of your medical credentials, in particular that you are registered with the GMC and HCPC or British Psychological Council. I am sure that this is not the case and I would be grateful if you could let us have full details of your*

*medical qualifications showing your status to prepare the report."*

*In reply, Dr Thompson referred to his extensive list of qualifications in the report and continued:*

> *"4. You will see that I have considerable expertise in the subject area and that I am a Full Member of the British Neuropsychological Society, Principal Fellow of the Higher Education Academy and registrant of the UK Register of Expert Witnesses.*
>
> *5. I do not belong to the HCPC [the Health and Care Professions Council] which is for practitioners nor am I registered with the GMC [General Medical Council] which is for doctors!"*

*80.2 Dr Thompson did not have the advantage of examining Mary. This necessarily limits the weight that can be placed on his opinion. Indeed, when Dr Thompson was questioned by Carolyne's representatives about the Mini Mental State Examination results in 2006, he accepted that Mary's score was within the expected range but went on to add that MMSE was "a simple and sometimes unreliable measure" and should always be considered together with questioning by a professional and the impression gained by a professional. (He gave a similar response in respect of the results of the 6-CIT examination in 2011.) Dr Thompson never had an opportunity of forming an impression of Mary.*

*80.3 Dr Thompson did not have the advantage of familiarity with the witness evidence. Of course, he could not see the witnesses give evidence at trial, as I have done. But as appears from the letter of instruction and from his report, the documentation provided to him comprised only: the medical records; the statements of case; the Will and the LPA and the documents relating to their preparation and execution (though this will not have included Mrs de Vall's notes, which were only produced at trial); and court orders. If one cannot form an impression of a testatrix from a direct encounter, there is much advantage in doing so from considering the evidence of those who knew her. In addition, there are objective facts (such as the accuracy and cogency of testamentary instructions) that are or might be relevant to the question of testamentary capacity, but the existence or significance of which one is unlikely to be able to assess without reference to the wider body of evidence.*

*80.4 For reasons set out below, I regard Dr Thompson's conclusion as to testamentary capacity as inadequately reasoned and evidenced. I think it was Lord Goff of Chieveley who remarked that an ounce of reasoning is worth a pound of opinion; whoever made the remark, it has much to commend it.*

*80.5 As mentioned above, section 4 of the report contains Dr Thompson's summary of the "main points" in the documents. The only paragraphs that seem to have any possible bearing on Mary's testamentary capacity in 2008 are paragraphs 4.4, 4.5 and 4.6. (Those, indeed, are the paragraphs that Dr Thompson identified, as being relevant to memory problems in 2008, when he responded to questions put by those acting for Carolyne.) The three points in these paragraphs are: (i) memory problems in 2006; (ii) confusion over dates in August 2006; (iii) a diagnosis of dementia in July 2011. I have commented on points (i) and (iii) above and shall do so again below. As for point (ii), the "confusion over dates on 2 August 2006", the document referred to by Dr Thompson is an entry by a practice nurse in the GP records, which reads:*

> *"Telephone encounter with patient slightly confused over dates for inr [International Normalized Ratio: a blood test to assess how long blood takes to clot], book says to have inr taken on 15th but also has appointment on Friday for inr at St Woolos. Advised Friday because*

> *of facial pain and medication dr wants inr to be checked. Appointment given to attend surgery on 15th as per inr clinic instructions."*

*I do not think it reasonable to treat that entry as a genuine piece of evidence relating to testamentary (or any other) capacity. To refer to it as evidence of "confusion over dates" is to give a misleading impression. Those acting for Carolyne asked Dr Thompson whether he agreed "that the confusion is not a general confusion but specific to the fact that Mrs Wadge was given 2 appointments for inr tests within 2 weeks of each other (because she had reported facial pain and was taking warfarin) and was querying whether this was correct." Dr Thompson replied, "Yes, this may have been in respect of dates." I do not regard the entry as having any evidential value on the issue of testamentary capacity.*

*80.6 The answer to question no. 1 (paragraphs 5.1 to 5.4) is, in my view, poorly reasoned and inadequately supported by evidence. There is no doubt that Mary was experiencing memory problems in 2008 and that she was diagnosed with dementia in 2011. Neither fact implies that she had any wholescale inability to make or remember decisions at the earlier or even at the later date. Dr Thompson does not identify the nature of the decisions that he thinks Mary could not make or remember in 2008; he just says that she "did not have the mental ability or capacity to make decisions or to remember important decisions made by her during 2008." As it stands, that is obviously wrong: regardless of whether or not she had testamentary capacity, Mary was plainly able to make some decisions in 2008. Not only is this clear from the evidence as a whole; it is positively stated in the joint assessment of Pam O'Brien and Dr Linton (both of whom had actually examined Mary on several occasions) in November 2012. Dr Thompson does not engage with that assessment. In fact, there seems to be no evidence at all that Mary was incapable of making decisions of whatever sort in 2008.*

*80.7 On the specific issue of testamentary capacity, Dr Thompson correctly referred to the test in Banks v Goodfellow, to which he had been directed in the letter of instruction. However, the reasoning that led to his conclusion is, in my view, unconvincing and indeed opaque. The reason he gives for his opinion is that Mary had memory impairment in 2008. As I have said, and as seems to me to be obvious, memory tends to deteriorate with age; this is especially true of short-term memory, as appears to have been the case with Mary. A degree of memory impairment is capable of being consistent with testamentary capacity. Banks v Goodfellow does not lay down a memory test. Rather it requires (to paraphrase) that the testatrix understand the nature of the act she is performing, the extent of the property of which she is disposing, and the claims to which she ought to give effect. Memory impairment is relevant to testamentary capacity only if it takes away this understanding. The question whether a person had testamentary capacity is one for the court to answer on the basis of all the available evidence. There is, in my view, no evidence that, either when she gave instructions for the Will or when she executed it, Mary was in any way lacking in relevant understanding or had any relevant lapse of memory.*

*80.8 Perhaps because he did not have the benefit of witness statements, but only of statements of case, Dr Thompson did not actually address the question whether there was evidence that Mary did indeed lack the necessary understanding. As I have said, in my view there is not such evidence. Unless one accepts that Mary did not know what she was doing and that the instructions for the Will were given not by her but by Carolyne—which I find not to have been the case—, Mary appears to have understood the nature and extent of her estate; indeed, the defendants have not suggested the contrary. She also appears as a matter of fact to have understood the nature of what she was doing in making a will; and I so find. As for the claims to which she ought to give effect, she was positively scrupulous in identifying those who might reasonably expect to be provided for in the*

*Will. The only serious questions in that regard concern the small provision made for James and the express decision not to benefit Vicky. I have dealt with those matters above. Dr Thompson does not mention them or, apparently, consider them.*

*80.9 A diagnosis of dementia a little more than two years after the Will was made can hardly support a conclusion of incapacity at an earlier time. What is required is evidence of capacity or incapacity at that earlier time. It may, perhaps, be that Mary's memory impairment from about 2006 was due to incipient, undiagnosed dementia. But that, if so, is not the point: the question is not whether there was some incipient, undiagnosed dementia at the earlier time but whether Mary had testamentary capacity. Further, it is surely of significance that, unlike Ron, Mary was not diagnosed with dementia in 2008 or until 2011. It was only in answers to questions by those acting for Carolyne that Dr Thompson engaged with the tests of mental capacity that had indicated the likelihood that, notwithstanding her own concerns about memory deficit, Mary's cognitive functioning was within the normal range well after the Will was made. Even then, his answers (to the effect that the test results are fallible and must be taken in conjunction with the assessment of professionals), while no doubt correct, serve only to highlight his disadvantage in having no impression of his own with which to counter the test results or the absence of any diagnosis of dementia at the earlier dates.*

*80.10 Those acting for Carolyne asked Dr Thompson whether he agreed "that generally most but not all people with mild dementia will retain capacity to make a will". He replied, "No, it is very much on an individual basis. Dementia is complex." This answer only throws the problems with Dr Thompson's evidence into sharper relief.*

# PRACTICE AND PROCEDURE

## The Court of Protection (Amendment) Rules 2025

These Rules were laid before Parliament on 15 July, and come into force on 1 October 2025. They make a number of changes in relation to committal proceedings, especially to pick up the problems identified by Poole J in *Esper v NHS North West London ICB* [2023] EWCOP 29.

Rule 3 amends rule 4.1(4) of the 2017 Rules to remove a defunct cross-reference.

