HEALTH, WELFARE AND DEPRIVATION OF LIBERTY
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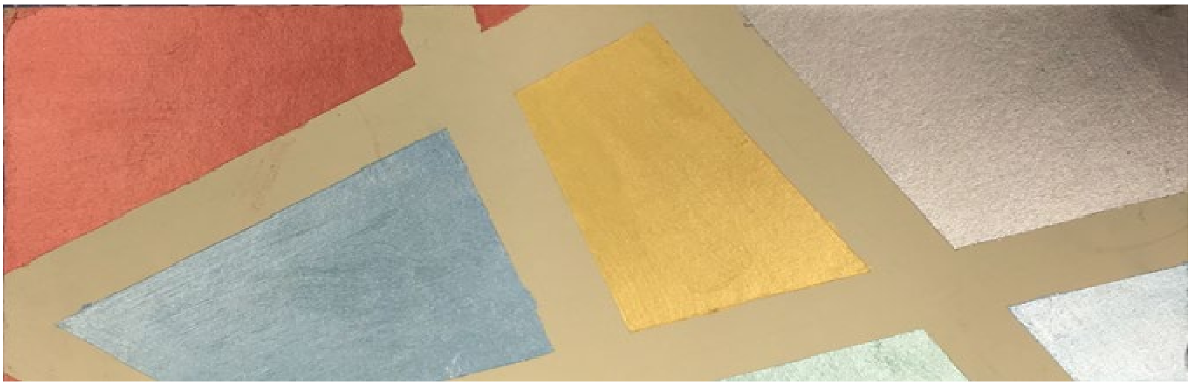

Welcome to the May 2026 Mental Capacity Report. Highlights this month include:

(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

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]*he 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.

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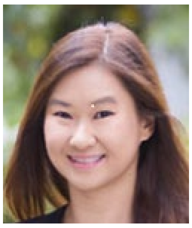

Annabel has a well-established practice in the Court of Protection covering all areas of health and welfare, property and affairs and cross-border matters. She is ranked as a leading junior for Court of Protection work in the main legal directories, and was shortlisted for Court of Protection and Community Care Junior of the Year in 2023. She is a contributor to the leading practitioners' text, the Court of Protection Practice (LexisNexis). To view full CV click here.

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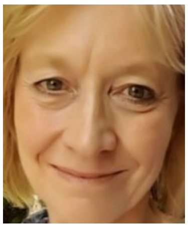

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Conferences

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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