WEBINAR: WHOSE DECISION IS IT ANYWAY? NAVIGATING TREATMENT DECISIONS AFTER THE TOWNSEND JUDGMENT

12 March 2026

Ian Brownhill
Jenni Richards KC
Katie Scott

DECODING TOWNSEND, WHAT DID THE COURT ACTUALLY DECIDE?

12 March 2026

Ian Brownhill

WHAT I'LL COVER

- The *very* basics
- Paragraph 68 – Traffic lights
- Paragraphs 69 and 74
- Three ways of reading it?
  - Maximalist
  - Continuing treatment
  - Aligning health with welfare

THE VERY BASICS

- *TOWNSEND v EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST* [2026] EWCA Civ 195
- Appeal heard by the COA, following refusal of *granting permission to bring* proceedings by Theis J, VP: s 50(2) MCA 05.
- In April 2025, Mr Barnor (Mrs Townsend's father) collapsed after suffering a stroke, further strokes followed, he sustained extensive and irreversible brain damage. He never recovered consciousness. He was in PDOC/TDOC. Family considered he was demonstrating improvement but agreed he lacked capacity to make decisions re his treatment. Three "second opinions" agreed.
- Professor Turner-Stokes in her opinion had said to the treating clinicians, "*It is first up to the clinical team to decide which treatments are on offer. A clinician may decide that a given treatment would be futile or clinically inappropriate within the particular context of a patient's presentation, in which case they are under no obligation to offer it, and such decisions are made routinely as part of everyday clinical practice."*
- In short, a clinical decision was made that Mr Barnor should not be offered further dialysis.

PARAGRAPH 68 – TRAFFIC LIGHTS

68. The following principles are therefore clearly and consistently established by the case law and professional guidance.

(1) All decisions about incapacitated adults, including clinical decisions, have to be made in the patient's best interests, taking into account all relevant circumstances and taking the steps identified in s.4 of the MCA.

(2) If all parties (including family members, treating team and, if obtained, second opinion) are in agreement that it is not in the patient's best interests to continue life sustaining treatment, then this can be withdrawn without application to the court.

(3) If, at the end of the clinical decision-making process, there is disagreement between any of the parties that cannot be resolved by discussion and/or mediation, then the matter should be referred to the Court of Protection.

(4) If a court application is required, the NHS commissioning body with overall responsibility for the patient should bring and fund the application.

(5) In exercising its powers to make declarations and orders about the patient's best interests, the Court of Protection cannot compel the doctor to give a treatment that he or she considers clinically inappropriate.

PARAGRAPH 69

69. Any decision about the care and treatment of a mentally incapacitated adult, including the withdrawal of life-sustaining treatment, must be taken in the patient's best interests. There is no carve out for “clinical decisions".

Issues:

1. Best interests decisions vs clinical decisions vs commissioning decisions
2. Has it been that there has been a long term conflation of clinical and best interests decisions? (Hence the advice from Professor Turner-Stokes)
3. Was it, for Mr Barnor, a best interests decision all along?

PARAGRAPH 74 – WAS THIS CASE ACTUALLY ALL ABOUT THE REFUSAL TO GRANT PERMISSION?

Once proceedings have been started, however, the judge will exercise their case management powers as the circumstances require. Many of these cases are very urgent and, as proposed by Lady Hale in N v ACCG in the context of a refusal to fund treatment, it is open to the Court to use its case management powers to adopt an abbreviated process. That again is a matter for the Court to determine, not the parties. In cases such as Mr Barnor's, where the view of the treating team and the second opinion experts is that continuing treatment is clinically inappropriate, the Court will scrutinise the evidence to determine whether withdrawal or withholding treatment is in P's best interests. In many, perhaps most, cases, the Court will conclude that it is not in P's best interests for treatment to continue, and it may reach that conclusion swiftly. In no circumstances can the Court compel the doctors to provide treatment that they consider clinically inappropriate. But the decision is for the Court, not the clinicians

THREE WAYS OF READING IT: MAXIMALIST

- Many people have taken the judgment and focussed on paragraph 69. There can be no clinical decisions about a person who lacks capacity (presumably around their treatment). Everything is a best interests decision.
- If that is right, it may lead to odd situations, in particular in respect of experimental treatments, or treatments not ordinarily funded by the NHS – this has always been the role of judicial review.
- However, best interests decision making as a concept is fixed in respect of available options. Here, was it that *actually* continuing the treatment was an available option and continuing the treatment was prolonging his life?