Rule 4 amends rule 21.4(2) of the 2017 Rules, which requires a committal application to give information to a defendant about their rights including their right to silence, to incorporate a requirement to warn the defendant of the risk of a court drawing adverse inferences from that silence if that right is exercised. This follows the decision in Inplayer Ltd. and another v. Thoroughgood [2014] EWCA Civ 1511 and aligns with the position in criminal proceedings.

Rules 5 and 6 amend, respectively, rules 21.7 and 21.8 of the 2017 Rules, concerning hearings in contempt proceedings, in response to the decision in *Esper*:

1. Rule 21.7 of the 2017 Rules is amended to require the court to consider, before the first hearing of any contempt proceedings, whether to make an order under rule 21.8(5) for the non-disclosure of the identity of the defendant in the court list. This is to prevent the utility of any subsequent non-disclosure order being undermined by the prior public notice of the identity of the defendant.

2. Rule 21.8 is amended to provide that the court has a discretion to order the non-disclosure of the identity of any person during contempt proceedings, where certain criteria are satisfied. Currently, the rule mandates non-disclosure where those same criteria are satisfied, but only in respect of a party or witness to the contempt proceedings. Rule 21.8(11A) is inserted to clarify that the court's discretion does not extend to restricting the disclosure of the identity of a defendant who has been convicted and sentenced to a committal order. An amendment to rule 21.8(13) clarifies that the judgment is transcribed and published solely where the court has made an order for committal.

## Disclosing position statements to observers

*Re AB (Disclosure of Position Statements)* [2025] EWCOP 25 (T3) concerns a question of increasing importance given (in particular) the sterling work of the Open Justice Court of Protection Project: namely when and how can position statements be provided to observers? [6] Poole J has rolled up his sleeves, and given the following answer:

> *36. There is presently no guidance on the provision of position statements to observers of Court of Protection hearings. I am told that practice varies and there is some confusion amongst parties, representatives, and observers as to the correct procedure and whether copies of position statements may be provided to observers on request or whether a court order is required. I confess to having taken a less than rigorous approach in the past, simply indicating that I was content for position statements to be provided to observers who had a copy of the Transparency Order. Hence, having been compelled now to take a deeper look at the legal position, pending any formal*

[6] Note: Tor, Nicola and Katie having been involved in this case, they have not contributed to this summary.

*reconsideration of the standard terms of the Transparency Order or changes to the COP Rules, it might be helpful for me to draw some of these threads together and to set out what I believe to be the procedure that ought to be adopted:*

*1. Position statements are documents "put before" the Court within the terms of the Court of Protection template Transparency Order. They also become documents within the court record once filed and they are filed once sent to the court listing office or a judge's clerk or court clerk.*

*2. Parties preparing position statements should foresee that an observer at an attended hearing in public might request an electronic or hard copy and should therefore prepare suitably anonymised position statements which comply with the Transparency Order. I also suggest that it would be helpful to include a warning on the front sheet of the position statement - a rubric similar to that which appears on published judgments, namely that "there is a Transparency Order in force and that irrespective of what appears in the position statement, the Transparency Order must be strictly complied with. All persons, including representatives of the media and legal bloggers, must ensure that this condition is strictly complied with. Failure to do so may be a contempt of court."*

*3. An observer does not have an automatic right to see position statements, whether they are being used in a hearing they are to observe or have been used at a hearing they have previously observed. A change in the court rules and/or relevant practice direction (or to the standard Transparency Order referred to in the practice direction) would be required to create such a right.*
*4. If an observer wants to see a party's position statement they should ask the party in advance of the hearing and state their reason. If they cannot contact a party in advance of the hearing (whether at court or otherwise) they may make the request (with reasons) to the court and that request can be passed on to the party or their representatives.*

*5. When a hearing is in public and a Transparency Order has been made, a party is free to provide a position statement to an observer attending a hearing without requiring a Court direction provided that (i) the position statement does not include the information protected by the Transparency Order and (ii) the observer has been provided with a copy of the Transparency Order so that they are bound by it.*

*6. At a hearing in public, a party must ask the Court for permission to provide a position statement to an observer who has requested it if the document does include the information protected by the Transparency Order, provided that the party is otherwise content to provide it. The Court can then allow a variation of the Transparency Order to allow for the provision of that non-anonymised position statement to that observer at that hearing, if the Court considers that an appropriate step to take without hearing further submissions. That variation should be recorded in the subsequent court order. To re-iterate, the order would be a variation of the Transparency Order for the purposes of a specific hearing and on request of the party or legal representative who would otherwise be in breach of the Transparency Order by providing the position statement to an observer.*

*7. If a party refuses to provide a position statement to an observer on request, the observer may apply to the Court for a direction, as provided for by the standard terms of the template Transparency Order, that they be provided with a copy on such terms as the Court considers fit.*

*8. Such an application need not be made formally under the procedure in COP Rules Part 10. There is insufficient time to allow for a formal written application to be made and the Transparency Order allows for its variation to be made of the court's own motion or on application with no requirement for such an application to be made in writing. That is a much more suitable process for a request*

*by an observer at a hearing. The application may be made orally to the Court at the outset of the hearing.*

*9. The Court will hear submissions by the observer as to how access to the position statement will advance the open justice principle, for example by allowing them to follow the case. If needed, the Court will then hear submissions from the party refusing to provide its position statement as to countervailing factors such as the risk of harm or proportionality. The observer may respond and the Court will give a short ruling and allow the application on such terms as it thinks fit, or refuse it. Dring will be applied.*

*10. If, after a hearing has concluded, a non-party - whether or not they observed the hearing - requests to be provided with a position statement that was used at the hearing, then they should make a Part 10 application under r5.9(2). That process must be adopted because the application should be on notice with an opportunity for the party concerned to respond. The applicant observer will need to make out a case in support of their application. The hearing having concluded, the more immediate, less formal process outlined above will no longer be appropriate. Again Dring will be applied (and see In re HMP below).*

Poole J noted that:

*37. That procedure would be broadly consistent with the approach taken in Moss (above). It is not a straightforward procedure but unless or until there is a change to the rules, practice directions or the standard Transparency Order,*[7] *it appears to me to be the best that can be achieved. For my part, I would add that:*

*1. I am concerned in this case with an application by an observer. The rules, practice directions, and standard Transparency Order distinguish between parties and non-parties, but not between observers and reporters. Hence the same procedures set out above should, in my judgement, apply to applications by accredited journalists and legal bloggers.*

*2. The Transparency Order is the mechanism through which persons are prohibited from communicating or publishing certain information. In most cases it will not be necessary to consider further prohibitions in respect of information within a position statement when deciding whether to permit or direct its provision to an observer at an attended hearing. After all, the position statement is a means of avoiding longer oral submissions at the hearing. In the absence of a written position statement, an advocate would make the same submissions orally and those would be heard by the observer and could be communicated or published provided there was compliance with the Transparency Order. Although it is good practice to prepare anonymised Position statements, I would usually allow a variation of the Transparency Order so that a non-anonymised position statement may be provided to an observer who is at an attended hearing and who has the Transparency Order, rather than insisting on full anonymisation as a condition of provision. The observer will be bound by the Transparency Order. My practice is to refer to P by name during a public hearing with observers present, safe in the knowledge that the Transparency Order prohibits them from communicating or publishing P's identity outside the hearing. If there have been breaches of Transparency Orders by observers, I am not aware of any. I can see that a hard copy*

[7] We would add to this list the Mental Capacity Act 2005, because many of the problem with the sometimes convoluted procedure around transparency orders stem from the fact that there is no adequate protection in primary legislation for the privacy rights of P when proceedings move from private to public (reflecting the fact that the MCA 2005 was drawn up at a time when the idea of routinely holding hearings in public would have struck many as unthinkable).

