Essex CHAMBERS

MENTAL CAPACITY REPORT: COMPENDIUM

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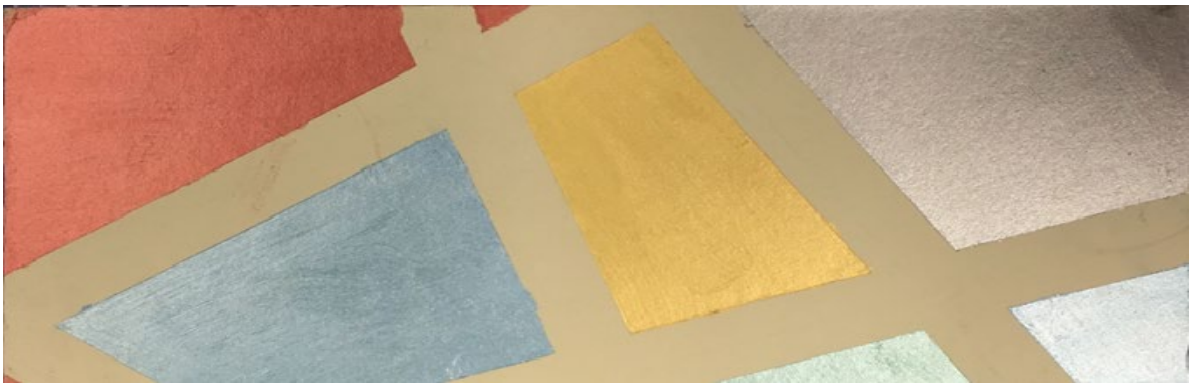

Welcome to the May 2026 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: *Townsend* updated, sex before the Court of Protection again, and a profoundly disturbing report on dementia in acute hospitals;

(2) In the Property and Affairs Report: new OPG investigation requirements and the consequences thereof;

(3) In the Practice and Procedure Report: importance guidance on instructing experts, when habitual residence can be revisited, and a very useful new book on coercive control;

(4) In the Mental Health Matters Report: the legal gaps for those in mental health crisis in ED and misunderstandings of the MCA in the mental health context;

(5) In the Children's Capacity Report: deprivation of liberty of children in statute and in unregulated placements and what procedural fairness (does) not require in assessment;

(6) In the Wider Context Report: the MCA and suicide, and new guidance on consenting to clinical trials.

(7) In the Scotland Report: an update on the new AWI accreditation programme being run by the Law Society of Scotland.

We offer our hearty congratulations to Sir Stephen Cobb on his appointment as President of the Family Division and of the Court of Protection. For anyone who wants reassurance that the new President truly 'gets' the Mental Capacity Act, we suggest reading his judgment in the case of 'Stitch,' his last decision as a Tier 3 judge of the Court of Protection.

A reminder that that whilst Chambers have launched a new and zippy version of our website which may look unfamiliar, all the content that you might need – our Reports, our case-law summaries, and our guidance notes – can still be found via here.

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The picture at the top, "*Colourful*," is by Geoffrey Files, a young autistic man. We are very grateful to him and his family for permission to use his artwork.

Contents

HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

Townsend

The Trust has sought permission to appeal this decision to the Supreme Court (it is now identified as *Barnor-Townsend v Epsom and St Helier University Hospitals NHS Trust*); see here.

Ceilings of treatment in context

Royal Free London Hospital NHS Foundation Trust v RH & AH [2026] EWCOP 18 (T3) (Peel J)

Best interests – medical treatment

Summary

This application related to 'RH,' who was 35 years old. The Trust sought orders to set ceilings of treatment on RH's renal replacement therapy, mechanical ventilation and attempts at CPR. The clinicians would be allowed to escalate beyond these ceilings of treatment if clinically indicated, but would have the court's consent not to do so. This position was broadly supported by the Official Solicitor acting on behalf of RH, and opposed by RH's mother, AH.

RH had a history of liver disease for which he had received significant treatment since childhood (including a liver transplant in his teen). Sadly, RH developed liver cancer in 2024, and his health deteriorated further. In December 2025, he had a further liver transplant, which was a complex procedure involving major bleeding. His health deteriorated further the surgery, and even following multiple rounds of invasive intervention, 'by the end of February/beginning of March 2026, RH was critically ill, very frail, experiencing delirium and ongoing abdominal sepsis infection, requiring mechanical pressure ventilation by a tracheostomy, intravenous nutrition and antibiotics. He was subject to an ongoing large bile leak. He was permanently bed bound. Thereafter, RH deteriorated further with oxygen desaturations, rising inflammatory markers, worsening renal functioning and fluid overload. He had a collapsed lung and required an emergency bronchoscopy.' [17] An MDT in February 2026 concluded that RH was dying, and the decision 'was to carry out no further or new interventions (vasopressors, renal replacement therapy, significant increase in ventilator support and cardiopulmonary resuscitation), but ongoing treatment would continue.' RH then deteriorated further in March 2026, and clinicians did not think any other treatment options were available. RH's family opposed his being put on a palliative care regime and asked the hospital to make a court application. Notably, the hospital's decision to bring an application appears to have been based at least in part on the *Townsend* decision in the Court of Appeal:

> *22… The doctors received legal advice in the light of the* ***Townsend*** *case that treatment should be given to save life while the dispute was resolved and accordingly vasopressors for blood pressure support, and renal replacement therapy were instigated, along with the mechanical ventilation. The introduction of RRT caused significant blood loss. But within two days, RH was weaned off mechanical ventilation, and placed on a relatively low sedative dose. For a few hours on 24 March 2026, the sedative was completely stopped, but RH said he was in pain and it was restarted.*

However, the hospital ultimately confirmed that it was willing to make the treatments available if ordered by the court, and Peel J considered that the effect of *Townsend* on the present case was 'marginal' (paragraph 56).] The judgment did not engage with *Townsend* or make any findings in respect of it.

Further evidence was sought on capacity in light of concerns that RH was sedated and had fluctuating states of consciousness and delirium – RH did not appear to have any pre-existing conditions to his severe deterioration which would have led to his capacity to be challenged. When further evidence was obtained, RH was so unwell and struggling to sustain consciousness long enough to discuss his care that the parties ultimately agreed he lacked capacity.

On best interests, the clinical evidence was that RH was in multi-organ failure, was dying and was experiencing pain or discomfort when being administered the treatments for which the Trust sought ceilings of care. AH held the view that RH would recover and felt he was much improved since receiving renal replacement therapy. She considered that he was experiencing discomfort but did not think he was in pain. She considered he would want as much time with his family as possible, and would want as much treatment as possible.

Peel J accepted the unanimous evidence that RH had no prospect of recovery, and the family's hope was for a medical miracle which in the judgment of the court "*can be all but discounted*" (paragraph 48). Peel J considered that "[t]h*e medical context of this application is therefore RH's irreversible condition, his progressive deterioration and his very short life expectancy*" (paragraph 48). Peel J did not consider it appropriate to treat the current care as a 'threshold' from which care should be considered, and the matter needed to be looked at holistically. RH did not appear to be in intolerable pain, but was experiencing pain and discomfort on interventions. His current overall picture was one of drowsiness and low consciousness. Peel J accepted that continuing time with his family was a benefit to him, but

> 52. [s]*et against the benefits to RH and his family of their precious times together are the many current and potential future burdens of invasive treatment. Nobody disputes that RRT, mechanical ventilation, vasopressors (maintained by a central line), and other intravenous-based treatment are burdensome. He, in my judgment, experiences not just discomfort, but confusion, delirium and pain as well, particularly from mobilisation; I did not hear from any nursing staff but they are recorded as being very concerned about the pain he feels when being moved. These aggressive treatments will become more invasive, more burdensome and less tolerable as he deteriorates. He will be less conscious, more delirious during waking times, and less able to interact with his family. Such treatment would be futile and would prevent him from being able to spend his final time with his family in a peaceful setting away from the ICU. To prolong life would, in my judgment, exacerbate suffering.*

Peel J approved the palliative treatment plan.

Comment

This case did not ultimately engage with the issues thrown up in the *Townsend* judgment, but is notable as the first reported case to have been brought before the Court of Protection specifically on the basis that the hospital had considered it was obliged to do so by the decision of the Court of Appeal.

Sex, contact and capacity

Lancashire County Council v BC & Anor [2026] EWCOP 18 (T3) (Poole J)

Mental capacity – sexual relations

In this case, Poole J was concerned with a woman, BC, in her early 30s who was born into and brought up in an ultra-orthodox religious community. BC began her relationship with EF, who also came from the same ultra-orthodox community, some ten years ago. The key issues for Poole J to decide were whether BC had capacity to make decisions about residence and engagement in sexual relations.

BC was diagnosed with "*autism spectrum condition, complex PTSD, cerebral palsy, partial deafness, R*[a]*ynard's deafness, R*[a]*ynard's syndrome, diplegia and agoraphobia*." An independent expert confirmed her agreement

with the diagnosis of autism spectrum condition and complex PTSD, which, for her, was characterised by hypervigilance, periods of dissociation, emotional dysregulation and thoughts of suicide and self-harm. The expert concluded that:

(i) BC was unable to make decisions about this litigation or to conduct proceedings;

(ii) BC had capacity to make decisions about residence, provided that the options presented to her are capable of meeting her care and support needs. She lacked capacity to make decisions about her care and support;

(iii) BC may gain capacity over time in relation to decisions about her care and support, and that capacity should be re-assessed in all areas in six months' time;

(iv) BC lacked capacity to make decisions about contact with others;

(v) BC had capacity to engage in sexual relations, however she might lose this capacity in a dissociative state;

(vi) BC had capacity to manage her property and financial affairs.

In her oral evidence, the expert said that BC was likely to dissociate in any and all sexual encounters.

Poole J set out the legal framework for assessing capacity under the Mental Capacity Act 2005 and the relevant case law. In relation to capacity to engage in sexual relations, Poole J set out the relevant passages from the Supreme Court's decision in *A Local Authority v JB* [2021] UKSC 52. In relation to residence, care and contact, Poole J drew on helpful and well-established guidance in *LBX v K* [2013] EWHC 3230. In relation to all of the domains, Poole J emphasised that capacity is decision-specific and must be assessed in relation to the specific decision at the time the decision needs to be made.

In conclusion, Poole J accepted that the presumption of capacity was not displaced in relation to BC's decision-making about her property and financial affairs. His Lordship also agreed with the parties that it was established by the evidence that BC lacked capacity to conduct proceedings, and to make decisions about her care and support and contact with others. However, his Lordship also wished to *"sound a note of caution"* in relation to contact:

> *BC has decisions to make about contact with carers and staff at GG or, if she were to leave, elsewhere; contact with others in the community; about contact with her family; and about contact with EF. With regard to contact with others, I believe that, without dividing up the area of decision-making too finely, a declaration of incapacity should not overreach. In my judgement, the evidence does not support a finding that BC lacks capacity to make decisions about contact with others which do not engage concerns about her safety or vulnerability to abuse from others. Dr Camden-Smith's opinion about BC's capacity to decide on contact with others was grounded on BC's "inability to identify when she is not safe from others, and her inability to understand abuse." Thus, it is not proved that BC lacks capacity to decide on contact with others when there are no such issues, for example, going into a shop to buy an item.*

Thus, in relation to contact, Poole J was only willing to make interim declarations of incapacity with a view to her capacity being re-assessed in the future. Furthermore, he also limited his declarations of incapacity to contact with others

where such contact might involve issues of her safety and vulnerability to abuse from others.