THREE WAYS OF READING IT: CONTINUING TREATMENT

- More I read the judgment, more I think that the focus on paragraph 69 is unfortunate. Paragraph 74 is, in my view, more important.
- Is the ratio of the judgment really focussed on cases where treatment is already being given and then is being taken away. The argument being, how can treatment that is already being given, not be an available option? That ties back in to the SMT guidance, the decision in GUP v EUP & Anor [2024] EWCOP 3.
- Is it therefore just wrong to focus on paragraph 69 and think about the judgment holistically? Is it really about continuing or withdrawing treatment already being provided.
- Maybe but then, why the comments re *N v A CCG*…

THREE WAYS OF READING IT: ALIGNING HEALTH WITH WELFARE

- Really common issue before the CoP is to explore why other alternative options are not available, especially in cases involving deprivation of liberty. The Supreme Court was very clear, you cannot simply say we will not commission an alternative, the court has the right to probe.
- Again, is paragraph 69 a red herring? Actually, are SMTs being aligned with welfare cases where the court, can, probe why something is not available even if it cannot compel the clinicians to provide it?

WHOSE DECISION IS IT ANYWAY? NAVIGATING TREATMENT DECISIONS AFTER THE TOWNSEND JUDGMENT

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Jenni Richards KC

WHAT DOES THE ESTABLISHED CANON OF CASELAW TELL US?

- In the Supreme Court:
  - *Aintree University Hospitals NHS Foundation Trust v James*
  - *An NHS Trust v Y*
  - *N v A CCG*
  - *Montgomery v Lanarkshire Health Board*
  - *McCulloch v Forth Valley Health Board*

- In the Court of Appeal:
  - *R (Burke) v General Medical Council*
  - *AVS v A NHS Foundation Trust*
  - *R (JJ) v Spectrum Community Health CIC*

AINTREE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST V JAMES

- [2013] UKSC 67, [2014] AC 591
- First case under the Mental Capacity Act 2005 to come before the Supreme Court
- COP proceedings issued by hospital trust seeking declarations that it would be in Mr James' best interests for specified treatments (invasive support for circulatory problems; renal replacement therapy; CPR) to be withheld “in the event of a clinical deterioration".
- Judge decided against making the declarations sought; the Court of Appeal allowed the trust's appeal.
- Supreme Court held that the fundamental question is whether it is lawful to give the treatment, not whether it is lawful to withhold it [20]-[22].
- The Court provided guidance as to the approach to assessing best interests [39]: including consideration of welfare in widest sense, the nature of the medical treatment, what it involves and prospects of success, and the likely outcome of the treatment.

AINTREE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST V JAMES

- Note [18] of Baroness Hale's judgment: *"This Act is concerned with enabling the court to do for the patient what he could do for himself if of full capacity, but it goes no further. On an application under this Act, therefore, the court has no greater powers than the patient would have if he were of full capacity. The judge said [2012] EWHC 3524 at [14]: 'A patient cannot order a doctor to give a particular form of treatment, although he may refuse treatment. The court's position is no different.'"*
- And at [45]: *"The purpose of the best interests test is to consider matters from the patient's point of view. That is not to say that his wishes must prevail, any more than those of a fully capable patient must prevail. We cannot always have what we want."*

AN NHS TRUST V Y

- [2018] UKC 46, [2019] AC 978
- Concerned whether an application had to be made to the court in every case where clinically assisted nutrition and hydration (CANH) was to be withdrawn (answer – No [126] – but [109] *"if a dispute has arisen and cannot be resolved, it must inevitably be put before the court"*; see to similar effect [125])
- At [92] Lady Black recorded: *"It is also important to keep in mind that a patient cannot require a doctor to give any particular form of treatment, and nor can a court: see, for example, R (Burke) v General Medical Council [2006] QB 273, paras 50,55, and the Aintree case [2014] AC 591, para 18."*