*of a position statement naming P might be left on a desk and seen by someone other than the observer but, again, if that has happened I am unaware of any such instances. The addition of the rubric I have suggested to the first page of a position statement would add a further reassurance. So the Transparency Order would protect "the information" even if names or other protected information is included in a position statement provided to an observer. If there are a large number of observers then I might vary this practice and insist on a position statement being fully anonymised before provision to observers. Even if every observer were to abide by the Transparency Order, the purpose of protection the information referred to in a Transparency Order would be de facto defeated if, say 50 observers were all provided with that information.*

*4. Some of the submissions received on this issue emphasised the private nature of material within position statements and that the default position for COP hearings is that they be heard in private. However, the great majority of COP welfare hearings are in public and subject to a Transparency Order. Information relayed to the court whether orally or in writing is indeed personal, but the Transparency Order allows reporting and communication of it without undue interference with the Article 8 rights of P and others. That is the balance struck. A hearing that is in public can be attended by anyone who can hear even intimate information about P. I do not believe it necessary to limit the purpose for which position statements are provided to an observer. The answer to the concerns raised is to make an application for the hearing to be heard in private. Upon such an application the Court will consider whether to proceed in public or in private, applying the relevant rules, practice directions and case law. It was submitted that position statements should be provided only to allow for understanding of the hearing but with a prohibition on an observer quoting from them. I do not believe it necessary for the Court to engage in that distinction - the Transparency Order prevents publication of the relevant information. If there is further information included in position statements that requires "protection", then the Transparency Order may need amending, as indeed has been done in this case at the hearing on 22-23 May 2025.*

## Habitual residence, moving jurisdictions and 'lawful authority'

*Re A (Habitual Residence)* [2025] EWCOP 22 (T2) (HHJ Millar)

*International jurisdiction of the Court of Protection – other*

### Summary

In this case, HHJ Millar set out a helpful worked example of determining whether a person's habitual residence has changed following a loss of capacity, and where the move has not been at the behest of professionals, but family members.

As he held at paragraph 13:

*In my judgment the following reasons lead me to the conclusion that A's habitual residence is in Spain;*

a. *He lived and was settled there for 33 years which is a significant period. I accept that there is no evidence that he wished to or intended to return to Wales to live when he had capacity. He chose to return to Spain following his period of ill health in 2018 whilst still suffering complications;*

b. *A was integrated into life in Spain. His permanent home was there. He built a life there over*

*many years. He may not have spoken Spanish to any great extent nor socialised much through choice, but in all other respects his integration was complete;*

c. *He had owned property in Spain. He owns no property in England or Wales. It is suggested that he and B lived in rented accommodation from 2011. This is also a significant commitment demonstrating integration into that community. It is a lengthy duration and was settled, stable accommodation;*

d. *A established business in Spain;*

e. *He held bank accounts in Spain not in the United Kingdom. His finances were operated from those accounts;*

f. *He received health care in Spain. His medical notes from E Hospital record that he 'lives in Spain';*

g. *He obtained residency in Spain;*

h. *It is clear A chose to live and make his life in Spain;*

i. *A played no part in the decision to move him to Wales. I accept he did not understand he was moving permanently to Wales. It is accepted that he lacked the capacity at the time to make that decision. At all times since he moved to Spain and had capacity to decide, it was A's settled intention to reside and make his home there;*

j. *It was not his decision to leave Spain and move to D. He was taken there;*

k. *There is much objective evidence from the records and evidence from his litigation friend that he wished to return to Spain;*

l. *Subjectively the evidence is overwhelming that A was settled in Spain and wished to live there.*

*14. I accept that B and C had no lawful authority to move A to Wales. He had refused to sign a lasting power of attorney in Spain which indicates he objected to others making decisions about him. His permanent removal from Spain was likely to be contrary to his wishes.*

*15. B and C did not act in bad faith. However, options for care in an area wider than the immediate locality in which B and A lived in Spain were not explored.*

*16. I therefore find that A remains habitually resident in Spain.*

## Comment

In relation to paragraph 14, it should be noted that 'lawful authority' does not solely mean authority granted (for instance) under an LPA or court order. In contrast to the position in Scotland, where ordinary residence cannot change absent such express authority,[8] it is possible for 'lawful authority' to take the form of a decision made relying upon the defence in s.5 MCA 2005. For an example of such a

[8] See the cross-border guidance produced by the Law Societies of England & Wales and Scotland;

case, see *Re PO* [2013] EWCOP 3932.[9] However, it is only possible to rely upon this defence where the person(s) doing so reasonably believe that they are acting in P's best interests, which has two consequences:

1. There must be some basis for that belief – i.e. a purely subjective belief that you are doing the right thing is not enough: see *Re QD (Jurisdiction: Habitual Residence) (No 1)* [2019] EWCOP 56 at paragraph 21;

2. It is going to be very difficult to make out the grounds for the defence where the action – as here – is against all the person's known wishes, feelings, beliefs and values, and also where appropriate steps have not been taken to comply with the other provisions of s.4 MCA 2005.

## Cross border mental capacity frameworks: new joint information note from the Law Societies of Scotland and England & Wales

In a coincidence of timing (both projects having been started and running independently, albeit with two common joint participants),[10] the recent publication of the new pan-UK protocol for judicial communications for cases involving adults who lack capacity and accompanying handbook[11] has now been joined by a new information note prepared by the Law Societies of Scotland and England & Wales on cross-border mental capacity frameworks. The information note complements the handbook (for Scotland, England & Wales), the handbook focusing primarily on procedures before the relevant courts and the information note on the legal frameworks more widely.

The information note can be found on the Law Society of Scotland's website here, and the website of the Law Society of England & Wales here.

## Short note: experts blurring the lines

*Liverpool City Council v Ms A & Ors* [2025] EWHC 1474 (Fam) is a case concerning children, but the observations made about the approach taken by the expert are equally applicable in the Court of Protection:

> *13. The united position of all parties is that Dr Parsi di Landrone wholly misunderstood and failed to comply with her instructions as an expert. Most crucially, her conclusions and recommendations were fundamentally flawed by reason of her failure to proceed on the basis of the factual findings made by HHJ Coppel.*
>
> *14. Dr Parsi di Landrone was notified in writing by the parties of their concerns and that they would be seeking for adverse comments to be made regarding her report within this judgment. Dr Parsi di Landrone has attended two hearings before me to deal with this issue and has submitted a lengthy response to the parties' concerns. Within the response, Dr Parsi di Landrone denies that she refused to accept the findings of HHJ Coppel. She argues that in carrying out a psychological*

[9] Albeit that, in that case, Munby J talked of reliance upon the doctrine of necessity. For the reasons discussed at nerdily great length here, Alex is not sure he was quite right to do so.
[10] The common participants being (now Sheriff) Helen McGinty for Scotland, and Alex as one of the contributors for England & Wales on both
[11] As to which see also the Scotland section of this report for a correction to the Protocol.

> *risk assessment she must consider not just historical findings but a wide range of factors including current risk indicators. She opposed being named within any published judgment.*
>
> *15. The Court does not take issue with the methodology for carrying out a psychological risk assessment as set out by Dr Parsi di Landrone in her response. The fundamental difficulty is that contrary to the duties of an expert, Dr Parsi di Landrone did not consider the Court's findings within that broader framework of assessment, but challenged the validity of the findings themselves. It is not a case of different professionals utilising different assessment tools, but a court appointed expert failing to proceed on the basis of the facts as determined by the Court in carrying out the risk assessment as instructed. The Court notes the objection raised by Dr Parsi di Landrone that she was not given an opportunity to respond to concerns before a new psychologist was appointed. However, given the fundamental and pervasive nature of this failing, the Court is satisfied it was not susceptible to remedy through the raising of questions or points of clarification. The Court also has to note that Dr Parsi di Landrone's detailed response, continues to conflate the factual findings of the Court (which are not subject to question or challenge), with the process of assessing current risk.* (emphasis added)

Harris J made clear that:

> *16. In terms of the impact these failings have had on proceedings, it ultimately led to further cost and delay whilst a new psychologist was instructed. The assessment of Mr O had to be undertaken de novo. For those reasons, I am satisfied the fees of Dr Parsi di Landrone should not in principle be met from the public purse. The Court understands that Dr Parsi di Landrone has in fact already been paid in full by the local authority and the legal aid agency for her work. In light of the Court's comments, I would invite her to consider whether she should out of good will return her fee to those public bodies.*

The court, further, went on to name Dr Parsi di Landrone, on the basis that:

> *There is a clear public interest rooted in ensuring the fair, just and efficient administration of family justice that experts should not be anonymised, the more so when their assessments and recommendations have been found to be flawed. The Court observes that experts have clear and important duties to the Court as set out within Part 25 of the Family Procedure Rules 2010. It is vital instructed experts understand those rules and comply with them. If they fail in those duties, it not only causes harmful delay and significant cost to the public purse, but undermines fair, sound and just decision-making by the courts.*

## The impact on P of assessment

We cover the case of *N v N (Expert Evidence on Gender Affirming Treatment)* [2025] EWHC 1325 (Fam) (Family Division (MacDonald J)) in the Children's Capacity section because it concerns a 17 year old. We want to flag it for readers who spend their time thinking about adults as well, though, because of its wider implications for the instruction of experts in the Court of Protection.

# MENTAL HEALTH MATTERS

## Mental Health Bill progress

The Mental Health Bill has now completed committee stage in the House of Commons, with Report stage and Third Reading yet to come. Tim Spencer-Lane has prepared excellent summaries of each day, available here: first day; second day; third day; fourth day; fifth day.