In relation to residence, Poole J found that the options for residence were inextricably linked to decisions about care and support and contact with others. BC could not weigh or use for herself information relevant to decisions about residence such as who would be living there, what the contact arrangements would be at any placement and what care and support would be provided. Thus Poole J found that BC lacked capacity to make decisions about her residence.

Regarding sexual relations, Poole J recounted that BC generally had capacity in relation to engaging in sexual relations but was liable to lose capacity in the moment due to dissociation. His Lordship considered the case law in relation to fluctuating capacity. He noted that, in the present case, the decision that BC faced regarding sexual relations was person-specific: it involved her partner, EF. She had not had sexual relations with anyone else for a decade or so and had not expressed any wish to have sexual relations with anyone else. Poole J held:

> *This is not a straightforward case but, in my judgement, it has not been established that BC is unable to decide to engage in sexual relations including with EF even though, at present, she lacks capacity to decide on contact with him.*

Although Poole J accepted that BC would remain at risk of losing capacity in the moment of sexual relations if she were to dissociate, that risk was not sufficient ground to rebut the presumption of capacity. Furthermore, although his Lordship had not received any evidence or submissions on BC's best interests, he stated that it was *"clear that a TZ style plan would support and protect her until she is in a position to make decisions about contact with EF for herself"*.

Comment

Whilst not setting down any new principles or guidance, this is an interesting case for considering the various "domains" when it comes to mental capacity and, in particular, their interaction with each other.

On the one hand, the judge took a somewhat broad and intersectional approach to the issue of residence, finding that it was so intertwined with issues of care and support and contact with others (in respect of which BC lacked capacity), that BC also lacked capacity to make decisions about her residence. Indeed, counsel for BC had argued that it would not be practicable for decision-makers to divorce decisions about residence from decisions about care and support and contact with others. Counsel for the Official Solicitor sought clarification on this point following circulation of the draft judgment as the independent expert had advised that, if BC were presented with two placements which met her assessed needs, she could choose between them. Poole J put it this way:

> *I accept that if all matters concerning care, support and contact with others… were made on her behalf, there may be residual matters concerning residence which BC could decide for herself, but so much of the information relevant to decision-making on residence would be beyond her ability to understand, retain and weigh or use, that I do not believe it would be correct to call what was left, an ability to make decisions about residence. As I have already noted, it is unhelpful to identify "the matter" for decision too narrowly.*

On the other hand, Poole J raised the apparent incongruence between BC's capacity in relation to contact with EF and capacity to engage in sexual relations:

> *It is not disputed that this inability includes an inability to make decisions about contact with EF. How then could BC have capacity to decide to engage in sexual relations with EF? In Hull CC v KF [2022] EWCOP 33 I observed that it was difficult to see how a person who lacks capacity to decide to have contact with a specific person could have capacity to decide to engage in sexual relations with that person*

Ultimately, the correct approach to be taken has to be carefully informed by a close appraisal of the factual circumstances and the degree to which there is overlap. As Poole J recognised:

> *The apparent paradox that troubled me in Hull CC v KF (above) arises from (i) the comparatively low bar that is set for capacity to engage in sexual relations which is itself a product of the prohibition on making best interest decisions about engagement in sexual relations; and (ii) the different information relevant to decisions about contact and decisions about engagement in sexual relations. In some cases such as Hull CC v KF, there will be such a large overlap of the reasonably foreseeable consequences of making a decision or not making a decision about contact and making or not making a decision about engaging in sexual relations that it would be inconsistent to find that P had capacity to engage in sexual relations with a specific person but not to decide to have contact with them. In other situations a person may be unable to make decisions about contact but able to decide to engage in sexual relations with the same person. Here, for example, concerns have been raised about BC's ability to understand and weigh or use information about financial control and emotional abuse but she may simultaneously be able to understand and weigh or use all relevant information concerning engagement in sexual relations.*

Short note – advance statements and 'risk feeding'

In *Barking, Havering and Redbridge University Hospitals NHS Trust v AS & T* [2026] EWCOP 15 (T3), Peel J considered an application for declaration that it was in the best interests of a woman identified as AS to continue 'at risk feeding', and to place her on a palliative care approach to ensure her comfort before discharging her from hospital, back to the community. The application was opposed by her family, who wished for her to have all treatments, including either nasogastric (NG) or PEG feeding.

In June 2025 AS had signed an 'Advance Statement' in which she stated that in the event she lost capacity and her health became poor, she would '*want all treatments and care necessary to prolong*' her life.

AS suffered a massive stroke a little over two months later. She was provided with an NG tube for several weeks, but this was then removed. She was assessed as having an impaired swallow. The plan was for 'at risk feeding', which was carried out both in the community and during AS's several stays in hospital over the following months. During one of those hospital stays, AS refused the re-insertion of the NG tube. She was assessed to have capacity to make this decision.

AS was re-admitted to hospital at the beginning of 2026. She was by then very frail, with reduced oral intake. She was assessed as lacking capacity to make decisions about her medical treatment. The Trust made a decision that (i) further NG feeding was inappropriate, and that (ii) the risks of a PEG outweighed the potential benefits and so was also inappropriate. By the end of February 2026 the Trust had taken the

view that IV fluids should also cease due to the risk to AS of fluid overload. AS was by this stage refusing oral intake and she was thought by the clinical team to be at the end of her life as a result of natural disease progression.

Peel J heard evidence from the treating consultant geriatrician (Dr G) that as a result of AS having a swollen gut, her ability to absorb feed and derive nutritional benefit from clinically assisted nutrition and hydration (CANH) was much reduced. CANH would likely cause her to suffer from diarrhoea, in circumstances where she already has broken skin on her buttock, and this would likely exacerbate dehydration and require uncomfortable repositioning, which in turn would increase the risk of pressure ulcers. Further risks from NG feeding included vomiting and regurgitation (which AS had suffered when she was considerably less frail) and refeeding syndrome. In short, it was Dr G's view that NG feeding was unlikely to prolong life and could shorten it. Further, it would not rehydrate AS, as the fluids from the IV fluid were already leaking into her tissues.

Peel J accepted (i) that AS's severe neurological and brain injuries were incurable and irreversible, and the cause of her presentation; and (ii) the risks of NG feeding were likely to occur and would represent an intolerable burden to AS who was extremely frail.

With respect to AS's wishes and feelings, Peel J accepted that the Advance Statement represented her wishes at the time that it was made, but took into account the evidence that since that time AS had made it clear that she found the NG tube uncomfortable and painful, and that she had refused its re-insertion at a time when she had the capacity to make that decision.

Peel J concluded that in those circumstances it was in AS's best interests to move to a palliative care plan.

Comment

This is an interesting case, because of the evidence of AS acting in direct contradiction to her Advance Statement. It is an important reminder of the need to be on the lookout for such evidence to try and help the court to unpack whether P's current wishes and feelings are concordant with previous expressions.

Updated guidance note on relevant information and further tools to support capacity assessors

We have updated our guidance note on relevant information for different types of decision, available here, with the reminder that it is intended to serve as a starting point for consideration, which must always be tailored to the particular circumstances of the case.

This is also a useful opportunity to flag that the Capacity Guide website has been updated (a legacy of the Mental Health and Justice project Alex was involved in), in particular to include two tools developed by James Codling of Cambridgeshire County Council, based upon the approach set out in the Guide:

1. A supportive questioning tool for different categories of decision, to be found here.
2. A capacity determination recording tool can be found, to be found here.

The use of restrictive practices in the everyday care of people living with dementia in hospital settings: an ethnographic study

Well known academic and MCA-watcher Lucy Series and colleagues Andy Northcott, Shadreck Mwale, Megan Wyatt, Karen Harrison Dening and Katie Featherstone have published a deeply troubling report funded by the National Institute for Health and Care Research, analysing the use of restrictive practices in hospital.

Carried out over 225 days across 18 months, involving 168 individuals, in nine different wards of six different English hospitals, this extensive piece of research analyses the use of restrictive practices in the treatment of people living with dementia ("PLWD") who have been admitted to hospital on an acute and unscheduled basis.

Given that DHSC now estimates that between 25 and 50% of all acute hospital admissions are now PLWD, the study has significant implications.

It found that tolerance of risk in hospital was extremely low, and that restrictive practices were frequently deployed immediately and without accompanying risk assessment in order to avoid any risk from eg wandering or falling patients. A common practice of depriving PLWD in their beds with raised guard rails was noted, resulting in patients effectively being confined to their beds in potential breach of their article 8 rights.

The consequences of restricted practices were noted to be an increased risk of further dependence, falls and incontinence; an increased risk of iatrogenesis, falls; exacerbation of physical and psychological symptoms of dementia, mobility problems, injuries, and increased duration of hospital admissions.

Researchers found that PLWD who were classified as at risk of falls or wandering were more likely to have DoLS instituted and that, once this was done, DoLS were frequently left in place throughout a person's admission, without any review – and often despite patients' requests to be released. Many PLWD were noted to have experienced these restrictive admissions as episodes of imprisonment or hostage, often resulting in increased emotional distress and visible physical and cognitive deterioration. Practices varying from bed rails to using meal trays as a means of keeping patients in chairs, had become so routine in the treatment of elderly dementia patients, that many staff no longer even noticed their restrictive nature.

Perhaps somewhat counter-intuitively, mental health wards were identified as often providing examples of good practice which could be transferred to acute settings by eg promoting organisational flexibility, supporting staff in approaches to care tailored to individual need, having staff attuned to the emotional needs of working with PLWD, promoting positive risks in the support of mobility and independence, and through discussion of the appropriate legal frameworks governing admissions.

More frequently however the study identifies:

> *We identified that ward staff found defining and identifying what constituted restrictive interventions in their routine practices as challenging. However, the use of legal frameworks in a patient's care was recognised as a sign that patient was, or could be, restrained, particularly allowing for the use of sedative medication such as lorazepam or haloperidol. However, there was significant variation in the application of legal frameworks, such as DoLS or the MCA across these wards, varying from everyday usage (site B) to not at all (Assessment Units).*

The use of DoLS was most typically observed to be instituted for PLWD who were described as at risk of leaving the wards (referred to within these settings as 'absconding') or a patient who routinely left the bedside and walked within the wards (referred to within these settings as 'wandering'). These behaviours were observed to be of immediate and significant concern for wards staff particularly when a patient walked towards the ward exit, walked away from the bedside and around the ward, or followed visitors as they exited the ward.