N V A CCG

- [2017] UKSC 22; [2017] AC 549
- Dispute between the parents of a young person with severe learning and physical disabilities and the CCG over the CCG's refusal to provide or fund the care package preferred by the parents
- At [1] in Baroness Hale's judgment: *"The decision has to be that which is in the best interests of P. But it is axiomatic that the decision-maker can only make a decision which P himself could have made. The decision-maker is in no better position than P. So what is the decision-maker to do if he has reached the conclusion that a particular course of action is in the best interests of P but the body who will be required to provide or fund that course of action refuses to do so?"*

N V A CCG

- At [35]: *"So how is the court's duty to decide what is in the best interests of P to be reconciled with the fact that the court only has power to take a decision that P himself could have taken? It has no greater power to oblige others to do what is best than P would have himself. This must mean that, just like P, the court can only choose between the "available options"."*
- Discussion of the CoP's "case management" powers at [40]-[42]
- At [44]: *"This was … a case in which the court did not have power to order the CCG to fund what the parents wanted. Nor did it have power to order the actual care providers to do that which they were unwilling or unable to do. In those circumstances, the court was entitled to conclude that, in the exercise of its case management powers, no useful purpose would be served by continuing the hearing."*

MONTGOMERY V LANARKSHIRE HEALTH BOARD

- [2015] UKSC 11, [2015] AC 1430
- *Montgomery* and the subsequent Supreme Court decision in *McCulloch* are not cases about the Mental Capacity Act/Court of Protection: they are clinical negligence cases which concern the extent and nature of the clinician's duty to provide information and advice to patients.
- They do however say something relevant to any analysis of the implications of the *Townsend* judgment
- *Montgomery* concerned the failure of a clinician to tell a pregnant, diabetic woman who was having a larger than usual baby about the risks of shoulder dystocia in vaginal delivery.

MONTGOMERY V LANARKSHIRE HEALTH BOARD

- In concluding that a duty to provide such information arose, the judgment of Lord Kerr and Lord Reed (with whom all other Supreme Court justices agreed) includes the following observation (underlining added) at [87]:

  "An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken. The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments."
  (see also the reference to *"available treatment options"* at [95])
- Baroness Hale in her concurring judgment at [115] noted that the patient *"cannot force her doctor to offer treatment which he or she considers futile or inappropriate".*

MCCULLOCH V FORTH VALLEY HEALTH BOARD

- But see also [109] in *Montgomery* where Baroness Hale recognised that *"it is not possible to consider a particular medical procedure in isolation from its alternatives. Most decisions about medical care are not simple yes/no answers. There are choices to be made, arguments for and against each of the options to be considered, and sufficient information must be given so that this can be done."*
- This question of alternative treatments fell to be considered by the Supreme Court in *McCulloch v Forth Valley Health Board* [2023] UKSC 26, [2024] AC 925: the issue was the extent to which a doctor was under a duty of care to advise the patient about alternative treatments and the legal test to be applied to the assessment of whether an alternative treatment is available and requires to be discussed

MCCULLOCH V FORTH VALLEY HEALTH BOARD

- At [57]-[58]: *"A doctor will first seek to provide a diagnosis (which may initially be a provisional diagnosis) having, for example, examined the patient, conducted tests, and having had discussions with the patient. Let us then say that, in respect of that diagnosis, there are ten possible treatment options and that there is a responsible body of medical opinion that would regard each of the ten as possible treatment options. Let us then say that the doctor, exercising his or her clinical judgment, and supported by a responsible body of medical opinion, decides that only four of them are reasonable. The doctor is not negligent by failing to inform the patient about the other six even though they are possible alternative treatments. The narrowing down from possible alternative treatments to reasonable alternative treatments is an exercise of clinical judgment to which the professional practice test should be applied."*

MCCULLOCH V FORTH VALLEY HEALTH BOARD

- *"The duty of reasonable care would then require the doctor to inform the patient not only of the treatment option that the doctor is recommending but also of the other three reasonable alternative treatment options (plus no treatment if that is a reasonable alternative option) indicating their respective advantages and disadvantages and the material risks involved in such treatment options."*
- *"It is important to stress that it is not being suggested that the doctor can simply inform the patient about the treatment option or options that the doctor himself or herself prefers. Rather the doctor's duty of care, in line with Montgomery, is to inform the patient of all reasonable treatment options applying the professional practice test."*
- (see also [59] *"deciding what are the reasonable alternative treatments is an exercise of professional skill and judgment"* – for professional read "clinical")

