

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.

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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.¹

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

¹ Note, thanks to the efforts of the Chief Coroner, it is now easier than it was to search PFDs via this [website](#).

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 referrals 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.*

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.²



² Putting to one side the curveball of the Court of Appeal's decision in *Townsend*.

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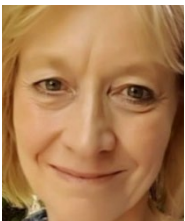
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Conferences

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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