The application of DoLS places significant limitations on the autonomy of a person and requires assessment and periodic review once in place. For PLWD, however this review would often be overlooked, with the repercussions of the safeguarding order remaining in place across the person's admission. "*During our observations, the restrictions put in place by these orders were never explained to the PLWD at any site, which meant they were unable to object to their use in their care or to request reassessment*." (p.26)

The authors set out the following implications for decision-makers:

> *1. Training in de-escalation practices and positive risk taking within acute hospital wards could be carried out by mental health nurses' secondments. Training is required to support staff in recognising distress and how to manage and reduce distress in PLWD. Ward staff expressed a feeling of inadequacy and of helplessness with the responsibility of supporting PLWD within their wards. In response, training should promote the use of interactional approaches, de-escalation and drawing on the resources available to the ward, before the use of restrictive practice.*
>
> *2. Promoting organisational ward flexibility and slower pace in the delivery of timetabled care at the bedside (this includes medications, personal care, observation rounds, continence care and mealtimes) to PLWD. By focusing on the person and flexibility in delivery, this supports and recognises the importance of maintaining a calm ward environment to support patients living with dementia.*
>
> *3. Ministers making decisions about the introduction of LPS should examine our findings that the DoLS are not working within the acute setting to reduce the use of restrictive practices. Our findings suggest the urgent need to invest in the development and delivery of evidence-based nursing and allied professional education on restrictive practice and the legal frameworks underpinning their use in acute hospital settings.*
>
> *4. What is recorded as a key metric by hospital trusts has wider consequences. A key performance metric in the acute settings is the recorded number of falls, which is a legitimate concern in the care of PLWD. There is need for NHS trusts to appreciate the unintended consequences of how such policies are consequential in sustaining and normalising cultures of restrictive practice in the care of PLWD. There is need for continued institutional evaluation of falls monitoring practices and their consequences on PLWD. Reducing the risk of falls and managing ward falls statistics was deeply embedded in staff rationales in rationalising the use of restrictive practices.*
>
> *5. Our findings identified that a significant proportion of the everyday restrictive practice employed in the care of PLWD remained unrecognised and unrecorded. To improve care and promote the minimisation of restrictive practice in everyday care, it is vital that all restrictive practices are recognised and recorded, alongside why it was utilised. This will support an increased recognition and visibility of the impacts of restrictive practice on the PLWD, the staff caring for them, and on their discharge pathways and ability to return home following an admission.*
>
> *6. Guidance and data on use of restrictive practice in the care of PLWD in acute wards settings are required. One way to do this could be expanding the application of Seni's Law [Mental Health Units (Use of Force) Act 2018*

statutory guidance] from mental health to acute settings.

7. Guidance is needed on making better use of the resources already available and in place within and around wards, such as skilled one-to-one carers, use of day rooms, garden spaces and entertainment such as televisions and laptops.

8. National Institute for Health and Care Excellence Guidelines should have specific guidance around the application of restrictive practice on PLWD during an acute hospital admission.

The study is so troubling it requires a disclaimer on the offensive nature of some of the transcripts. Reading it is genuinely upsetting – many patients unaware of why they are in hospital, expressing a wish to leave, who are faced with staff who, while mostly caring and compassionate, have insufficient time and support to explain to PLWD where they are, why they are there, or to facilitate them to engage in any kind of meaningful activity – or even to get out of their beds to stretch their legs.

PROPERTY AND AFFAIRS

OPG requirements for professionals seeking to instigate investigations

The Office of the Public Guardian has set out new requirements for triggering investigations. As the letter outlining these sets out:

> *Professionals will now need to provide relevant documentary evidence at the point a concern is raised with OPG, to enable OPG to assess the concern and determine whether it can be taken forward for investigation. This may include bank statements, capacity assessments, unpaid invoices or similar material.*
>
> ***Evidence required when raising a concern***
>
> *Concerns raised by legal professionals will usually need the following as evidence for a concern to be reviewed:*
>
> ***Professional Attorney***
> *Bank statements*
> *Capacity evidence*
>
> ***Legal professional***
> *Capacity evidence*
> *Bank statements*

The letter identifies that:

> *OPG will continue to consider all concerns raised. Requiring documentary evidence at an earlier stage will help us assess concerns more quickly and provide concern raisers with a faster response.*

We have every sympathy with the OPG, which is wildly under-resourced, but we are duty bound to note that the gatekeeping approach may help the OPG manage those limited resources, but is going to cause serious problems in practice, especially where (as so often) the concern arises out of information about or access to the person being withheld.

PRACTICE AND PROCEDURE

Welfare deputyship to be considered by the Court of Appeal

In our observations on the flurry of recent cases concerning welfare deputyship in the April Report, we noted that we hoped that it would be possible for the appeal in *HDEB* to go to the Court of Appeal. We are therefore very pleased to see the news that Theis J has provided for exactly such a 'leap-frog.' Views may vary as to what the right outcome would be, but we anticipate that there will be consensus that the question of when welfare deputies are to be appointed is an issue which requires appellate level determination.

Instructing experts (and contested deprivation of liberty)

Bristol City Council v CC & Ors [2026] EWCOP 19 (T3) (Theis J)

Court of Protection jurisdiction and powers – experts

Summary

This is both an important and an interesting decision. It is important because Theis J set out a clear set of expectations instructing experts, and interesting because it is an example of what is now a rare beast, a contest as to whether circumstances gave rise to a deprivation of liberty. It also includes what is now an increasingly standard reminder that dividing care and residence decisions can frequently be artificial.

Instructing experts

The guidance provided by Theis J requires reproduction in full.

10. At the invitation of the court the parties have liaised and produced an extremely helpful agreed note on the instruction of experts in the Court of Protection. This issue arose due to my concerns in this case as to (i) the length of the letter of instruction sent to the expert in this case (27 pages, 12 of which were under the heading 'Legal Framework'), and (ii) the incoherent management of the way documents were sent to the expert prior to this hearing by the local authority (he was sent large pdf bundles with no agreed guide as to what he should read/focus on). As a result, I hope what follows will be a useful reminder of the framework in which experts are instructed in the Court of Protection and how such instructions should be managed. Those willing to give expert evidence in cases in the Court of Protection are an invaluable resource to assist the parties and the court reach decisions in these difficult cases. The parties and the court need to ensure that all necessary steps are taken to enable them to undertake that important role.

11. The procedural rules on the instruction of experts in the Court of Protection are contained in rule 15 of the Court of Protection Rules 2017 ('COPR 2017'), as supplemented by Practice Direction 15A. The test is 'necessary' (rule 15.3(1) COPR 2017) and permission may only be given if it is necessary to assist the court to resolve the issues in the proceedings and could not otherwise be provided by a rule 1.2 representative or in a report pursuant to s49 MCA 2005 (rule 15.3(2) COPR 2017).

12. When making an application for the instruction of an expert on form COP9 the application must include a draft letter of instruction to the expert (rule 15.5 (2)(f) COPR 2017). The expectation is that the draft letter of instruction

should be approved by the court or, if not (due to urgency or some other reason), clear directions in the order for the letter to be finalised with the questions for the expert being approved or overseen by the court.

13. The letter of instruction must be focussed and adapted to the facts of the particular case. Previous cases provide helpful guidance (such as Poole J in AMDC v AG and CI [2020] EWCOP 58 [28 (b)] "28… (b) [t]he letter of instruction should, as it did in this case, identify the decisions under consideration, the relevant information for each decision, the need to consider the diagnostic and functional elements of capacity, and the causal relationship between any impairment and the inability to decide. It will assist the court if the expert structures their report accordingly. If an expert witness is unsure what decisions they are being asked to consider, what the relevant information is in respect to those decisions, or any other matter relevant to the making of their report, they should ask for clarification." [emphasis added]). Lengthy and unwieldy recitations of the background facts and procedural history are to be avoided, as well as detailed descriptions of previous case law.

14. It may be helpful to keep in mind the following as the key components of a letter of instruction to an expert:

(1) A brief neutral statement of the essential facts of the case.

(2) A list of materials with which they are being provided for the purpose of the assessment the expert is undertaking.

(3) A core legal framework setting out the central principles of the MCA 2005, a summary of the relevant sections of the MCA 2005 should suffice and, if appropriate, to reflect, for example, the order in which a capacity assessment should be approached, as set out by the Supreme Court in A Local authority v JB [2021] UKSC 52. Any such references should be kept succinct and must be relevant.

(4) If assessing capacity, identification of the relevant decisions to be assessed, with the relevant information for each decision as agreed between the parties. If required there can be a brief explanation as to where the information derives, providing confirmation that what the relevant information consists of should ultimately be a matter for the relevant expert to determine when undertaking the assessment, and a reminder of the importance that the expert is not an arbiter of fact.

(5) Confirmation as to whether the proceedings are in public or private and details of any Transparency Order in place.

(6) Details of any person(s) the parties consider the expert should or may meet with, and remind the expert of the importance of there not being any unrecorded/informal discussions.

(7) The letter should clearly identify timescales for the report, dates of hearings/oral evidence, confirmation of who the report will be disclosed to, and a reminder about the ability to pose questions of clarification (rule 15.7. COPR 2017). It should also contain information about the expert's fees.

15. Questions to the expert after the filing of their report should only be done in accordance with rule 15.7(2) COPR 2017 or by order of the court (rule15.7(3) COPR 2017). In accordance with rule 15.7(2)(c) COPR 2017, any such questions must be for the purposes of clarification only.

> *16. In addition to ensuring experts have all the relevant documents at the point of their instruction, the parties should keep under active review what further evidence or documents should be sent to the expert with a suitable covering message identifying the relevant documents. If agreement is not possible, a COP9 application will need to be issued setting out the issue and the parties' competing positions with a draft order attached. This will enable the court, if appropriate, to determine the issue on the papers.*
>
> *17. If an expert is going to give oral evidence at a hearing, they should be provided with the following in advance of the hearing by the lead instructing party:*
>
> *(i) An updated court bundle at the same time as the bundle is lodged with the court.*
>
> *(ii) A list of updating documents that have been filed since their instruction, which should highlight the specific documents that the parties consider that they should review in advance of the expert giving oral evidence.*
>
> *(iii) Any further 'loose leaf' documents filed immediately prior to the hearing, that the parties will likely refer to in the course of their questioning of the expert.*

Deprivation of liberty

Official Solicitor sought to argue that the individual in question was not deprived of their liberty, whereas the public authorities (in this case the local authority, the NHS Trust and the ICB) argued that he was. The Official Solicitor's position was founded on her contention that the acid test was not satisfied, on the basis (paragraph 82)

> *CC's professional support is limited to 30 hours per week, CC has no outside support over the weekend at all or at times during the week when the professional support is not present. Ms Sutton submits that whilst CC's grandmother is aware of where CC is when support staff are not with him she does not supervise him for that time. There is no evidence that CC has attempted to abscond or refused to return when he is out. The doors and windows are not locked at CC's grandmother's home. CC has a key. He is not subject to personal searches or any other restrictive practices when in the property. He has access to all rooms and is able to move around the house.*

Conversely, the public authorities founded themselves on the approach of the local authority:

> *67. The local authority submit CC's current and proposed care arrangements amount to a deprivation of liberty and rely on the following matters. CC is effectively prevented from leaving home and is kept under continuous supervision and control there. The restrictions in the various plans require CC to reside at his grandmother's property, must be accompanied in the community by a responsible adult save for specific relaxations, he is cared for by two carers for 30 hours per week and the police will be immediately notified if CC accesses the community other than in accordance with the restrictions and be returned to his grandmother's property. These restrictions amount to a significant amount of control preventing CC from accessing other places and it is this control, submit the local authority, that meet the requirements of control in the acid test. The fact that it is imposed by the family for part of the time does not prevent it from being control as CC is not free to leave in the way described*

by Lady Hale in Cheshire West at [48]. Mr Auburn submits the fact that the majority of care and supervision (i.e. outside the care package of weekdays) is by CC's family is relevant to the issue of State imputability, but not to whether the acid test is met. He submits the deprivation of liberty is imputable to the State as it is decided upon, arranged, funded, overseen and reviewed by the State in the form of the local authority.