The Joint Committee on Human Rights conducted legislative scrutiny on the Bill, its report being here. The Government has now responded to the JCHR report, essentially justifying decisions to make no further changes to the Bill in light of that scrutiny. One section may be of particular interest to readers of this Report, on the interface between the MHA and the MCA. The JCHR expressed the view that:

> *It is disappointing that the Mental Health Bill has not taken the opportunity to provide greater clarity to the interface between the Mental Health Act and the Mental Capacity Act and to make clear when detention and treatment under one or the other should be authorised. In a legislative scrutiny inquiry like this one, we are not in a position to conclude which of the possible alternative approaches to the interface between the Mental Health Act and Mental Capacity Act would best provide the necessary human rights protection.*
>
> *The Government should, however, carry out an urgent review of the interface between the Mental Health Act and Mental Capacity Act and take prompt action to provide the clarity that is currently lacking.*

The Government's response was as follows:

> *Both the Mental Health Act and Mental Capacity Act provide appropriate procedural safeguards to ensure that the individuals Article 5 human right to liberty and security is protected during their detention. The nature of the safeguards provided under the two Acts are however different. We note the concerns raised regarding the complex nature of the interface between the Mental Health Act and Mental Capacity Act and recognise that in some cases, this may present challenges for decision makers. We will provide guidance on this in the Mental Health Act Code of Practice. We will engage with stakeholders to understand what support and guidance could help clinicians when deciding which of the two Acts must be used or where there is a choice, is most appropriate for individual patients as part of our consultation on the new Code of Practice. We have committed to keep the interface and the matter of fusion legislation under review.*

In relation to the (to many) vexed question of the impact of removing learning disability and autism from s.3 MHA 1983, the Committee noted that:

> *There is an inherent lack of justification for detaining a person for treatment based only on their learning disability or autism, giving rise to clear concerns over compatibility with Article 5 European Convention on Human Rights (ECHR). We welcome the Bill's attempts to remove autistic people and people with learning disabilities from the scope of detention for treatment under the MHA. We recognise that the change in the law would leave open a possibility of these groups being detained on other grounds. We are pleased to see that the Government has committed to monitoring the number of autistic people and people with learning disabilities who are detained under the Mental Capacity Act. The Government should report these numbers to Parliament within a year of the relevant clauses of the Bill coming into force, and stick to their commitment to take action if they*

*indicate that the Mental Capacity Act is being used inappropriately.*

The Government's response is as follows:

*The Department has been clear that we do not want to see people detained in hospital through alternative legislative routes, where this is not appropriate. We therefore do accept this recommendation in part. Through the national Assuring Transformation dataset, NHS England currently collect data on the number of people with a learning disability and autistic people in inpatient settings under different legal frameworks. As the Committee has noted, the Government has committed that ahead of the changes to Part 2, Section 3 we will monitor and publish data on the number of detentions of people with a learning disability and autistic people under the Mental Capacity Act and will include a line on this in our standard publications. As part of standard practice to avoid risk of disclosure of personal information, any figures below five would be suppressed in publications (represented with an asterisk). Should detentions rise to five or more in future, we will publish the number rounded to nearest five. If there is evidence of inappropriate use of the Mental Capacity Act, action will be taken. This must be tailored to and informed by the data and intelligence from local areas.*

## Victim Impact Statements before the Mental Health Tribunal

With effect from 25 June 2025, victims of certain offenders subject to hospital orders with restriction orders (sections 37 and 41 of the Mental Health Act 1983) are able to make a Victim Impact Statement (VIS) to the Mental Health Tribunal or the Mental Health Review Tribunal for Wales ("the Tribunal"). A statement from the Ministry of Justice gives more detail:

*Section 21 of the Victims and Prisoners Act 2024 introduces this new entitlement when the Tribunal receives an application or referral for discharging the patient. The entitlements apply to victims of offenders convicted of a sexual, violent or terrorism offence, and victims can opt into the Victim Contact Scheme (VCS) at any point, even if they have previously opted out.*

*Where a tribunal hearing is due to take place and the victim has applied to attend the hearing (remotely) to read their VIS aloud, section 21 also requires that application be granted by the Tribunal, unless there are good reasons not to.*

*Victims who are eligible for, and engaging with, the VCS will be invited by their Victim Liaison Officer (VLO) to submit a VIS. The VLO will support the victim throughout this process.*

*The VIS allows the victim to explain the impact the crime has had on them and provides the Tribunal with context for any discharge condition requests they make. For example, it may cover:*

*· any physical, financial, emotional or psychological injury the victim has suffered and/or any treatment they may have received as a result of the crime;*

*· if they feel vulnerable or intimidated;*

*· if they no longer feel safe; Title 2 ·*

*the impact on their family;*

*· how their quality of life has changed on a day-to-day basis.*

*The VIS must not include the victim's views on whether the restricted patient should be discharged because the Tribunal cannot take it into account. The VIS will not have any impact on the Tribunal's consideration of whether to discharge the patient; that decision will continue to be made using the existing criteria under the Mental Health Act 1983. The Tribunal will only consider the VIS at the point that they are considering which discharge conditions to apply.*

*A victim who is within the victim contact scheme does not have to apply to attend the Tribunal or lodge a victim impact statement. They can continue to make representations on the conditions the Tribunal may make if the patient is conditionally discharged.*

## The tort consequences of a finding of Not Guilty by Reason of Insanity

The Supreme Court heard the appeal against the decision of the Court of Appeal in *Lewis-Ranwell v G4S Health Services (UK) Ltd & Ors* [2024] EWCA Civ 138 on 15 and 16 July 2025. Alex's summary of the case can be found here – the CRPD point noted in it then featured before the Supreme Court, and he for one will wait with interest to read the judgment when it is handed down in due course.

# CHILDREN'S CAPACITY

## 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' (paragraph 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 make decisions about "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 was 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 matter, as the 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.

# THE WIDER CONTEXT

## Terminally Ill Adults (End of Life) Bill

The Terminally Ill Adults (End of Life) Bill passed Third Reading in the House of Commons, and is now progressing to the House of Lords, where having had its First Reading, Second Reading is now understood to be in September 2025.

Progress of the Bill can be followed on Alex's website, including, most recently a discussion of the interaction between the NHS Ten Year Plan in England and the Bill.

## The Oliver McGowan statutory learning disability and autism training

On 19 June 2025, the Government published its response to the consultation on the Oliver McGowan draft code of practice on statutory learning disability and autism training, as well as the final code of practice. The draft code of practice was published in June 2023. We would note a few points regarding the guidance:

- The Guidance follows a requirement created in the Health and Care Act 2022 that health and adult social care staff at CQC-registered providers must undertake training around learning disabilities and autism. This followed a campaign by Paula McGowan OBE for this legislative change.
- The Oliver McGowan training is not the only form of permitted training, but the Code notes that it is the Government's 'preferred and recommended' training, and it has been trialled with over 8,000 participants. A long-term evaluation is now underway, to take place over the next three years.
- There are a series of standards for training, including the minimum level of one hour of 'live and interactive' training which must be co-produced and co-delivered by people with a learning disability and autistic people and a 90-minute e-learning module.
- There are three 'tiers' of training:

  *The core capabilities frameworks defines 3 tiers of capabilities for health and social care staff:*

  - *tier 1: for staff who require a general awareness of people with a learning disability and autistic people and the support they need*
  - *tier 2: for health and social care staff and others with responsibility for providing care and support for a person or people with a learning disability or autistic people, but who would seek support from others for complex management or complex decision making*
  - *tier 3: for health and social care staff and other professionals with a high degree of autonomy, able to provide care in complex situations and may also lead services for people with a learning disability and autistic people*

  *The core capabilities frameworks are incremental. This means that someone acquiring a tier 3 capability must already possess the relevant tier 1 and tier 2 capabilities.*

- The CQC will hold responsibility for monitoring compliance with the training requirements, and may be subject to enforcement activities if they fail to do so.
- The code is to be reviewed at least once every five years.
- DHSC has commissioned Skills for Care to develop and maintain a list of quality assured training providers that can deliver the training to the adult social care workforce.

## Facilitated communication – the pitfalls

Facilitated communication is described in the NICE Clinical Guideline on Autism spectrum disorder in adults: diagnosis and management as:

> *A therapeutic intervention whereby a facilitator supports the hand or arm of an autistic person while using a keyboard or other devices with the aim of helping the person to develop pointing skills and to communicate.*

The Guidelines expressly provides (at paragraph 1.4.3) "[d]*o not provide facilitated communication for autistic adults*."