MCCULLOCH V FORTH VALLEY HEALTH BOARD

- See also the endorsement of observations by the BMA and the GMC at [67]-70] regarding the importance of clinical judgment in determining reasonable alternative treatment options, which are described by the court as providing *"strong support for the view that the determination of reasonable treatment options is a matter of medical expertise and professional skill and judgment"*
- And [71], rejecting the argument that the law should require a doctor to inform a patient about an alternative treatment which that doctor (exercising professional skill and judgment and supported by a responsible body of medical opinion) would not consider to be a reasonable medical option.
- And [77] the concern about defensive medicine *"with the doctor advising on all possible alternative treatment options, however numerous or clinically inappropriate they may be"*

R (BURKE) V GENERAL MEDICAL COUNCIL

- Turning to the Court of Appeal – the decision in *Burke* [2005] EWCA Civ 1003, [2006] QB 273 concerned the lawfulness of guidance issued by the GMC which addressed withholding and withdrawing life-prolonging treatment and in particular the withdrawal of CANH
- See [31] (addressing the position of the patient with capacity) *"The proposition that the patient has a paramount right to refuse treatment is amply demonstrated by the authorities … The corollary does not, however, follow, at least as a general proposition. Autonomy and the right of self-determination do not entitle the patient to insist on receiving a particular medical treatment regardless of the nature of the treatment." (*The Court went on to explain why it considered that a common law duty to provide CANH will ordinarily arise).

R (BURKE) V GENERAL MEDICAL COUNCIL

- At [50] the Court endorsed the following propositions:
- **(i)** The doctor exercising professional clinical judgment decides what treatment options are clinically available (i.e. will provide overall clinical benefit) for the patient
- **(ii)** The doctor then offers those treatment options to the patient, explaining risks/benefits etc
- **(iii)** The patient then decides whether he wishes to accept any of those treatment options and if so which
- **(iv)** If he chooses one of the offered options, the doctor will provide it

R (BURKE) V GENERAL MEDICAL COUNCIL

- **(v)** if he tells the doctor he wants a form of treatment the doctor has not offered *"the doctor will, no doubt, discuss that form of treatment with him … but if the doctor concludes that this treatment is not clinically indicated he is not required (i.e. he is under no legal obligation) to provide it to the patient although he should offer to arrange a second opinion."*

AVS V A NHS FOUNDATION TRUST

- [2011] EWCA Civ 7 – a patient suffering from sporadic CJD – refusal of permission to appeal
- This was *"a case about providing medical treatment for a patient who has been declared to lack capacity to make decisions as to his treatment and care. The problem in the case is that at the moment there is no medical practitioner ready and willing but also able to provide the treatment which the patient's next friend considers should be given to him"* [1]
- The patient had been treated with PPS through a pump subcutaneously implanted in his chest and there was a *"very tenable view"* that this had prolonged his life
- There came a point at which the pump failed and infusion of PPS ceased

AVS V A NHS FOUNDATION TRUST

- The hospital refused to undertake the necessary surgery to replace the pump and was not willing to continue treatment with PPS, the clinician explaining his assessment that the patient's current condition was now so poor that any further treatment with PPS was futile; the patient was in or near a vegetative state; the evidence of benefit from PPS in patients with sporadic CJD was weak and there was no evidence in literature that PPS could benefit a patient in a vegetative state. In short the clinical view was that there was no benefit in replacing the pump or resuming the infusion of PPS.
- Concluding that the litigation was going nowhere, the court reiterated the *"trite"* position that the court will not order medical treatment to be carried out if the treating physician/surgeon is unwilling to offer that treatment for clinical reasons conscientiously held by that medical practitioner [35]

AVS V A NHS FOUNDATION TRUST

- And at [38]: *"The harsh fact is that, although Mr NT and Professor R are willing to replace the pump, there is no evidence of their present ability to do so. No hospital has been identified where that surgery can be undertaken. Without a new pump being inserted, there is nothing Dr P can do This litigation is going nowhere. What the court is being invited to do is no more nor less than to declare that* ***if*** *a medical practitioner is ready, willing and able to operate and* ***if*** *a medical practitioner is willing, ready and able to replenish the supply of PPS, then it would be in the best interests of the patient to do so … Without that evidence that someone is "able and willing to take over the care of [the patient] and treat him with PPS", we are dealing with a purely hypothetical matter. A declaration of this kind will not force the respondent hospital to provide treatment against their clinicians' clinical judgment."*