68. Mr Auburn recognises there has been, and may be, some relaxation to CC's care plan that will permit him to undertake certain trips independently but satisfying the acid test does not require the supervision and control to be 24 hours a day 7 days a week. He submits this is based on the Strasbourg cases that Lady Hale relied upon when reaching her conclusion in Cheshire West (see Ashingdane v UK (1985) 7 EHRR 528*; HL v UK* (2004) 40 EHRR 761 *and Stanev v Bulgaria* (2012) 55 EHRR 22*).*

Theis J found the question to be a finely balanced one:

95. Turning, finally, to consider whether the current care arrangements amount to a deprivation of liberty that requires the authorisation of the court. This issue is finely balanced. I am satisfied in the particular circumstances of this case that CC is deprived of his liberty. That requires the authorisation of the court. Whilst I accept in part the submissions on behalf of DD and the Official Solicitor, I do consider on the particular facts of this case that the objective element of the test set out in Cheshire West is met, namely that CC is [49] 'under continuous supervision and control and was not free to leave' and [54] 'under the complete supervision and control of those caring for [him] and is not free to leave the place where [he] lives'.

96. It is acknowledged the combination of the care plans that set out the structure of care for CC mean, as a matter of fact, it could be said he is not under continuous supervision and control. It is a question of fact and degree in each case. I recognise CC is on his own in the home for three hours each weekday morning whilst EE is at work before the carers arrive, the windows/doors are not locked, there are no restrictions on his movement within the home, he is not the subject of any restrictions in the home (such as searching) and he is able to leave within the care framework (such as visiting a local shop). However, there is a continuous element of control provided by the care plans such as the requirement to spend each night at his grandmother's home and part of the care plan includes a protocol with the police, who are to be notified if CC accesses the community (save in accordance with the care framework), they are to find him and he is to be returned to EE's home. EE is aware of where CC is when the support staff are not present, although I recognise she does not supervise him for all the period. However, the overall effect of the care plan is that the police are to be contacted if CC accesses the community other than in accordance with the care arrangements. This is for the specific purpose of finding him and returning him home.

97. I accept the local authority submission that when looked at as a whole the effect of these care arrangements is that CC is not free to leave in the way considered by Lady Hale in Cheshire West at [48] as in reality CC "is not free to go anywhere without permission and close supervision". I agree that whether or not CC in fact attempts to leave is not

the point. In Cheshire West MIG had never attempted to leave her foster home but the fact steps would have been taken to restrain her had she done so was sufficient. As Lord Kerr observed in Cheshire West at [76] "Liberty…does not depend on one's disposition to exploit one's freedom." The court needs to proceed on the basis that the care arrangements upon which CC's residence and care are arranged will be observed. The limited and prescribed relaxation built into CC's regime does not prevent a deprivation of liberty arising. Article 5 does not require total supervision 24 hours a day, 7 days per week.

98, The parties agree the deprivation of liberty is imputable to the State as the care arrangements set out in the care plans are decided on, arranged, funded, overseen and reviewed by the State in the form of the local authority and the ICB jointly arranging and delivering the s 117 MHA 1983 care arrangements. Also, there is no issue between the parties regarding consent. The Supreme Court has heard argument and reserved judgment in the Northern Ireland reference UKSC/2025/0042, concerning the issue of consent. No party in this case is contending that CC consents to the restriction on his liberty of the police being called, finding him and returning him home should he access the community other than in accordance with the care plan.

Comment

In relation to the approach to experts, the precedent letter of instruction on the Court of Protection Handbook website will be amended to capture the guidance of Theis J when Alex and his fellow authors have a moment (although the amendments will be relatively minor, luckily).

Given that the Supreme Court's decision is awaited in '*Cheshire West 2,*' and the involvement of a number of us in that case: we will limit comments to (1) suggesting that Theis J's approach to the 'acid test,' in line with earlier domestic caselaw, recognises that the question is not how long the leash might be, but that there is a leash; (2) noting that the very existence of the 'acid test' has been put in issue by the DHSC in *Cheshire West 2*; and (3) recognising that some might note with a wry smile that, in contradistinction to the position before the Supreme Court, the public bodies in this case were arguing for the expansive approach to deprivation of liberty, and the Official Solicitor for the restrictive approach.

When and how can the Court of Protection revisit habitual residence?

Neath Port Talbot County Borough Council v CK & Ors [2025] EWCOP 47 (T3) (Morgan J)

International jurisdiction of the Court of Protection – other

Summary

The case of *Neath Port Talbot County Borough Council v CK & Ors* [2025] EWCOP 47 (T3) is the sequel to this decision, in which HHJ Miller 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. At the point of delivering that judgment, HHJ Miller concluded that – on the facts of the case – the subject of the proceedings, CK, accommodated in a care home in Wales, was still habitually resident in Spain. By the time the matter came before Morgan J for determination as to CK's

best interests as regards his future residence and care arrangements (including a potential return to Spain), the issue of his habitual residence came back to the fore.

As Morgan J identified:

> *18. This court has in my view to be careful not either inadvertently to approach its task as if acting as an appellate court in respect of the decision made on 10 June, or to substitute its own different decision on the same factual situation because it sits more easily with a best interests analysis. I recognise of course that as the determination stands, this Court retains a temporary jurisdiction pursuant to Schedule 3 MCA 2005 (7)(1)(d) but in circumstances where what is contemplated in terms of living and care arrangements for CK is for the rest of his life it seems to me that it would be stretching a reasonable understanding of what is intended to be understood by the word 'temporary' to embrace 'life-long'*
>
> *19. Both the applicant and the litigation friend at this hearing remind the Court that there is authority for the proposition that the Court of Protection must keep the issue of habitual residence under review to ensure that it retains jurisdiction at the date of the final substantive hearing, as to which reliance is placed on London Borough of Hackney v P [2023] EWCA Civ 1213, [116]; Re LM [2023] EWCOP 69, [37-38] and on behalf of the applicant to TD BS v KD QD [2019] EWCOP 56 . Developing on from that submission, the Litigation friend submits that the doctrine of perpetuatio fori does not apply to cross-border incapacity cases regardless of whether or not the 2000 Convention applies and in support of and to illustrate that submission relies on , Re O (Court of Protection: Jurisdiction) [2013] EWHC 3932 (COP), [2014] Fam 197, [21]. I accept that it is right that the jurisdiction of the Court may change during the duration of proceedings. What is more problematic in relation to those authorities to which the court's attention was directed in argument at this hearing when considering the obligation that the Court of Protection must keep under review the issue of habitual residence, is that it was noteworthy that in each of those authorities cited it was so as to ensure that it retains jurisdiction and not, as must be the situation with CK, so as to consider a situation where a determination that Habitual Residence is elsewhere with consequence that the court does not have jurisdiction (other than temporary protective). It follows that the court is not reviewing whether it retains it but considering whether the factual landscape has in the intervening period altered such that CK's habitual residence now lies in (England and) Wales. I note that in QD [2019] EWCOP 56 in which Cobb J as he then was in strikingly similar factual circumstances contemplated at para [32] not the prospect of a change in the factual basis which might cast habitual residence in a different light and lead to the English Court thereby acquiring jurisdiction but that it was possible that it might be acquired by the conferring of jurisdiction on the courts of England and Wales by Spain. It was common ground amongst counsel at this hearing that there was no authority in which the situation was as presents here.*
>
> *20. By reference to The Practical Handbook on the Operation of the 2000 Protection of Adults Convention counsel for the applicant developed her submission, supported by the litigation friend that it is permissible and appropriate to review, by considering whether there has been a change in the Habitual residence of the adult concerned. In particular there is express*

> *consideration within paras 4.13 et seq What happens when the "habitual residence" of the adult changes? of the prospect that such a change may be, including during pending proceedings for a measure of protection. (Explanatory Report to the convention para 51). Given the clarity of analysis which appears in QD I have paused to reflect carefully on whether I should accept that, HHJ Miller having reached the conclusion he did in June of this year, it is in the peculiar circumstances of this case right for me to look again at CK's Habitual residence now. I have narrowly concluded that it is and whilst there is much that is on all fours factually with the situation facing Cobb J in QD, very different here is the very long passage of time between the reaching of the conclusion and the best interests decision to be taken at this hearing. I accept Counsel's joint submission that it is permissible and appropriate to review (in the sense discussed, rather than by critique of HHJ Miller's original judgment) the question of CK's Habitual residence. That review is properly done by consideration of significant changes in the factual landscape or the emergence now, of facts which were not known in June 2025.*

Adopting that approach, Morgan J found that CK was now habitually resident in England and (more to the point) Wales. This made her task jurisdictionally very much easier. On the facts of the case, the best interests decisions it now fell to take to take on the basis of the 'full original jurisdiction' of the Court of Protection in relation to CK were relatively straightforward. Morgan J's closing observations on the case resonate strongly with our experiences:

> *35. It is not uncommon, sadly, for families to find themselves in situations where one of their members is diagnosed with conditions similar to CK, or is otherwise in failing health and where there are questions over their capacity, and that person is living outside of England and Wales. The parties have been at pains to emphasise that neither at this hearing or before HHJ Miller has any party invited the court to determine that the move of CK from Spain to the Z care home was made in bad faith. It is explicitly accepted by the Local Authority at this hearing that EK and JS did what they considered to be in CK's best interests. CK's circumstances have however illustrated all too clearly how the well intentioned can go wrong. At the outset of this hearing the litigation friend made the following overarching submission which encapsulates the wide anxiety: 'While the litigation friend considers that CK's habitual residence will revert to England and Wales, the litigation friend is troubled by a conclusion which ostensibly authorises CK being removed from the country where he had chosen to live, and the perverse incentives this may create for future individuals to avoid processes which protect vulnerable adults internationally. It should be emphasised that the circumstances confronting this court are unusual and confined to their own facts'.*

Morgan J was asked to give guidance as to future cases; she expressed reservations about doing so, but the observation set out below are undoubtedly of relevance for any cross-border case:

> *37. Consideration of capacity at an early stage should be at the forefront of everyone's mind. Specifically, if what is under consideration involves a decision to leave one country and go to live in another, the person's capacity to decide that, must be considered at an early stage. There may be all sorts of*

instances in which the family members doing what they think is right, regard it as the best - or perhaps even the only - decision to be made, but that does not obviate the need to ask the question, does the person have the capacity themselves to make the decision.

38. If a public body becomes aware that there is a prospect of a person returning from a country where they are resident to the United Kingdom to be placed within a registered care setting, that public body should alert those involved of the need for the person to consent to that process and to follow the laws of the country in which they are habitually resident.

39. Registered care settings, should, before granting admission to a person who is resident in another country, satisfy themselves either that the person is consenting (i.e. that they have the capacity so to consent) to a return to the United Kingdom and placement within a care setting or that the return follows a lawful process in the country in which they are resident or there is a valid substitute or surrogate decision making power governing the process under that country's law.

40. Where a person has moved from one jurisdiction to another in circumstances such as CK did here, supervisory bodies for the purposes of Schedule A1 of the MCA 2005 should not authorise a deprivation of liberty by means of the administrative process of DOLS but should make urgently an application to the Court of Protection, within which application should be highlighted for the purposes of gatekeeping decision making that there is or is likely to be an issue to be determined in respect of habitual residence.

Comment

This decision is important for reminding practitioners that the position in relation to adults lacking capacity is very different to the position regarding children, and it is not possible to 'freeze' habitual residence by initiating proceedings. It is also helpful for flagging the relatively recent (2024) Practical Handbook to the 2000 Hague Convention on the International Protection of Adults. Despite the fact that for complicated and rather unsatisfactory reasons England & Wales is not a 'Hague State,' the way in which Schedule 3 to the MCA 2005 mirrors the Convention and the body of cases that have been decided under Schedule 3 means that it was possible for Alex to feed in that experience to do his bit to make the Practical Handbook actually practical.