In the most recent issue of the Challenging Behaviour Foundation's newsletter, Mary [Busk] and her husband relay how problematic facilitated communication can be in relation to their (adult) autistic son.

## Short note: Care Act support and employment status

In *Scully v Northamptonshire County Council (Contract of Employment for Provision of Care - Direct Payments - Identity of Employer)* [2025] EAT 83, the Employment Appeal Tribunal considered a claim by a Mr Scully of race and disability discrimination and claims for arrears in payment arising out of his work as a carer for 'S,' an adult with a learning disability.

Mr Scully was paid through a Care Act direct payment administered by S's sister, 'V' t; S had an employment contract which was arranged with S's family. S was listed as the employer on both the contract and payslips, despite the finding of incapacity in relation to S. The payroll functions of the direct payment were carried out by a charity commissioned by the local authority, and Mr Scully arrangements around working hours, holiday, etc, were arranged by S's family. It was concluded in the Tribunal that Mr Scully had never received instructions from the local authority in his work.

However, Mr Scully argued that he was in fact an employee of the local authority, Northamptonshire County Council due to the payments they made to S's brother, and brought the claim in the employment tribunal against the local authority. The local authority denied this, and Mr Scully was unsuccessful before the First-Tier Tribunal, which concluded that he was employed either by S, or by S's brother acting on behalf of S. The FTT expressed significant doubt that S had capacity to enter into an employment agreement, and 'that little or no thought was given by the claimant, [V] or S to the employment law implications of the arrangements put in place from 2013.' [14] However, in the absence of evidence, the judge did not make findings on this point.

Mr Scully argued that the Tribunal had erred in law *'by failing to consider…the underlying statutory*

*purpose of the arrangement whereby the claimant was paid for his caring services provided to S, in particular the Care Act, 2014, as well as the possibility of how the employment contract with S might have been vitiated due to lack of capacity. Had he done so, he would have concluded that the respondent was the claimant's employer given that control over S's care was always a function of the respondent's statutory duty (however it chose to discharge that duty)"* (paragraph 16). He argued that the local authority was ultimately in charge of the care provided, and this made the local authority his employer; the contract did not reflect the reality of the situation. Mr Scully argued that V was not lawfully receiving the direct payments as the process in s.32 Care Act had not been followed. He was opposed by the local authority.

The Employment Appeal Tribunal rejected Mr Scully's argument, finding that:

- a local authority could discharge a duty to provide care and support by making a direct payment;
- The making of a direct payment 'neither requires nor implies' direct employment of a carer by a local authority or through an agent (paragraph 35).
- S had taken control of the budget from 2013, and '[t]he arrangements for the care and support of S were fully and accurately reflected in that contract of employment and were consistent with the statutory scheme.' (paragraph 35).
- Mr Scully had not proven any irregularities with the direct payment on the facts, and the burden to do so rested with him.
- In the absence of medical evidence on S's capacity, it was not open to the Tribunal to conclude that S lacked capacity to enter into the contract (which would have in any event been voidable rather than void).

Notably, the EAT made a finding that personal assistants employed by the person receiving direct payments were exempt from CQC registration requirements for those who provide personal care:

> *41. The appellant's submission that the provision of care by him other than as an employee of the respondent would have contravened the provisions of the Health and Social Care Act, 2008 and the Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014 is not correct. In terms of regulation 3 of the 2014 Regulations, read with Schedule 1 (in particular, paragraphs 1(3)(c) and 13(2)(c)), the services provided by the appellant to S were excluded from the scope of regulated activities.*

## Royal College of Emergency Medicine Learning Disability Toolkit

We have only just come across the Learning Disabilities Toolkit from the Royal College of Emergency Medicine. It contains lots of useful information and resources including signs and symbols for typical medical procedures. There is also a very important section on 'soft signs' that someone is unwell, which family or carers are able to pick up on but which could easily be missed by health professionals who don't know the patient. Practical advice is given, including a list of resources and equipment that emergency departments should have, including ear defenders, dimmer light switches, sensory toys, Makaton cards and communication boards. The Toolkit also says that patients with a learning

disability should be prioritised for clinical assessment within their triage category, and flags up additional steps and monitoring that should be undertaken. Lots of the information in the Toolkit will be useful in other settings such as preparing a patient with a learning disability for a planned visit to a GP or hospital.

# SCOTLAND

## Joint attorneys in dispute: appropriate remedies

In almost a quarter of a century since the provisions of Part 2 of the Adults with Incapacity (Scotland) Act 2000, establishing a regime of continuing and welfare powers of attorney, came into force, many adults have been well served – or at least "well enough" served – by that regime. Cases where they have not might be a small proportion of the total, but allegations that they have not been well or appropriately served are not infrequent in total. Each such case is cause for concern. There is no automatic supervision of how attorneys act: that would be a major task, requiring a substantial increase in costs, and effectively defeating one of the main purposes of any such regime of providing an accessible and affordable alternative to guardianship and similar measures, serving the objective subsequently set out in Principle 1.1 of Council of Europe Ministerial Recommendation (2009)11: "*States should promote self-determination for capable adults in the event of their future incapacity, by means of continuing powers of attorney and advance directives.*" Addressing unsatisfactory situations accordingly requires someone either to seek to have the matter investigated by the Public Guardian or the local authority (under sections 6 and 9 respectively of the 2000 Act), or to seek from the sheriff either directions under section 3(3) of the Act, or remedies under section 20.

Sheriff Lugton, sitting at Alloa Sheriff Court, received and has determined such an application in the case of *C v M*, [2025] SC ALL 29, in terms of a judgment dated 20th March 2025 and appearing on scotcourts on 5th June 2025, followed by an ancillary order made on 9th May 2025. The main issues raised in the case are not particularly unfamiliar, but the judgment is to be commended for its careful consideration of several significant points. It is also, however, open to criticism for seeming not to address some apparent omissions.

I shall use the terminology adopted by the sheriff. He referred to the granter of the power of attorney as "the adult". She granted a continuing and welfare power of attorney ("the POA") on 13th May 2015. It was registered with the Public Guardian on 5th June 2015. She appointed two attorneys with both continuing and welfare powers, referred to in relation to the litigation as "the applicant" and "the respondent". They are two of the adult's four sons, the other two sons being referred to as Daniel and Michael.

The POA conferred wide continuing powers on the attorneys to manage the adult's property and financial affairs, which came into effect upon registration of the POA. It provided for the welfare powers to be brought into effect upon issue of a letter or certificate by a medical practitioner, stating that the adult was not capable of exercising the welfare powers, or any of them. The judgment does not provide full details of all the powers conferred. The welfare powers, as described by the sheriff, appear to be unhelpful in addressing situations of partial or fluctuating incapacity in such manner as to comply with section 16(5)(b) of the Act. I explain and comment later in this Report. A major concern, however, arises from the provisions described by the sheriff as follows:

> *"The POA entitles the attorneys to act separately or together, but each informing the other of all actions taken by them as soon as practicable."*

The adult granted the POA shortly after the death of her husband in January 2015. As matters

developed, a serious rift emerged between the applicant and Daniel on the one hand, and the respondent and Michael on the other, though each of the four was different, as regards his actions, his evidence, and the sheriff's assessment of his credibility. The applicant sought orders under section 20 revoking the respondent's continuing powers, and his appointment as continuing attorney, and ordaining the respondent to submit to the Public Guardian accounts covering his tenure as attorney.

The sheriff concluded that in relation to the adult's financial affairs, the respondent's breaches of duty were so serious that it was necessary to make orders under section 20(2) for the purpose of safeguarding the adult's property and her financial affairs; that he could identify no feasible alternative to such an intervention; and that no feasible alternative was canvassed by either party in submissions. See his judgment, and note appended thereto, for his account and analysis of the evidence, and the findings in fact and in law upon which he reached those conclusions. His account of his methodology in doing so may well be of assistance in subsequent such cases.

In his findings in fact and law, the sheriff held that the respondent had breached his fiduciary duty to the adult in several ways. In brief summary, the main points on which the sheriff founded in reaching those conclusions were that the respondent misled the applicant regarding the manner in which he had dealt with income from a property owned by the adult, and as regards the management of the property; that the respondent withdrew £6,000 from a bank account of the adult for the purpose of paying the adult's share of a common repair to the driveway of another property, without informing the applicant and obtaining his views and agreement; and that he transferred funds of the adult held within an ISA to his own bank account, for his personal benefit and to the detriment of the adult's interests, without informing the applicant and obtaining his views and agreement.