R (JJ) V SPECTRUM COMMUNITY HEALTH CIC

- [2023] EWCA Civ 885, [2024] PTSR 1: case concerned a prisoner - full capacity to take treatment decisions - required to be fed by a care team due to physical disabilities - wished to eat the food of his choice; healthcare provider refused to feed him foods which posed elevated risks of aspiration or choking
- At [55]-[57] (drawing on *Montgomery* and *McCulloch*): *"The question in this appeal is whether, when a patient wishes to choose treatment that is not clinically recommended and therefore not offered, that patient can nevertheless require the clinician to provide the treatment in question. In my judgment, the law is clear: a clinician cannot be so compelled. A patient may only choose between the treatment options that are available to him, although as between those available options he or she may choose one which the clinician believes to be the least inappropriate or even positively ill advised."*

R (JJ) V SPECTRUM COMMUNITY HEALTH CIC

- And see [65]-[68] – the Court distinguishing withdrawal of treatment cases from JJ's case, which was concerned with the provision of treatment – and the unequivocal No to the question of whether there is a common law right of autonomy which allows a patient to demand, and obliges a clinician to provide, *"medical treatment that is not offered to that patient by their doctors"*
- And [70]-[72]: the fact that the healthcare provider made clear that it would comply with any order or declaration made by the court did not convert the case from one in which the option was "off the table" as a treatment option and could not therefore be chosen to one in which the option was merely "ill-advised" and capable of being chosen

MEDMOUNE V FRANCE

- Recent decision of European Court of Human Rights
- *Affaire Medmoune c. France (55026/22), 5 February 2026*
- NB judgment available only in French
- Decision to withdraw life-sustaining treatment, despite the individual having drawn up advance directives stating that he wished to continue to be kept alive (even artificially should he lose consciousness permanently and be unable to communicate with family
- Claim under Article 2 did not succeed

MEDMOUNE V FRANCE

- At [48]: *"Furthermore, the court reiterates that when it comes to the withdrawal of life-sustaining treatments, reference must be made, in the context of examining a possible violation of Article 2, to Article 8 … while Article 8 guarantees the right to personal autonomy as an element of the right to respect for private life, it does not oblige Member States to give binding legal effect to advance directives … Furthermore, the Council of Europe guide "on the decision-making process relating to medical treatment in end-of-life situations, which should be taken into account … indicates that "autonomy does not imply a right for the patient to receive any treatment that he/she may request, in particular when the treatment is deemed in appropriate, since the decision regarding health care results from the meeting of the patient's wishes and the assessment of the situation by a professional subject to his/her professional obligations and, in particular, those arising from the principles of beneficence and non-maleficence, as well as justice"."*
- See [53]-[58] for a description of the decision-making process followed by clinicians in that case

DISCUSSION

- Nothing in the Townsend judgment suggests the Court was deliberately seeking to depart from any of the relevant Supreme Court or Court of Appeal judgments: indeed the Court appears to have considered that its approach was consistent with the various authorities to which it referred
- At the very least, however, there is (a) a tension between Townsend and the line of authorities referred to above; (b) a lack of clarity about what the Court is saying; (c) a real concern that the judgment trespasses upon the sphere of decision-making that, under established principles of public law, are reserved to the public bodies whose responsibility it is to provide services and treatments
- Some of the practical implications will be explored in the next talk – but perhaps worth emphasising that the ramifications of the judgment are not limited to clinical decision-making: decision-making about social care packages, direct payments, fitness for discharge from hospital may all be encompassed by this approach

WHAT DOES THIS MEAN FOR PRACTITIONERS AND THE FUTURE OF THE COURT OF PROTECTION?

12 March 2026

Katie Scott

WHAT DOES THIS MEAN FOR PRACTITIONERS?

- Can those advising Trust's and other public bodies ignore the decision?
- Immediate steps – training front line professionals about the difference in decision making dependant on whether the patient/service user has or lacks capacity in relation to the decision at hand.