One small caveat to / clarification of Morgan J's otherwise admirably clear judgment. To the extent that paragraph 40 could be read as suggesting that a local authority cannot authorise the deprivation of liberty of a person who is not habitually resident in England and Wales, that is incorrect: the requirement for DoLS purposes is simple physical presence in the hospital or care home; if the person is not ordinarily resident in the area of a supervisory body applying the rules set out in Schedule A1, then the supervisory body will be that for the area where the hospital / care home is located. However, what Morgan J meant – we suggest – is that a local authority must be astute to the potential that there is an issue as to whether the person has been brought to England & Wales in circumstances meriting further consideration; at that point, they should simply not close their eyes to that issue and authorise the deprivation of liberty, but ensure that steps are taken to resolve the issue.

Book Review

Oliver Lewis, *Coercive Control and Vulnerable Adults: Law and Practice in the Court of Protection and the Inherent Jurisdiction of the High Court* (Bloomsbury, 2026, 242 pp, hardback / ebook, £48.60)

If I have done one useful thing in the past few years, it was to have a conversation with the barrister (and CRPD specialist) Dr Oliver Lewis about a book idea he was working on. The rest is down to him (and to Bloomsbury, who have done an excellent job from the publishing side), but it is incredibly pleasing to see the end result – namely this extraordinarily practical and comprehensive book which should be on the bookshelf of every practitioner who appears before the Court of Protection. I say 'every' practitioner because one of the most important aspects of the book is how it highlights the pervasiveness of the potential for coercive control, far beyond 'obvious' domestic abuse situations. Reading Chapter 2, in which this is set out, should be required to enable practitioners to be on the alert for the potential for coercive control to be in play (especially where the coercion is framed as 'care'); the following chapters then set out clearly how the law can be made to respond. Similarly, Chapter 10, setting out the traumatic effects of coercive control, is also an exceptionally useful summary of some often very complex clinical literature, enabling those acting in such cases have a clearer understanding of the minefield that they are crossing.

The book straddles both the Court of Protection and the inherent jurisdiction of the High Court: anyone who has anyone had any involvement with a case such as the ones that Lewis describes will know, capacity can be exceptionally difficult to navigate given the interaction between any impairment that the person might have and the 'spider's web' effect of the pressure from the abuser. Lewis gives (in chapters 3 and 4) a very straightforward set of tools for those seeking to identify which side of the line the person is as regards their decision-making capacity in material domains, but is clear-eyed about the challenges involved. In many situations, the case may end up before the High Court on the basis that the person has capacity but is vulnerable. Lewis is a defender of the inherent jurisdiction – or, perhaps, to be precise, recognises that, since it exists (notwithstanding those who suggest that it should not), it can and should be used in ways which support the autonomy of those subject to coercion. The chapter on law and procedure under the inherent jurisdiction, together with guidance on fact-finding and remedies under the inherent jurisdiction are exceptionally helpful for Court of Protection practitioners who may find themselves very much out of their comfort zone in a case which either starts or moves into that jurisdiction (a jurisdiction which is governed by a set of procedural rules – the CPR – singularly ill-suited for the purpose).

Practicality is a hallmark of the book. It benefits from Lewis' deep and sustained work in international human rights (see, in particular, the discussion in the concluding chapter about the inherent jurisdiction, capacity and disability rights), but never at the expense of becoming abstract or theoretical. If I could single out three chapters in particular in this regard, I do hugely wish that when I first started doing these cases I had had sight of the three chapters on representing the victim / survivor, the local authority, and the controlling person respectively, as they are sure-footed, thoughtful, and above all eminently applicable

to some of the most difficult cases to appear in.

I have in this review highlighted the importance of this book for legal practitioners. It is, however, equally important, I would suggest, for social workers and others who are working with victims / survivors of coercive control as an entirely reliable guide as to the law that they will be applying outside court, and also for understanding of when and how they should be seeking to take matters to court to secure the rights of those victims and survivors.

Few books can really be said to matter; this one does.

Alex Ruck Keene

[Full disclosure: I had sight of and made comments on the legal chapters in draft stage; I am also grateful to the publishers for providing me with a copy of this book. I am always happy to review works in or related to the field of mental capacity (broadly defined)]

Anonymity even from the litigants

A Local Authority v CD & Ors [2026] EWHC 980 (Fam) is – as Peel J identified – an 'exceptional' case. It is, however, an example of two (linked) phenomena that are showing themselves equally in the Court of Protection context: (1) litigants in person who are (to put it mildly) operating in a parallel legal universe; and (2) whether in consequence of (1) or otherwise, are so opposed to the professionals involved that they pose active risks to those professionals. In *CD*, Peel J found that the risks posed to the professionals (of both psychological and physical harm) were so high that their names and identities could and should be withheld from the parents in the context of ongoing care proceedings. We trust, but sadly without much hope, that the complex jurisdictional route that Peel J had to follow to provide for their protection is not one that Court of Protection judges will find themselves having to follow.

'Cuckooing' to become an offence

In particular for cases which straddle the Court of Protection and the High Court's inherent jurisdiction, it is always important to have in mind what other remedies might be available to address abuse. In that regard, it is helpful to note that the Crime and Policing Act 2026 which recently received Royal Assent includes a new offence of 'cuckooing.' When commenced, the relevant section of the Act will make it an offence to exercise control over another person's dwelling without their consent for the purpose of enabling the dwelling to be used in connection with the commission of specified criminal activity.

The specified criminal activity includes the types of criminal activity that cuckooing is typically used to facilitate, for example, drugs offences, sexual offences and offensive weapons offences. The Act provides for a power for the Secretary of State to amend the list of specified offences to future-proof this new offence against exploitative criminals who might adapt cuckooing to other crime types.

It will be an offence to control a person's dwelling in connection with criminal activity without that person's consent. A person cannot consent to control of their dwelling if: they are under 18 years old; do not have capacity to give consent; have not been given sufficient information to enable them to make an informed decision; have not given consent freely; or have withdrawn their consent. The consent of an occupant may not

freely be given where it is obtained by coercion, deception or other forms of abusive behaviour.

The offence will carry a maximum penalty on indictment of five years' imprisonment or a fine (or both).

MENTAL HEALTH MATTERS

Amendments to the MHA 1983

On 6 April 2026, two further amendments to the MHA 1983 were commenced. Section 51 of the Mental Health Act 2025 inserts a new s.142C into the 1983 Act and extends to England and Wales, Scotland and Northern Ireland. For context, *YL v Birmingham CC* [2007] UKHL 27 ruled that an independent care home providing local authority-arranged accommodation was not a "public authority" under s.6(3)(b) HRA 1998. Parliament patched the gap for care homes (Health and Social Care Act 2008, s.145; later Care Act 2014, s.73) and for some directly-arranged NHS services. However, this did not cover those in care homes with s.117 MHA 1983 after-care (*Sammut v Next Steps Mental Healthcare Ltd* [2024] EWHC 2265 (KB)) or informal patients in private mental health services.

This amendment extends the remit of the Human Rights Act 1998 to private care providers, requiring them to act compatibly with the Convention rights set out in the Human Rights Act 1998, when providing services as set out in section 142C(2) of the 1983 Act. The geographical extension to Scotland and Northern Ireland is unusual for a 1983 Act amendment and reflects the cross-border reach of independent mental health provision.

The second is section 52 of the 2025 Act (England only) which imposes a duty on the Secretary of State to review regulation 18 of the Care Quality Commission (Registration) Regulations 2009 to consider the circumstances in which the CQC ought to be notified where a person under 18 is an inpatient in a hospital or registered establishment and is being treated for, or being assessed in relation to, mental disorder.

A report setting out the conclusions of the review must be laid and published by the Secretary of State within 2 years of 18 December 2025.

HSSIB concerns about the care of people in emergency departments in mental health crisis

The Health Services Safety Investigation Body ('HSSIB') have been sufficiently concerned in the course of the investigation into this issue that they have published an interim report.[1] In headline terms, the investigation has found that:

- There is an absence of clear legal powers to lawfully prevent vulnerable individuals from leaving the ED while awaiting assessment or admission.
- This legal ambiguity exposes patients to increased risk of harm and/or being unlawfully deprived of their liberty, and places staff in a position of uncertainty when attempting to manage safety.
- For those requiring formal admission to a mental health hospital, an application under the Mental Health Act 1983 cannot be completed until a bed has been identified, which can take days.
- Staff and organisations reported they are often faced with choosing "the least harmful way to break the law" in order to try and keep patients safe.
- EDs are not designed to provide therapeutic mental health care and prolonged stays may worsen patients' conditions and create challenges in maintaining a safe environment for everyone.

The HSSIB has made two safety recommendations:

[1] Alex acted as a legal subject matter adviser.

HSSIB recommends that the Department of Health and Social Care urgently reviews the current legal framework and addresses the current legislative gaps in emergency care for people in mental health crisis and clarify the extension of legal powers for health professionals to hold someone in the emergency department. This will safeguard people who are currently arriving at the emergency department in a mental health crisis and the staff who care for them to support safe, consistent and legally compliant care.

HSSIB recommends that the Care Quality Commission works with stakeholders to produce a position statement on existing legal powers, and the expectations for support for staff, for the care of people experiencing a mental health crisis in emergency departments (including mental health emergency departments and mental health crisis assessment services), who are not detained under a formal legal framework. This should include a review of current guidance and existing powers to help support safe, consistent, and legally compliant care in the absence of comprehensive legislation, while minimising harm and addressing the unique challenges of prolonged stays in the emergency department.

The MHA, the MCA, misunderstandings and misapplications

Alex was asked to provide (and to speak to) an expert report on the MHA 1983 and the MCA 2005 for purposes of the Nottingham Inquiry. The report covered a significant amount of ground seeking to set out common misunderstandings and misapplications of the MHA 1983 and the MCA 2005, as well as the complexities that arise where the law is out of step with Codes of Practice. The report can be found here, a transcript of Alex's evidence here, and a recording of his evidence here. A particular issue that he highlighted in the oral evidence session was around the category error of talking of 'capacity to commit a crime': for more on why this is legally nonsensical, we recommend watching the webinar held in 2023 Chambers on When P is an Offender.

Mental healthcare aspirations in Wales

The Welsh Government published in March 2026 two quality statements (the Mental Health Quality Statement and Self-harm Quality Statement, defining the outcomes and standards which services must deliver, with a view to helping Wales to be the first nation in the United Kingdom to deliver same-day, open access mental health care.

Article 3 in the County Court

Ali v Northamptonshire Healthcare NHS Trust [2026] EWCC 13 (County Court (Mr Recorder Adrian Jack))

Other proceedings – civil

Summary

In a rarely reported case from the county court, Mr Recorder Adrian Jack considered a damages claim under the Human Rights Act 1998 for breaches of Articles 3 and 8 ECHR. The claimant prisoner, Mr Ali, sought damages limited to £5,000 for not receiving the mental health treatment he required in order to have a reasonable prospect of release from custody.

Mr Ali was sentenced for rape to indefinite detention for public protection. During his time in prison, there were repeated incidents of a sexual and violent nature. He attempted suicide twice. He was diagnosed with several personality disorders and moved to Rampton Psychiatric Hospital. Following a deterioration in Mr Ali's behaviour, when he caused extensive damage to

two rooms at Rampton, the hospital determined that it could no longer provide care for him. Mr Ali was moved back to prison.

Whilst back in prison, Mr Ali said that he would like to return to Rampton, but was told he needed to follow the pathway therapy route before he could self-refer. He raised a formal complaint about not being referred back to Rampton. His claim for damages stemmed from the alleged failure of the defendant NHS Trust to provide the requisite mental health treatment, the pathway therapy, so he had no realistic prospect of being referred back to Rampton, and therefore no realistic prospect of receiving the treatment which would reduce the risk of his reoffending if he were released.