However, both the applicant and the respondent breached their duty to act with reasonable skill and care by failing to take reasonable steps to manage and maintain one of the adult's properties, to ensure that it was validly insured, and to make efforts to secure a tenant. In consequence, it was necessary to make orders in relation to both attorneys.

Further findings contained in the judgment, but not in the findings in fact and law, were that: the respondent "took control" of the adult's bank account; and on 28th September 2018 the adult and the respondent signed a Loan Agreement for the purpose of providing funding for a former family business that had been taken over by the respondent and Michael, the funds were transferred, but the applicant was not advised of this arrangement and its implementation.

The sheriff noted that to exercise powers under section 20 the sheriff required to be satisfied (in terms of section 20) that the adult was "*incapable in relation to decisions about, or of acting to safeguard or promote [his] interest in, [his] property, financial affairs or personal welfare insofar as the power of attorney relates to them, and that it is necessary to safeguard or promote those interests.*" The sheriff was also required to comply with the section 1 principles. His approach to complying both with section 1 and with section 20 is worth noting. He concluded that:

> *"It is hard to envisage circumstances in which an order would be deemed necessary to safeguard or promote an adult's interests in terms of section 20, if it did not both benefit the adult in such a way as could not otherwise be achieved, and constitute the least restrictive option available, in terms of sections 1(2) and (3), respectively. Nevertheless, the general principles must be applied*

> *in their own right. Without diminishing their fundamental importance to all interventions made under the 2000 Act, in this context they also serve as a cross-check to the test of necessity for which section 20 provides."*

The sheriff also read section 20 together with section 3. After quoting sections 3(1) and (2), he concluded that:

> *"The import of this is that when making an order the court is not confined to the terms of the applicant's craves, but may make consequential or ancillary orders, provisions or directions if it is appropriate to do so. Just as under section 20, when the court is contemplating making an order in terms of section 3 it must apply the general principles."*

Also of importance is the sheriff's view that if he were to make orders not within powers craved, he ought to give notice to the parties of his intentions, and allow them an opportunity to address him. He did so, as narrated below.

There appears to be an omission in the sheriff's judgment in that the sheriff does not appear to have advanced any basis on which (in the words of section 20(2)) he "is satisfied that the granter is incapable in relation to decisions about, or of acting to safeguard or promote, [her] interest in [her] property or financial affairs"; nor any basis on which he concluded in his findings in fact and in law that:

> *"Since at least 16 January 2019 the adult has been permanently incapable in relation to decisions about, or of acting to safeguard and promote her interests in, her property and her financial affairs."*

He narrates that (paragraph 9 of his judgment) she was diagnosed with Alzheimer's dementia, and he narrates that (14 of his judgment):

> *"On 16 January 2019 the adult's GP assessed her as lacking capacity to act and to make, understand and retain the memory of decisions relating to medical treatment, her welfare and her financial affairs. The GP noted that the adult had very poor memory and recall and that she was not orientated."*

This was coupled with (15 of his judgment):

> *"On the same date the GP issued a Certificate of Incapacity under section 47 of the Adults with Incapacity Act 2000 ('the 2000 Act'). The GP noted that the cause of the adult's incapacity was dementia and that she was likely to be permanently incapable."*

In [10] of his subsequent, and separately numbered, note, the sheriff narrated that:

> *"On 16 January 2019 the adult was certified as lacking capacity by her GP. The applicant confirmed that he had arranged the GP's capacity assessment as a result of concerns regarding the adult's mental health. Later in 2019 the adult was moved to B Care Home."*

Further information is given in the account of cross-examination of Michael. At [74] there is a reference to:

> *"an entry in the records dated 16 January 2018, which read: 'son came in – mother cognitive function deteriorating – wandering / he will try and get permission for home visit.' Michael said that at this time his mother was her usual self – it was possible to have a conversation with her and she would play sudoku and read the paper. Sometimes she was sharp as a tack but at other times she was a little bit forgetful."*

At [76] it is narrated that Michael was referred to an entry in the GP records, dated 16 January 2019, in the following terms:

> *"assessed today at home – memory poor – confused about who was – not orientated in time poor memory – no recall of address – did manage her date of birth and counting backwards but not her age – did not seem to recognise her own dog."*

In the several pages of the judgment under the main heading "Capacity" ([99] to [118]), the sheriff explored the applicable law, and noted the dearth of evidence before him in this case, for example in [107]:

> *"In this case there was a significant gap in the evidence: the adult's GP and treating consultants were not called as witnesses. Similarly, no evidence was led from an independent medical expert in relation to the adult's capacity. While the lay witnesses were asked about various entries in the adult's medical records, those entries were not spoken to by their authors or interpreted by a skilled witness with appropriate qualification."*

He went on to assert [108] that:

> *"It is unfortunate that evidence of this kind was not available, but I do not consider that this precludes the court from determining that the adult lacks capacity for the purposes of section 20 of the 2000 Act. This is because on 16 January 2019 the adult's GP assessed her as lacking capacity to act and to make, understand and retain the memory of decisions relating to medical treatment, her welfare and her financial affairs. The GP noted that the adult had very poor memory and recall and that she was not orientated. On the same date the GP issued a Certificate of Incapacity under section 47 of the Adults with Incapacity Act 2000. The GP noted that the cause of the adult's incapacity was dementia and that she was likely to be permanently incapable. While the GP did not give evidence, the January 2019 assessment of incapacity is admitted by the applicant on record."*

However, on the basis of everything contained in the judgment and note, was the "significant gap" adequately closed? The sheriff may have taken the view that the court was not precluded from determining that the adult lacked capacity for the purposes of section 20, but in a matter as important as this, was there sufficient before the court to determine that the adult was incapable in the comprehensive terms suggested to him. It is difficult to see how he may have felt able to come to that conclusion. There is much evidence about the adult's deteriorating mental health, the diagnosis of Alzheimer's dementia, and the development of symptoms compatible with that, but it is trite that although under the Act a diagnosis of mental disorder is a prerequisite for a finding of incapacity, that is the limitation of its function. By itself, it amounts neither to evidence of incapacity nor a determination of incapacity: see the definition in section 1(5). It is also trite to say that capacity can be different, at different times and/or for different purposes, and in different circumstances. There appears to have

been evidence of such variations, but no clear evidence of the basis for a finding of incapacity, or of such a finding in such comprehensive terms as asserted, or of methods and recording of assessment, all of which would require to have been robust.

Moreover, the accounts of the alleged assessment seem to be closely intertwined not only with questions of diagnosis, but the process of issuing a section 47 certificate, which in these circumstances appears also to have been irrelevant. On the part of some of the witnesses, there is a flavour of various quite common misconceptions about section 47. Only the certifying professional is self-authorised to act under section 47, and only in relation to the proposed treatment specified in the section 47 certificate, though the certifier may authorise others to carry out the relevant medical treatment, either under the certifier's instructions, or with the certifier's approval. The finding of incapacity is only applicable to the particular medical decision. It has no relevance beyond that, and creates no presumption of capacity except in relation to "the medical treatment in question". Thus it has no relevance to any other medical matters, nor beyond that to any other personal health and welfare matters, and plainly not to any aspect of the adult's property and financial affairs.

Where, as here (presumably), attorneys are empowered to make relevant medical decisions, the doctor must consult the attorneys. The usefulness of the section 47 certificate is then that it establishes the adult's incapacity to make decisions about the medical treatment in question, so that the attorneys may either consent or refuse consent on the adult's behalf. That is the basis on which the treatment is authorised, if the attorneys do consent. If they do not, the matter must be referred for determination under section 50.

There is of course nothing novel about the proposition that capacity is task-specific: see for example Bell's *Commentaries*, 6th edition, 1858, page 10: "*The degrees of capacity required by law for different acts are various; and may so far be generally discriminated, that less capacity is required to make a Will or Settlement than to transact a bargain.*" He may have written the same in earlier editions. He was of course an institutional author, so this has the status of a decision on appeal by the Court of Session. Be all that as it may, it is odd that there was apparently no information before the court (or at least, none reflected in the judgment) as to what was the medical treatment authorised by the section 47 certificate, nor whether the attorneys were in fact consulted, nor what was the result.

Reverting to the position described earlier, there appears to have been no "trigger" bringing into operation the welfare powers in the power of attorney, though welfare powers are not in issue. However, although the property and financial powers came into force upon registration of the POA, regardless of capacity, to the extent that the adult's capacity was considered relevant (and it must have been, otherwise it would not have been addressed) there does not appear to have been any evidence of incapacity, nor does the question of undue influence (or other vitiating factors), often more significant than issues of capacity, appear to have been addressed.