IN THE EVENT OF A DISPUTE

- Mediation and other forms of ADR
- Timely second opinion
  - Share with the family
- If no agreement can be reached a COP application will be necessary.
  - Even if you are not willing to offer/fund the treatment/care package

WHAT TO INCLUDE IN THE COP APPLICATION

- Evidence that the person lacks capacity to make the decision in respect of which there is a dispute
- Evidence that there is a dispute that requires resolution.
- The decision making process undertaken by the public body. Must cover two stages:
  - First what the treatment is, why the particular clinician or team is not prepared to provide that treatment and the reasons for that.
  - Second, the BI stage – evidence that s.4 has been complied with and what the decision on BI is with reasons or balance sheet.

- The steps taken by the public body to ascertain whether another public body/clinician would make the treatment/service available

WHO IS TO BRING THE APPLICATION?

For disputes about medical treatment – it is to be the NHS commissioning body responsible for the patient

- W/d of patients in nursing homes in PDOC – going to be the ICB.
- Less clear who this is for a patient in hospital.

  - Hospital trust not commissioning bodies.
  - Are all these claims to be brought by the ICB for the area in which the patient lives?

WHAT WILL THE COURT DO? THE PROCESS

- Paragraph 74:
  - The decision as to the process is for the Court to determine, not the parties
  - It might only be an *"abbreviated process"*
  - The Court may reach decision that the treatment is not in BI swiftly
- What does this mean?
  - Will it be necessary to have oral evidence from the clinician?
  - Will it be necessary to have oral evidence from second opinions/experts?
  - Can this be determined on oral submissions only?
  - Can it even be determined on the papers on the basis of written submissions?

WHAT WILL THE COURT DO? THE ROLE OF THE COURT

- The role of the court is to "*scrutinise the evidence to determine whether withdrawal or withholding treatment is in P's best interests*."
- Clear that the Court can use case management powers to probe the decision that the treatment is not being offered however the Court cannot compel clinicians to undertake treatment they consider to be clinically inappropriate.
- It is axiomatic, that it must be open to the Court to determine that a treatment or option that is not on offer, is in the patient's best interests.

AND IF THE COP MAKES A DECISION THAT THE UNAVAILABLE OPTION IS IN THE PATIENT'S BEST INTERESTS – WHAT THEN?

- Public body/clinician must consider the Court's decision i.e. effectively re-take the decision taking into account the Court's view on BI.

- Advisable to record the conclusion of this, with reasons, in case JR proceedings brought. Need to be able to defend on public law grounds

- This process necessarily leads to examination of individual clinician's decisions on what they are and are not prepared to do, as opposed to BI decisions which are by their nature collective
  - Consider how to protect individual clinicians

SOME ISSUES TO THINK ABOUT (THERE WILL BE LOTS MORE.....)

- What if a P has no family. Is the clinician to engage an IMCA to consult with under the MCA in respect of a treatment that they are not willing to provide in order to meet with the requirements of MCA and BI decision making?

- What if Court says a treatment that is not on offer is in the patient's BI, family find someone who is willing to give the treatment, but the patient cannot be moved?
  - Does Trust have to allow treatment to be provided in their hospital?
  - Do they have to pay for it?

FURTHER SHOCKWAVES

- **INTERNAL GUIDANCE AND POLICY**
- All public bodies providing care and treatment to incapacitated people need to review this to ensure compatibility with the decision.

- **PROFESSIONAL GUIDANCE**
- There is a range of medical professional guidance that will require re-writing in light of this decision, not least:
  - Royal College of Physicians 'Prolonged Disorders of Consciousness following Brian Injury' 2025
  - BMA - Best interests decision-making for adults who lack capacity toolkit

AND FINALLY PARAGRAPH 86

- *Finally, it is clear from the arguments advanced in this case, including those set out in Profesor Turner-Stokes' report quoted above, that there continue to be grave concerns amongst professionals about the procedure to be followed in these cases. I am aware that very substantial medical and legal resources are taken up by treating patients in PDOC. There are plainly arguments to be made for a different approach. But that can only come about after a proper process of careful assessment and consultation**. It may be that this will be incorporated in the revised Code of Practice which is anticipated shortly**. Until that happens, these cases must be conducted and managed in accordance with the MCA and procedure specified in case law and existing guidance.*

Not according to **Re Y**

QUESTIONS?