The Trust accepted that it was responsible for the medical care of the claimant for some, but not all, of the time that the claimant was in prison. There was however some confusion during the trial when the Trust sought to argue that the recommendation regarding a referral to Rampton Hospital sat with a private contractor, Practice Plus Group ("PPG"), and not with the Trust. The judge disallowed this new evidence to be adduced and held that the Trust was bound by its concession in its witness statement that the Trust was responsible for healthcare provided to Mr Ali at the material times.

In assessing Mr Ali's claim, the judge considered extensively the case law of the European Court of Human Rights on Article 3. In fact, the judge readily admitted that he *"set out somewhat more than would be normal due to Mr Ali's potential difficulties accessing the relevant case law himself"*. Of particular relevance was the case of *Murray v The Netherlands* [2016] ECHR 408, where the Grand Chamber identified at 108(d) that:

> *Where the assessment leads to the conclusion that a particular treatment or therapy may indeed help the life prisoner to rehabilitate himself or herself, he or she is to be enabled to receive that treatment to the extent possible within the constraints of the prison context… This is of particular importance where treatment in effect constitutes a precondition for the life prisoner's possible, future eligibility for release and is thus a crucial aspect of de factor reducibility of the life sentence."*

The Grand Chamber concluded at para 112:

> *In conclusion, life prisoners should thus be detained under such conditions, and be provided with such treatment, that they are given a realistic opportunity to rehabilitate themselves in order to have a hope of release. A failure to provide a life prisoner with such opportunity may accordingly render the life sentence de facto irreducible.*

The judge made relevant findings of fact, including that Mr Ali needed to undergo the pathway therapy to be considered for transfer to Rampton, and that he had not been offered the chance to participate in that therapy. However, Mr Ali had adduced no expert evidence as to the likelihood of his mental state improving or that completing the therapy on its own would be sufficient to ensure a transfer. Nevertheless, the judge accepted that it was possible that Mr Ali's mental state could improve when undergoing pathway therapy.

Ultimately, the judge concluded that the Trust owed a duty to give Mr Ali access to the pathway therapy, even if the therapy would not have succeeded in bringing about a situation where he was eventually released. What mattered is that he should have that chance, *and "the failure to give him that chance in my judgment is a breach of his Article 3 rights."* It was not strictly necessary for the judge to consider Mr Ali's

Article 8 claim but he would have decided it in Mr Ali's favour for much the same reasons.

In assessing the level of damages to be awarded, the judge held that *"a modest award of damages"* was necessary to afford just satisfaction to Mr Ali in the amount of £2,000.

Comment

In a world where county court judgments are rarely reported or made publicly available, this is an extremely welcome and valuable insight into the workings of the civil justice system, particularly where issues of mental health and human rights are considered. Although initially allocated to the small claims track (presumably because of the limited monetary value of the claim), it was then transferred to the multi-track. This perhaps speaks to the significance of the claim, not in terms of monetary value, but in relation to claimant's mental health, and the missed opportunities for his rehabilitation. Furthermore, the case required extensive consideration of the case law of the European Court of Human Rights, adding extra layers of legal complexity which, understandably, might pose difficulties for a litigant in person such as Mr Ali.

Although not setting any formal precedent as a decision of the county court, the approach taken by the judge could potentially have wide reaching ramifications for mental health trusts. Article 3 ECHR claims, for prohibition against torture, inhuman or degrading treatment, have historically been understood to present a high threshold to overcome in order to succeed. However, in interpreting the ECtHR case law on Article 3 in a mental health and prison context, the judge rejected the argument that the threshold was as high as the defendant NHS Trust put it. He made an unequivocal finding that the Trust owed a duty to the claimant prisoner to provide the therapy required for his potential rehabilitation. Furthermore, the judge made clear that, even if the Article 3 claim had not succeeded, he would have found that the Trust's failure to provide treatment breached Article 8.

We understand that the Trust attempted to appeal the decision in *Ali v Northamptonshire Healthcare NHS Trust (No. 2)* [2026] EWCC 21. In relation to the various grounds advanced, the judge had no difficulty dismissing those grounds based on alleged errors of fact. However, but for the fact that the application for permission to appeal was out of time, the judge would have granted permission to appeal in relation to the legal issue, namely:

> *a novel and important question that has not previously been the subject of considered appellate authority: what is the scope and content of the Article 3 duty – as articulated by the Court of Appeal in ASY v Home Office [2024] EWCA Civ 373; [2025] KB 87 – when applied to an NHS Trust acting as a mental health care provider within a multi-agency prison healthcare system? That question has potential implications for a significant number of NHS Trusts operating in custodial settings and is a sufficiently compelling reason for permission to appeal to be granted.*

The judge noted that a renewed application to the High Court for permission to appeal was also out of time, although it was still open to the defendant to apply. Given that the judge indicated that he would have granted permission to appeal, it would be interesting to know if the defendant NHS Trust made a renewed application to the High Court for permission to appeal. If not, we will have to await a future (reported) case in which the issue might arise. Watch this space…

Independent review into mental health conditions, ADHD and autism: interim report

The interim report of the independent review into mental health conditions, ADHD and autism was published on 31 March 2026. The review states that it was commissioned:

> *in response to mounting pressure across multiple parts of the current system, and to the growing difficulty many people face in obtaining timely, appropriate and proportionate support. Referrals for mental health and neurodevelopmental conditions particularly ADHD and autism have risen substantially. Waiting times for assessment and treatment have increased. Schools, universities, employers, general practice, other public services and specialist services all report sustained pressure. At the same time, public discussion of mental health conditions, ADHD and autism has become more prominent, more urgent and, at times, increasingly polarised around questions of available support, the role of diagnosis and different interpretations of rising demand.*

The interim report is clear that it does not offer conclusions or recommendations, which will be made in the final report, and instead focuses on understanding "*why many people who are autistic, have ADHD and/or experience mental health conditions are not getting the support they need as quickly or as early as they need it; and what needs to change to address this*." It observes that demand has increased, and notes that the review seeks to understand "*how changes in population prevalence, psychological distress, administrative diagnosis, self-identification, service demand and underlying need relate to one another, and what that implies for policy and service design that will improve lives.*" The report indicates how neurodevelopmental conditions are associated with "*mental health difficulties, neurodevelopmental conditions and not being in education, employment or training – particularly for young people. The Review intends to do further work in this area so that its recommendations can inform the Rt Hon Alan Milburn's review on Young People and Work and wider work on reforming the SEND (Special Educational Needs and Disabilities) system."* The interim report highlights the need to resolve gaps in data as the work goes forward.

The report sets out some preliminary findings on trends in mental health and neurodevelopmental disorders:

- Common mental health conditions (anxiety and depression) and psychological distress have increased over the past two decades, particularly among young people.

- Recent evidence suggests a shift in historical trends, whereby young people are experiencing more psychological distress than older groups. "*The nature of distress is also changing. The largest increases among young people are seen in emotional symptoms, loneliness, sleep problems, loss of confidence and difficulty concentrating, rather than across all domains of mental health equally. Evidence suggests that, among those reporting high levels of distress, functional impairment has also increased over time, indicating that these difficulties are not only more frequently reported but may also be more disruptive to day-to-day life… Rising distress among young people is linked to educational disruption, school absence, disengagement from work and training, and high rates of young people not in education, employment or training (NEET). This highlights the importance of understanding mental health trends not only in relation to services, but also in relation to participation and life chances.*"

- While it appears that population prevalence of ADHD has been stable, "[r]*eferrals, waiting lists for assessment and recorded diagnoses for ADHD have increased substantially, particularly among adolescent and young adult females. NHS England monitoring data show that the number of children and young people waiting for an ADHD assessment rose from around 21,000 in April 2019 to around 270,000 by December 2025* […] *This does not imply that one set of trends is "real" and the other is not. The evidence points to a more complex picture in which relatively stable underlying prevalence can coexist with rapidly rising diagnosis, referral and service demand.* […] *There is substantial pressure on services providing ADHD assessment. The next phase of the Review will examine more closely the quality and consistency of assessments, variation in diagnostic practice, and the extent to which diagnosis is followed by evidence-based treatment. Among children and young people, the proportion of diagnoses followed by medication prescribing has roughly halved in the post-pandemic period, suggesting a shift in case mix or wider contextual changes that require further investigation.*"

- The trends for autism are similar to those for ADHD, with relatively stable prevalence, but "[s]*elf-identification and diagnoses within health and education systems have increased substantially.* […] *That increase has been particularly marked in the education system. By 2025, autism-related identified need accounted for around 3.1% of school-age children within the SEND system and growth has been especially rapid among girls and pupils without learning disability, indicating changing patterns of recognition*."

Short Note: falling between the disposal cracks

Summary

The case of *R v Wood* [2026] EWCA Crim 480 is an interesting appeal involving the MHA 1983, the MCA 2005 and the criminal law. On 3 April 2018 firefighters found David Wood unconscious in his Sheffield Council bungalow after passers-by spotted smoke. Expert evidence showed the fire had been started deliberately by igniting a curtain draped over the sofa. He had dyspraxia, was alcohol dependent, and had significant cognitive impairment from a 2015 fall causing a basal skull fracture and frontal brain haemorrhages, leaving him with dysexecutive syndrome. At the trial, no intermediary was provided, the court psychiatrist had not seen the medical records regarding his brain injury, and a concerned jury member passed the following note to the judge:

> *Sir, I hope you do not find this premature or critical, but I have immediate concerns over the mental capacity of the defendant based on his appearance, manner, behaviour in the dock. Is the legal system or the mental health system more appropriate? Perhaps this will be addressed. Sorry if this offends but it is an honest reflection.*

The trial continued and he was convicted of arson being reckless as to whether life was endangered, and sentenced to an extended sentence of 9 years, consecutive to 11 months activated from a suspended sentence imposed the previous year for an earlier attempted arson. On appeal, fresh psychiatric and neuropsychological evidence unanimously concluded he had been unfit to stand trial, but that his condition was not treatable, so a hospital order was not sought.

A Care Act assessment concluded he had eligible needs for a supported living placement, but a supervision order was unavailable because neither the local authority nor the Probation Service would act as supervising officer.

Moreover, he was found to have capacity to make decisions as to residence and care so there would be no means of enforcing any requirements imposed by a supervision order, particularly to prevent him accessing alcohol.

Accordingly, in the absence of a hospital or supervision order disposal, the Court allowed the appeal, quashed the conviction, substituted findings of disability and that he did the act, and made an order for absolute discharge. The local authority was to arrange supported living accommodation to which Mr Wood consented to avoid street homelessness, and Probation would trigger MAPPA arrangements to manage the risks.

Comment

Aside from the impressive intervention of the juror regarding Wood's fitness to stand trial, this case illustrates the difficulties navigating the hospital order/supervision order/absolute discharge options of the criminal courts for those found unfit. In relation to his capacity, given the repeated fire-setting incidents, it would have been interesting to test the evidence as to whether his mental impairment was causing him to be unable to 'use' the information relevant to residence and care. The case certainly illustrates the importance of multi-agency co-operation when someone has a brain injury, alcohol dependency and an offending history when the person cannot be detained in prison, hospital or in social care.