For the purposes of this Report I shall only mention very briefly (because they do not appear to have been addressed in this case) the developing concerns about the appropriate interpretation of the 2000 Act in the face of growing understanding of the extent to which "capacity" can be infinitely variable from one individual to another, and for any one individual variable as to subject-matter, over time, in response to circumstances and the provision of support, and so on; and the international trend towards re-

considering whether "capacity" is a meaningful term at all. Against that background, it is to be noted that in the 2000 Act "adult" is defined solely by age, so that that definition applies where "adult" is used without qualification, for example to a large extent in Part 1. It would appear that exceptions in Part 1 prove the general proposition that without words of exception, "adult" is not to be interpreted by reference to capabilities, but only by reference to age. One of the first obvious exceptions in the Act is in section 6(2)(da), which contrasts starkly with the other provisions of section 6(2) in that "adult" is followed by the qualifying words "who is incapable for the purposes of this Act". Powers in relation to section 20 (and in relation to many other provisions outwith Part 1) are explicitly only applicable if the court or other intervener is satisfied that an adult "is incapable in relation to decisions about, or of acting to safeguard or promote his interests in, relevant matters". The sheriff's powers under section 3 are not explicitly so qualified, leaving unresolved questions as to whether (for example) a financial attorney is exercising functions under the Act when acting under a continuing power of attorney where the attorney is empowered to act in the absence of any evidence of impairment if the adult's capabilities, my view being that on balance it would be difficult to argue that such a continuing attorney is not exercising functions under the Act, because there is no requirement under the provisions of the Act to distinguish between actings where the adult's capabilities may to some extent be impaired, and where they are not; or in relation both to some aspects of which the adult's capabilities are impaired and those in which they are not.

Given that any "intervener" (covering the attorneys and the court) has an absolute obligation to comply with the section 1 principles in relation to any intervention, there is little or no evidence from the terms of the judgment that this was done by the attorneys or by the court. The adult was not present or represented at any stage of the proceedings. Any assumptions about her ability or inability to express present wishes and feelings are based, at best, upon untested hearsay. As to the adult's past wishes and feelings, it would have seemed essential to make enquiry into these, including in particular her reasons for granting the POA, and for doing so in favour of the two selected sons. Was she aware of the family rift? Did she consider that appointing those two sons might help bridge the rift? Did she receive appropriate basic advice, including as to the hazards of optimistically making any such assumptions? What precisely were her reasons for instructing the odd wording as to the allocation of powers, quoted earlier? Was she warned of the risk that the attorneys could make incompatible decisions at about the same time, and before either informed the other?

The judgment concludes with a decision to revoke the respondent's appointment as continuing attorney and order the respondent to submit accounts to the Public Guardian for audit for the period from 15th June 2015 to date of the court's order, relating to the respondent's intromissions *qua* continuing attorney. He decided to fix a hearing for discussion of whether the possible ancillary orders outlined in paragraphs [162] – [164] of his note should be made (and also for determination of all questions of expenses). He confirmed that his decision would be sent to the Public Guardian, in accordance with the relevant requirements of section 20. In addition he directed the Sheriff Clerk to send a copy of the judgment to the Procurator Fiscal at Alloa, for consideration of whether a criminal investigation should be instigated. He did explicitly note that in doing so, he recognised he different standard of proof relevant for any criminal proceedings.

At that point, the matter paused, pending the court's decision about ancillary orders. The discussion and outcome evidently proceeded rather differently from the section about ancillary orders referred to

above: that discussion is worth noting and considering by anyone concerned with a similar situation, but because the eventual outcome in this case was rather different, it is not narrated here. For the subsequent proceedings, we have only the ancillary order that was made. It is certainly of interest and relevance for anyone addressing similar situations, but as we have only the order, this Report concludes with simply quoting its terms:

> *"The sheriff, Makes an order under Section 3 of the Adults with Incapacity (Scotland) Act, Directing the Public Guardian to carry out an investigation into the attorneys actings' and the exercise of their functions relating to the property and financial affairs of the adult, namely (removed), from the date of registration of the power of attorney on 5 June 2015 to this date, fully utilising the Public Guardian's powers under Section 6 (2) of the aforementioned Act; Directs the Public Guardian to take any and all measures necessary to safeguard the property and financial affairs of the said adult, upon the conclusion of the investigation; Orders those appointed as continuing attorney on 5 June 2015, namely C and M, to comply with any and all requests made by the Public Guardian during these investigations and to submit an account of their actings' to the Public Guardian for audit for the period 5 June 2015 to date."*

*Adrian D Ward*

## "If at first you don't succeed …": *res judicata* in tribunal proceedings

In May 2024, Scottish Ministers granted a warrant sought by GA's responsible medical officer ("RMO"), under cross-border regulations, for transfer of GA to a hospital in England. In June 2024 the warrant was successfully appealed to the tribunal by GA and her father (GA's named person). Three weeks after that decision the RMO sought another warrant for the same purpose. It was granted by Scottish Ministers in September 2024. GA and her father appealed again. In December 2024, before a differently constituted tribunal, they were again successful, by reference to the doctrine of *res judicata*. That decision was appealed by the RMO to the Sheriff Principal. GA and her father moved for remit to the Inner House, Court of Session. Their motion was granted. The appeal was heard by the Second Division (Lord Justice Clerk, Lord Malcolm and Lord Armstrong) on 11th June 2025. The opinion of the court was delivered by Lord Malcolm, the decision being reported as appeal by Dr Agnes Louise Johnston (Appellant) against GA and another (Respondents), [2025] CSIH 18, 2025 S.L.T. 814. In the SLT report, the Applicant is designated "GA's responsible medical officer". That decision related to proceedings of the Mental Health Tribunal. It is reasonable to suggest that it is substantially relevant to proceedings before other tribunals: cases cited related mainly to such other tribunals. It also seems reasonable to suggest that it is substantially relevant to proceedings under the Adults with Incapacity (Scotland) Act 2000: the main distinction, recognised and addressed by the court in the application of *res judicata*, was between private law proceedings and public law proceedings. Moreover, ever since initial consultation on what became the 2000 Act, the alternative of jurisdiction before a tribunal rather than the Sheriff Court has been almost constantly "on the table", never more so than currently with recommendations by the Scott Review, accepted in principle by Scottish Government, that jurisdiction under the 2000 Act, the Mental Health (Care and Treatment) (Scotland) Act 2003, and possibly also the Adult Support and Protection (Scotland) Act 2007, be combined in a single tribunal.

While the December decision (the decision appealed against) referred to *res judicata* (the matter has been decided), Lord Malcolm preferred *res noviter veniens ad notitiam* (things newly come to light), but

Lord Malcolm made clear that:

> *"It does not follow from the non-applicability of strict res judicata that it is open season for repeated requests to a mental health tribunal until the desired outcome is achieved."*

That firmly rejected "try, try, and try again" in the eventuality that "if at first you don't succeed". The court addressed the question of when it might or might not be appropriate to "try again".

In relation to that question, it is relevant to quote Lord Malcolm's succinct and helpful summary of the findings of the June 2024 tribunal hearing. With numbers inserted for the tribunal's reasons for upholding the appeal, Lord Malcolm narrated that:

> *"Given GA's severe mental disorder, compulsory treatment remained necessary to ensure nutrition and survival. The improvement in her mental health had reached a plateau and the desire of the clinicians was to pass on the care to a suitable specialist unit more capable of addressing GA's complex needs. None had been found in Scotland but one had been identified near London. The tribunal considered it a very difficult case. It concluded that [1] a transfer so far away from family and friends was not the least restrictive option. [2] There had been insufficient investigation into the staff resources and skills available at the London unit to keep the patient safe. [3] None of GA's clinical team had visited it. [4] Reliance had been based on anecdotal comments rather than research into patient outcomes. [5] There had been no rebuttal of inspectors' criticisms. [6] There was no recovery plan should there be a traumatic response to the transfer. [7] The tribunal was not convinced that local solutions had been fully investigated, nor [8] that the benefits of a transfer would outweigh the serious risks for GA. [9] There was no clear evidence that the transfer would provide the patient with the maximum benefit or be in her best interests."*

For those reasons, a cross- border transfer order was refused.

Lord Malcolm's narration in relation to the December 2024 tribunal hearing is equally helpful:

> *"After hearing submissions on the issue, the December tribunal commented that in principle the rationale underpinning res judicata is as desirable in disputes about mental health care as in any other type of case, though they may not apply with their full rigour. The essence of the dispute was whether the anticipated benefits of in-patient care at the London hospital outweighed the practical disadvantages and the identified risks of the move. Material additional to that before the June tribunal had been presented, but it was insufficient to overcome the application of res judicata in respect of the prior refusal of the transfer. Some of the new information was administrative in nature; some did not bear directly on the issues highlighted by the earlier tribunal. Other material pre-dated the June decision. Recent documents vouching regulatory inspections were general in nature. The opinions of the RMO and other doctors were useful background but could have been presented in June. In any event, they did not rebut six of the nine identified particular concerns expressed by the June tribunal." [That is to say six of the nine "particular concerns" as numbered above.]*

The December tribunal referred to the judgment of Andrews LJ in *R (Abidoye) v Secretary of State for the Home Department* [2020] EWCA Civ 1425. He held that an earlier decision will be final and binding on the parties to it unless there is a legal justification for departing from it; but that absent a change in circumstances, material which could and should have been presented to the original tribunal cannot be

relied upon. As to what such legal justification might be, the Tribunal referred to *Ladd v Marshall* [1954] 1 WLR 1489. That test (again as summarised by Lord Malcolm) was that additional material *"(i) could not have been used at the earlier tribunal, and (ii) if given to the tribunal, would have had an important influence on the outcome."* Both (i) and (ii) had to be met. The tribunal held that none of the material upon which the RMO sought to rely met both. Interestingly, Lord Malcolm narrated that: *"the tribunal was sympathetic to the comment that the RMO did not have advance notice of the June tribunal's concerns"*. That seems to imply that the RMO was "caught out" by concerns raised in the course of the hearing. There appears to have been no discussion as to whether it would have been competent, and reasonable, for the RMO to request a short continuation to be able to address them.

See the published decision for a summary of the parties' submissions and the relevant case law.

On the difference between application of *res judicata* in public law matters, and those of *res noviter veniens ad notitiam* in private law matters (and that the boundary cannot always be strictly delineated), Lord Malcolm described the court's conclusions as follows:

> *"The well-established rules of res judicata as they apply to adversarial private law claims cannot simply be transferred to cases of the present nature, nor indeed to many public law claims. The plea is designed to provide certainty when a matter has been finally determined, for example that X can exercise a right of access, or Y has breached a contract. (That said, there are public law examples of this in operation, for instance in respect of a decision that the mental health tribunal had no jurisdiction in the matter, see C, Petitioner 2012 SLT 521.) The result is that the parties cannot re-litigate the same issue. However, with regard to a tribunal required to make decisions which are best for the patient as matters stand at the time, there can be no such finality. And that was not the effect of the June decision; the tribunal could not and did not say that the transfer could never happen. Amongst other things, it commented on evidence which was missing and which might have made a difference. If come December those deficiencies had been remedied, how could one stop the issue being reconsidered by the tribunal?"*

Further:

> *"The tribunal is a specialist body well able, as part of its case management powers, to assess the material relied on by the RMO and decide whether it justified exploration at an evidential hearing. Although not binding in the sense of res judicata, in the event the June decision was highly relevant to the outcome. To have granted an evidential hearing would, in effect, have allowed a repeat adjudication on substantially the same basis as that which occurred in June."*

In *RG v Glasgow City Council 2020 SC 1*, it had been held that in cases of this kind the decision-maker can examine whether proffered evidence does or does not merit the re-examination of findings made earlier in related but different proceedings. The key finding of the December tribunal was that:

> *"the significant concerns raised by the tribunal in its decision in June do not appear to have been met by the material on which reliance is now placed."*

That decision having been made, the interests of justice did not require that it be explored at an evidential hearing.

Lord Malcolm expressed the court's decision succinctly:

> *"While we might not have expressed matters in exactly the same way, we are satisfied that the December decision is not vitiated by a material error in law. It was a decision which the tribunal was entitled to make. It follows that the appeal is refused."*

The following comment would appear to have some relevance. More than once the judgment refers to the "best interests" of the patient. A test of "best interests" was rejected in relation to adults in Scotland, at least for the purposes of the 2000 Act, as long ago as 1995, in favour of a principles-based approach (see paragraph 2.50 of the Scottish Law Commission's 1995 Report on Incapable Adults). I have not been able to identify that "best interests" has nevertheless intruded into the principles in the 2003 Act, or otherwise in a manner which could have been relevant to this case.

It is interesting to note that GA and her father were both parties, and were represented by counsel who made submissions on their behalf. The functions of named persons under the 2003 Act and of nearest relatives under the 2000 Act are different, but it may be noted that while GA had the support of her father as named person in this case, in the case *"In respect of the adult HS"* [2022] SC PAI 24, which we described in the September 2022 Mental Capacity Report, the court removed HS's nearest relative without replacement, and did so without apparently considering the consequences and potential consequences for HS in leaving her with no nearest relative. The item in the September 2022 Mental Capacity Report is entitled "Functions of nearest relative – application under AWI s4".

Upon reading the judgment in the present case, having neither heard what took place nor seen the December 2024 decision, one is left with concerns, and a speculation, that can only be expressed tentatively. The concern is whether we see an example of current attacks on the doctrine of separation of powers by inappropriate attempts to expand executive power by failure to respect the essential role of the judiciary, not because any disrespect is by itself seriously wrong, but because the attitude that is perhaps revealed by this case is fundamentally wrong: that it was wrong in this case that the attitude of the relevant Health Board was to treat the tribunal's function as rubber-stamping what health professionals thought best, without adequate preparation for the first hearing and careful assembly and submission of available material likely to assist the tribunal in discharging its own function. Likewise, the same concern applies both to the Scottish Government granting the second warrant upon submission by the RMO of a further application with no substantially different information, and then – GA and her father again having appealed the second warrant to the tribunal – the Health Board jumping in to contest the appeal to the tribunal against the second warrant, and thereafter further appealing to the courts the outcome of that second determination by the tribunal. All of the foregoing perhaps occurred without either Scottish Government or the Health Board (in their respective roles) considering – with a modicum of humility – the terms of the tribunal decision. The speculation is whether the court aimed at such concerns its pungent comment that it is not "open season for repeated requests to a mental health tribunal until the desired outcome is achieved". The costs incurred by the Health Board must have been significant, and perhaps better applied in other ways.

*Adrian D Ward*

## UK Protocol on Judicial Cooperation amended

In the item in the June Report under this heading we quoted in full Article 2 of the UK Protocol on Judicial Cooperation. We commented on the peculiar wording as regards the references to Scotland

in Article 2.2. It was suggested that the age of adulthood of 16 in the Adults with Incapacity (Scotland) Act 2000 had somehow been "glossed" into 18 by the United Nations Convention on the Rights of the Child (Incorporation) (Scotland) Act 2024. We noted that this was contradicted both by paragraph (b) in the section entitled "Operation of the Principles" of the Protocol, and by the handbook published along with the Protocol. We argued in some detail why Article 2.2 appeared to be wrong. At the end of the relevant item in last month's Report, I wrote: "*I shall be pleased to hear from anyone who disagrees with my interpretation*". So far as I am aware, no-one has sought to dispute it.

Commendably, within a fortnight of having the apparent error drawn to their attention, the relevant senior judiciaries have agreed correction of Article 2.2, and the Protocol as thus amended appeared on the relevant judiciary websites. Article 2 now reads as follows:

> *2. In the Protocol, 'adults':*
>
> *1. for proceedings raised in England and Wales, includes persons who are aged 16 or over (section 2(5) of the Mental Capacity Act 2005);*
>
> *2. for proceedings raised in Scotland, includes persons who are aged 16 or over (section 1(6) of the Adults with Incapacity (Scotland) Act 2000); and*
>
> *3. for proceedings raised in Northern Ireland, includes persons who are aged 16 or over (section 1(1) of the Mental Capacity Act (Northern Ireland) 2016.*

Lady Wise announced the change at the launch of the Protocol on 24th June. Also, she intimated that Sheriff Joan Kerr, lead AWI sheriff in Glasgow, is Scotland's liaison judge for the purposes of AWI cases.

Both commended the work of Helen McGinty (now Sheriff McGinty) on the handbook, and Sheriff Kerr expressed her pleasure that Sheriff McGinty would be joining her in Glasgow Sheriff Court.

*Adrian D Ward*

# 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 and the European Court of Human Rights. 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 2019). 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.

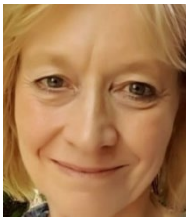
Nyasha Weinberg: Nyasha.Weinberg@39essex.com

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

## Scotland editors

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 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.

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