Given that "*Dependence on alcohol or drugs is not considered to be a disorder or disability of the mind*" (MHA s1(3)), the following paragraph of the judgment raised an eyebrow:

> *"48. A hospital order is not an option in the present case, because the medical professionals do not support it. Whilst alcohol dependency is a recognised mental disorder within the meaning of the Mental Health Act 1983, and qualifies as a mental health condition for the purposes of treatment, it does not qualify as a basis for detention in hospital.*

Whilst alcohol dependency is excluded from the 'mental disorder' definition, there can of course be mental disorders associated with it. Moreover, a brain injury resulting in personality and behavioural changes can also amount to a 'mental disorder', which is the cornerstone of any form of health or social care 'unsound mind' detention for Article 5(1)(e) purposes.

CHILDREN'S CAPACITY

Short Note: the inherent jurisdiction takes another blow, but staggers on

The Supreme Court in *X and Y (Children: Adoption Order: Setting Aside)* [2026] UKSC 13 held that, whatever the substantive merits of doing so might be on the facts of any given case, it was simply not possible to use the inherent jurisdiction of the High Court to set aside a validly made adoption order. In so doing, however, it did not take up the baton laid down by Professor Rob George KC (and Lady Hale), who have both challenged the very existence of the inherent jurisdiction as a mechanism by which the High Court can grant substantive relief in respect of children. Insofar as the High Court also continues to make decisions in relation to 'vulnerable adults,' the judgment therefore suggests that the question is less as to whether the jurisdiction exists, and more as to whether and how it is being operated in a manner that does justice to all the interests involved.

Children's Wellbeing and Schools Act 2026

The Children's Wellbeing and Schools Act 2026 received Royal Assent on 29 April 2026. Amongst a very varied range of matters it covers, it introduces a new framework which should narrow, but not eliminate, the need for the use of the inherent jurisdiction to deprive children of their liberty through the amendments made by s.15 of the 2026 Act to s.25 Children Act 1989. Significant questions remain in relation to this reform, including

1. Whether it covers all those children who are currently the subject of proceedings under the inherent jurisdiction, our suggested answer being 'no';

2. Whether it is capable of being operated compatibly with Article 5 ECHR, our answer being, in principle yes, although it is concerning that it does not spell out on the face of the primary legislation whether the basis upon which deprivation of liberty is justified is said to be Article 5(1)(d) (educational supervision) or Article 5(1)(e) (mental disorder). This does matter, as McKendrick J has recently reminded us;

3. Whether it will make any difference at all to the current situation where judges in the national DoL list are confronted with situations which are profoundly unsatisfactory, but where there is said to be no other option on the table for the child. If steps are not taken to prevent these situations arising, all the changes in the 2026 Act will do will provide another route to confront the judiciary with nigh-on impossible dilemmas, and will do nothing to serve the interests of the children whose circumstances are before those judges.

Depriving children of their liberty in unregulated placements

On 20 February 2026, Henke J sent a letter to family judges who sit at the RCJ and on the South Eastern Circuit hearing applications relating to deprivation of liberty for children, setting out the procedure for considering deprivations of liberty in unregulated placements. The letter has been approved for wider release and circulated by the COP Bar Association) and we reproduce its contents here so that applicants and other parties will understand what is expected when such an application is made:

> *The purpose of this letter is to ask that when determining an application for a Deprivation of Liberty order in relation to an unregulated placement, you consider the following:*

- *Evidence that planning permission has been obtained for the premise to operate as a children's home.*
- *Evidence of the placement provider actively progressing Ofsted registration.*
- *Requiring the Children's Guardian to visit the placement itself and thereafter considering the evidence of their observations upon it.*
- *Requiring the local authority to establish a regular scheme of visits to the placement, preferably weekly although individual circumstances may require a different regime of visiting.*
- *Requiring a senior member of the local authority leadership team to have regular oversight of the placement given its unregulated status.*
- *Requiring the local authority to commit to regular communication with the child or young person who is to be placed and to ensure that they visit that child or young person (in person or virtually) at least once a week and that the child or young person is seen during those visits and spoken to alone (in the absence of any member of staff).*

Short Note: what procedural fairness does (and does not) require in assessing children

In *ZHB v Cardiff City Council* [2026] EWHC 913 (Admin), Coppel J rejected the argument that a council assessing the age of an asylum-seeker must always appoint a guardian or legal representative: (1) to represent them; or (2) to ensure their informed participation in the assessment. Coppel J accepted that

> *35.* [….] *"informed participation in the age assessment procedure" should be regarded as a universal minimum standard, reflecting as it does an oft-stated requirement of Article 8 in the context of administrative and judicial procedures which affect private or family life ("the applicant must be involved in the decision-making process, seen as a whole, to a degree sufficient to provide him or her with the requisite protection of his interests": Lazoriva v Ukraine (appl. 6878/14, judgment of 17 April 2018, §63 and the authorities cited therein)).*

He declined to go further, however:

> *But the proposition that a legal representative/guardian and access to a lawyer are essential pre-requisites of every age assessment procedure would be inconsistent with (a) the express reference to domestic and EU law in the relevant paragraphs of Darboe and Diakité, (b) the distinction drawn in AC between age assessment of an asylum-seeker and age assessment for other purposes (the latter potentially requiring lesser safeguards), (c) the absence of any finding in AC that the failure to appoint a legal representative/guardian from the outset of the age assessment procedure gave rise to a breach of Article 8 and (d) with the margin of appreciation which is afforded to states when designing procedural safeguards for age assessment procedures. As to (d), given the diversity of law and practice amongst the Contracting States, and the recognised margin of appreciation, it would be surprising if the ECtHR had intended to lay down firm rules requiring a particular type, incidence and duration of representation and/or advice for persons undergoing age assessment.*
>
> *36. In my judgment, the correct analysis is that there is a minimum legal standard (reasonable steps/reasonable diligence in ensuring procedural safeguards) and a choice of means as to how states satisfy that standard in each case. That would be consistent*

> *with the approach generally adopted by the ECtHR of avoiding broad statements of principle as to when the domestic law of a Contracting State violates Article 8 or other Convention rights and focusing instead on the particular facts of individual cases (see, for example, Zakharov v Russia (2016) 63 EHRR 17, §164: "The Court has consistently held in its case-law that the Convention does not provide for the institution of an actio popularis and that its task is not normally to review the relevant law and practice in abstracto, but to determine whether the manner in which they were applied to, or affected, the applicant gave rise to a violation of the Convention" [citations omitted]).*

That having been said, Coppel J accepted (at paragraph 39) that:

> *in my judgment, a state which does not appoint a representative or guardian for a presumed child undergoing age assessment or which fails to ensure access to legal advice could, on the facts of a particular case, be held not to have acted with reasonable diligence, contrary to Article 8, even where these are not already requirements of domestic law.*

That had not happened on the facts of this particular case, Coppel J considered. He also held that (by operation of the statutory framework in play in Wales), the Council was not required to have regard to the provisions of the UN Convention on the Rights of the Child in assessing the age of the asylum-seeker in question (and that, even if it had been, it had discharged its duty).

Transition guidance

The Law Commission's Disabled Children's Social Care project was the latest in a long line of reports to identify that supporting young people to transition through to adult services is not working. Whilst we wait for the Government to respond to the Law Commission's recommendation that (in England) "[t]*he assessment of whether a disabled child is likely to have needs for care and support after becoming 18 and, if so, what those needs are likely to be, should begin by the school year in which they turn 14,*" NHS England has provided guidance (dated 8 April 2026) to support health care services in England to provide developmentally appropriate care for 0 to 25-year-olds. As it states in the introduction

> *It sets out proposed actions for integrated care boards (ICBs), providers and clinical teams to enable safe and effective transition between services. If adopted by systems, this approach will improve continuity of care, health outcomes and young people's experience.*

The guidance contains much very sensible information, but the observations about the law need to be taken with a pinch of salt (it is not, for instance, possible for family members and carers to apply to the Court of Protection to become an attorney under a Lasting Power of Attorney).

Supporting parents with a learning disability

Parents with learning disabilities are disproportionately represented in the child protection system and more likely to have their children removed. A very helpful briefing has been published by Research in Practice (part of the National Children's Bureau) on Supporting parents with a learning disability – the role of Adult Services. Its focus is to support leaders, commissioners and frontline practitioners across adult and children's services to understand how adult and children's services

can work together to support parents with learning disabilities and their children.

This is also an opportunity to flag that:

(1) 'capacity to parent' has nothing to do with capacity for purposes of the Mental Capacity Act 2005;

(2) Professionals working with parents with learning disabilities should join the (free) Working Together with Parents Network.

THE WIDER CONTEXT

Terminally Ill Adults (End of Life) Bill

The Bill fell with the proroguing of Parliament. It is unclear at the time of writing whether an attempt to bring it back will be made when Parliament returns, nor, if such an attempt is made, what provision Government will make to facilitate its progression.

The MCA and suicide

Two Prevention of Future Deaths ('PFD') reports have recently been made by coroners which raise issues about the MCA and suicide.[2]

Gunaratnam Kannan. In this inquest, the coroner considered a situation where an ambulance had been called to attend Mr Kannan by his family on discovering he had taken an overdose of medication. He was assessed by the paramedics as having the capacity to refuse to go to hospital. The paramedics made contact with Mr Kannan's GP, who also carried out an assessment of Mr Kannan's capacity to refuse to go to hospital and concluded he had capacity to make this decision. The GP advised the ambulance service to make contact with the crisis team at the relevant Mental Health Trust (NHCT) to review the patient urgently. It was the GP's understanding that it was for the NHCT to make a referral for a Mental Health Act (MHA) assessment of Mr Kannan.

The paramedics contacted the clinical line at NHCT who advised that they could not attend until the following day, and that it was for the GP to make a referral for a Mental Health Act assessment. The paramedics therefore made a further call to the GP, who reiterated that it was for the NHCT's crisis team to make the MHA referral. The paramedics having been unsuccessful in persuading Mr Kannan to go to hospital, left his address.

20 or so hours later, a further ambulance was called to Mr Kannan's address. By this time he had deteriorated and was assessed as lacking capacity to refuse hospital admission. He was taken to hospital. He suffered a cardiac arrest shortly afterwards and died.

The reason for issuing a PFD was because the ambulance service had given evidence that it was the responsibility of the NHCT to make a referral for an MHA assessment, but the evidence from NHCT was that this was the task of the attending medical practitioner (in this case the paramedic), or the GP or the family. This showed a clear lack of understanding between the services as to what actions should be taken and by who.

The PFD identified the following areas of concern:

- *Lack of joint agency working/ policy work on the Mental Capacity Act Assessments and Mental Health Act Assessments setting out the roles and remit of service providers.*
- *Lack of training of service providers on the Mental Capacity Act assessments and the process for ref errals for Mental Health Act assessments.*
- *There is a clear lack of understanding between these service providers as to what actions should be taken and by who in respect of an MHA assessment.*

[2] Note, thanks to the efforts of the Chief Coroner, it is now easier than it was to search PFDs via this website.

The Royal College of Physicians noted that in their response to the PFD that "[w]*e have concerns around the lack of priority given to urgent mental health services and for individuals with serious mental health concerns to receive timely and effective crisis management. Mental health teams, often within a single Mental Health Trust, need to be integrated to support a personalised care approach. It would be worth NHS England considering how mental health providers commission services to enable this to be developed in all policy and procedures for NHS Mental Health Trusts*."

The relevant ambulance service responded to the PFD saying that "[w]*hile local authorities can accept referrals for MHA assessments, the established expectation is that ambulance crews seek the least restrictive intervention first. This means referring patients to local mental health crisis teams for initial assessment and support before considering formal detention under the MHA. Ambulance crews are not mental health specialists and therefore cannot determine whether a statutory MHA assessment is required*."

The NHS Trust and the ambulance service responses refer to consideration at a national level by the ambulance services as to dealing with mental capacity and the MHA in the context of attempts at suicide. No date for the conclusion of this work is given.

It is of course not possible to tell from this report whether Mr Kannan would have met the criteria to be detained pursuant to the MHA 1983, had he been assessed, and if so whether his life might have been saved. These tragic facts however emphasise the importance of clinicians understanding how to access urgent MHA assessments in appropriate circumstances.

Robert Day was a 60 year old man who took his own life by taking an overdose of medication. At the time he was living in a Travelodge. He called his mental health nurse and informed them of the overdose, and so an ambulance was called. The paramedic assessed Mr Day as having capacity to refuse treatment and so he was not taken to hospital. He died the next day.

The Coroner has asked the government to address the concern expressed by the ambulance service that there was nothing they could practically do – Mr Day was assessed as having capacity to refuse treatment, the police could not deploy s.136 MHA as Mr Day was not in a public place, and there was no time to apply for a warrant under s.135 MHA. Further, it was said to be unrealistic to think that frontline paramedics would have a sufficient understanding of the various legal routes that could be considered. The government has until 19 May to respond to the Coroner's concern that "*the absence of any national guidance / advice to frontline emergency crews risks the lives of others who are found to be at time critical risk as a result of underlying mental health concerns.*"

Separately, the Health Services Safety Investigation Body ('HSSIB') is starting an investigation soon: Mental Health Crisis: Ambulance service response via NHS 111 and 999. The HSSIB sets out that

- Explore how ambulance services triage and prioritise calls about patients in mental health crisis.
- Explore ambulance crew education, training, and assessment of a patient's capacity when in mental health crisis.
- Explore ambulance crew decision making on when to convey a patient in mental health crisis to hospital, including access to relevant clinical advice and access to information held by other services.

Updated Health Research Authority guidance on consent

The Health Research Authority has published guidance on proportionate approaches to seeking and evidencing consent to trials falling within the Clinical Trials Regulations, as well as guidance on simplified approaches of seeking and evidencing consent to the new class of low intervention trials provided for within the (updated) Regulations where such simplified arrangements are allowed. Alex was a member of the expert advisory group for both pieces of work, and is particularly happy that both documents expressly include guidance as to how to encourage sponsors and members of the research team not to exclude those who cannot consent for themselves.

Short Note: clinical guidelines are just that

In *LXLP v St George's University Hospitals NHS Foundation Trust* [2026] EWHC 560 (KB), a clinical negligence case, Kimblin J gave a useful reminder of the status of clinical guidelines:

> *139.* […] *national guidance documents are held in high regard as guidance and are often followed by hospital trusts in crafting their own protocols. However, no element of guidance is a rule. If it were, it would no longer have the characteristics of guidance and the importance of medical observation, experience and care for the individual person in their particular circumstances would be diminished.*

And:

> *157. As for* […] *national guidance documents, I have already addressed their role in guiding clinical decisions. Their further role is to do the reading and analysis to help the busy clinician and that is what then informs the recommendations.*
>
> […]
>
> *158. However,* […] *national guidance documents cannot provide evidence for, nor establish, a position which goes beyond the evidence base which underpins them.*

In the clinical negligence context, in deciding whether a breach of a duty owed to a patient gave rise to actionable loss, this means that it would be "*a fallacy to equate a recommendation in national guidance with causation*" (paragraph 158). In the Court of Protection context, this should serve as a reminder that: (1) guidance documents are not a substitute for exercise of clinical judgment on the facts of a case; and (2) that judgment must, itself, be based on an appropriate evidence base to constitute a 'reasonable' treatment option.[3]

[3] Putting to one side the curveball of the Court of Appeal's decision in *Townsend*.

SCOTLAND

Incapacity Law and Practice Certification Course

Improvement of law and improvement of practice have been constantly headlined over several years as the principal AWI needs.

At the political level, law reform has been paused for the election. The Ministerial-led Oversight Group waits to know who will be the Minister to lead it. However, such has been the momentum for law reform sustained ever since the "gearing-up", that we reported in March 2025, that the Expert Working Group has been quietly continuing with its monthly schedule of work, progressing as planned through all the successive workstreams that were identified.

Improvement of practice is a wide-ranging issue. One could define the range simply by saying that it covers everyone and every institution or entity that engages with the lives of those actually or potentially within the scope of our AWI regime, with their families and carers, and with people seeking to make appropriate future provision for themselves. The story across the board has been one of unacceptable variations, ranging so often from excellent practice to unacceptably poor practice.

Many significant initiatives have been created and implemented to address that issue for different main groups, and they continue. In all cases, the need is for education and training. Perhaps the initiative that has addressed, and continues to address, the largest constituency is the joint work of Health Education Scotland and the Mental Welfare Commission for Scotland through the Turas "One for Scotland" training initiative, which – we understand – is now to be funded for another year. Training is being pursued by various professions. It is being delivered by the Office of the Public Guardian, by such means as are open to it, to guardians and attorneys. There has been a discreet but substantial gearing-up of judicial training: despite record levels of recruitment to the shrieval bench, the policy has been sustained on including compulsory AWI training in the inductions for all new sheriffs.

What about the solicitors' profession? Last year an initiative was commenced by the Law Society of Scotland: to be precise, it has been led by Rachel Steer, CPD Project Manager with the Society, in conjunction with Sandra McDonald, former Public Guardian for Scotland and now author and adviser on everything AWI, who needs no introduction to readers of this Report; and who among other things is a proactive member of the Society's Mental Health and Disability Committee. We go to press as they are mid-way through delivering the first running of the Incapacity Law and Practice Certification Course which they conceived, planned and structured, and for which (by dint of personality and persuasion, one must assume) they have secured a range of most suitable speakers to deliver.

We are indebted to Rachel Steer for kindly writing an account and assessment of this initiative. Direct quotations from her appear in italics. She confirms that the Law Society embarked on the creation of the course after identifying AWI law:

> *"as an appropriate area for certification to add to our growing programme of professional certifications. This decision reflected both the high number of practitioners engaging with incapacity work in some form, and the wide variation in experience, confidence and approach seen across the field. While some solicitors and firms practise almost exclusively in incapacity law, others encounter it as an adjunct to broader practice, often without access to structured training.*

> *"With work undertaken under the [Adults with Incapacity (Scotland) Act 2000] occupying a distinctive and demanding space within legal practice, frequently intersecting with some of our most vulnerable people in society, the Society aimed to create a course which goes beyond technical knowledge, and consolidates the specialist skill, defensible decision making and ethical judgement required of practitioners operating in this area."*

Rachel's first paragraph above points towards the diversities in standards referred to above, but in terms suitable for a Society that represents and has in its membership all practising solicitors in Scotland, and is there to serve all of them. In similar broad terms, she highlights the particular significance of AWI work, and its attraction for those who feel themselves challenged by an area of practice that tends both to attract lawyers of the highest standard, and to need them.

Rachel continues as follows:

> *"Early consultation with the Law Society of Scotland's Mental Health and Disability Sub-Committee was integral to the development of the course, enabling the Society to draw on specialist insight, address potential concerns, and ensure the certification reflects the realities of practice and the standards expected of solicitors working with vulnerable adults. The Society chose to partner with Sandra McDonald, former Public-Guardian for Scotland, author and adviser, to aid them in course design and delivery, drawing on her extensive experience and unique perspective.*
>
> *"The course was shaped in recognition of the uncertainty facing incapacity practitioners as a result of the Scottish Mental Health Law Review and the prospect of significant reform to the existing legislative framework. Alongside reinforcing statutory principles, the programme takes a forward-looking approach, addressing emerging areas of law, significant case law and anticipated reform. It is recognised that the course will need to remain fluid as reform progresses."*

That law reform has proceeded so unacceptably slowly at times, sometimes going nowhere at all for years, but is now moving steadily ahead as mentioned above, which has all been particularly challenging for those delivering legal services in the AWI field on a daily basis over that timescale. What is the best that current law and good practice enable me to deliver right now? Yes, I need to know where law reform is coming from, and where it is ultimately likely to go to, but in the meantime – right now – I have to perform to the full all my professional obligations to my clients.

The following is an indicative outline of the current course (not the full course programme).

Module 1: The Foundations of Incapacity Law, 2.45 HR – 23/04/2026

Welcome, introductions, housekeeping, motivations for joining the course

AWI Principles

POA Fundamentals

Access to Funds – and alternatives to financial guardianship (DWP appointee, intervention orders)

- What is it?
- How to recognise when it may be appropriate
- Application

- CTF

Public Guardian

- Code of Practice
- Role
- Investigation
- Reporting duties
- Importance of developing a relationship with OPG

Module 2: Guardianship in Practice, 3 HR – 30/04/2026

Guardianship process: Getting it right

Managing a Financial Guardianship

Module 3: Understanding and Assessing Capacity, 2 HR – 07/05/2026

Legal v Medical Definitions

Assessing Capacity: Practical application

- Insight v capacity
- SIDMA – assessing for POA and capacity for guardianship

Safeguarders, Curators and Guardianship Court Applications, a View from the Bench

Module 4: Emerging Challenges, 2 HR – 14/05/2026

Deprivation of Liberty

- Theory
- Use in practice
- What changes can we expect, and when
- Case law

Practical Update

Module 5: Advanced AWI Issues, 2 HR 10 – 21/05/2026

s.47 (Advance choices/Statement of wishes)

- Capacity to make decisions for medical treatment

s.13ZA

Advanced Powers of Attorney

Scott Review

On-demand:

- Cross-border issues and considerations

Module 6: Client (and Self) Care Workshop, 3 HR – 28/05/2026

Communicating effectively with incapacitated clients and their families

The solicitor's role in communicating difficult messages with incapacitated clients and their families

- Influence?
- What if you're unsure on capacity?

Independent advocacy skills: Good practice

Managing conflict

Looking after yourself – self-care and professionalism

On-demand:

Wellbeing module: The Cost of Caring: introduction to vicarious trauma

Can one say, half-way through the first delivery of this certification course, whether both the concept of the course and this delivery of it are proving to be successful? Let the final words be Rachel's:

"Launching formally in February 2026, uptake for the first delivery of certification exceeded expectations, with the course selling out within two weeks, necessitating an increase in places to meet demand. Delegates represent a broad mix of firm sizes and levels of experience, with strong representation from smaller high street firms in particular.

"As the course progresses, feedback and engagement has been positive. Many delegates cited the lack of in-depth incapacity-specific training and the opportunity to receive Law Society certification as key reasons for enrolling, valuing the ability to upskill and receive a recognised signal of competence that both the public and wider profession recognises."

Adrian D Ward

(with the assistance acknowledged)

[Editorial note by Alex: both Adrian and Jill have been involved in delivering the course; Alex has recorded the 'on demand' session on cross-border issues and considerations]

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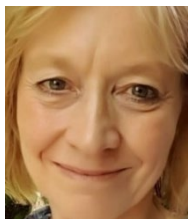

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Conferences

Members of the Court of Protection team regularly present at seminars and webinars arranged both by Chambers and by others.

Alex also does a regular series of 'shedinars,' including capacity fundamentals and 'in conversation with' those who can bring light to bear upon capacity in practice. They can be found on his website.

Advertising conferences and training events

If you would like your conference or training event to be included in this section in a subsequent issue, please contact one of the editors. Save for those conferences or training events that are run by non-profit bodies, we would invite a donation of £200 to be made to the dementia charity My Life Films in return for postings for English and Welsh events. For Scottish events, we are inviting donations to Alzheimer Scotland Action on Dementia.

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

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