Essex CHAMBERS

MENTAL CAPACITY REPORT: COMPENDIUM

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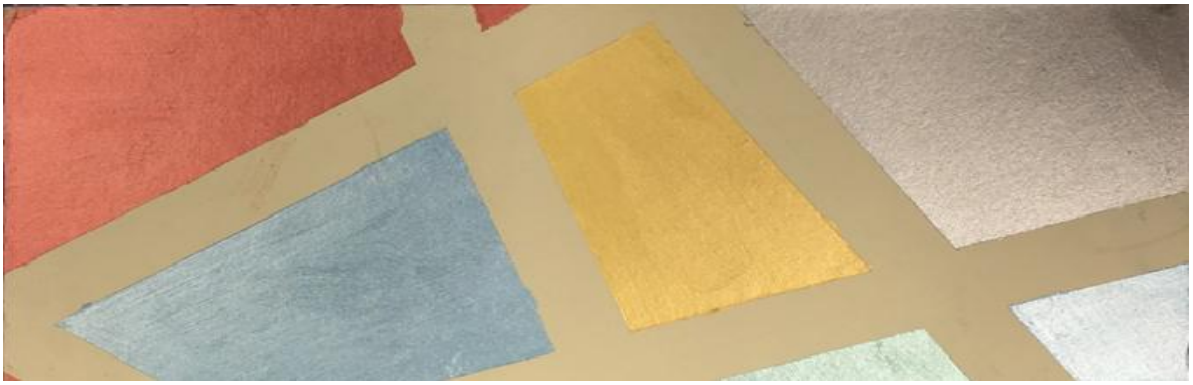

Welcome to the July 2026 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: Permission to appeal granted in *Townsend*; post-AGNI guidance; and a new Guidance Note on Capacity for Care Providers

(2) In the Property and Affairs Report: Statutory wills; charging for being an appointee; and guidance on assessing financial capacity

(3) In the Practice and Procedure Report: Court of Protection and child deprivation of liberty statistics; court fees rising; reasons challenges in the Court of Protection; medical treatment cases – whether to issue, and the consequences of waiting too long

(4) In the Mental Health Matters Report: EU Recommendation of the Committee of Ministers to member States on respect for autonomy in mental healthcare

(5) In the Children's Capacity Report: A CAMHS psychiatrist's view on child deprivation of liberty cases – and what interventions can help to break the 'vicious cycle' of restrictions and institutionalisation

(6) In the Wider Context Report: Adult social care reform; the Muckamore Abbey Inquiry Report is published; and what becomes of solicitors whose clients lacked capacity

(7) In the Scotland Report: Circumvention and undue influence

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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HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

Permission to appeal granted in *Townsend*

The Supreme Court has granted permission to the applications made by both the NHS Trust and Mr Barnor's family in the *Townsend* Court of Appeal judgment. It is understood that the hearing may be listed in December 2026 or January 2027, and we will continue to report on any updates in this matter.

Post-*AGNI* Guidance published

The DHSC has now produced initial guidance (15 June 2026) both as to the meaning of deprivation of liberty, and also steps to take by local authorities and other bodies. On 18 June 2026, ADASS issued a 'note' building on an initial statement on 5 June, supporting the DHSC guidance and setting out a number of points it considered should be followed by all councils.

The Department of Health in Northern Ireland issued interim guidance and an accompanying information leaflet on 24 June 2026 available here.

West Midlands ADASS has published updated DoLS forms to reflect the judgment – there are no statutory forms for the DoLs process, but

these forms are used by many local authorities, and the updated forms represent an operationalisation of the judgment (note, the relevant updated forms say April 2026, but they were prepared in June 2026).

Initial guidance provided on the day by Senior Judge Hilder to judges of the Court of Protection considering so-called 'community deprivation of liberty' orders is available here.

CQC has issued an initial statement (8 June 2026) here.

Guidance Note on Capacity for Care Providers

A Guidance Note on Capacity for Care Providers dated 23 June 2026 (authored by Alex Cisneros, Tor, Alex and Neil) has been published on the 39 Essex Mental Capacity Resource page. This guidance note is for provider settings such as care homes and supported living placements in England about:

(a) when is it necessary to carry out and record a formal assessment of a person's mental capacity, and in relation to which decisions;

(b) the difference between informally considering capacity as part of good care practice, and formally recording a capacity determination;

(c) when a formal written record is and is not required;

(d) how providers should approach capacity across the domains of a care plan; and

(e) what providers should do if they receive advice from a CQC inspector or local authority quality monitoring officer that appears to go beyond what the law requires.

Recognition of a Scottish order under Schedule 3 MCA

Midlothian Council v DM [2025] EWCOP 61 (T3) (Theis J, VP) (18 December 2025)[1]

International jurisdiction of Court of Protection – Recognition and Enforcement

Summary

After *Aberdeenshire Council v SF (No 2)* [2024] EWCOP 10 and *Argyll and Bute Council v RF* [2025] EWCOP 12 (T3), in which Scottish guardianship orders authorising a deprivation of liberty in England foundered on the Article 5 rocks, a Schedule 3 application has now succeeded. Theis J provided the judgment as a template, hoping that reporting what Midlothian Council did "will help and assist any other public authority that may be looking at other practical ways to meet the concerns set out in the *RF* case" (paragraph 23).

DM, aged 28, had autism and a learning disability, and since January 2021 had been placed in a care setting in Workington under a welfare guardianship order made under the Adults with Incapacity (Scotland) Act 2000. Midlothian Council sought recognition and enforcement of the renewed order made by Edinburgh Sheriff Court on 13 March 2025. Recognition was granted in light of the following measures to ensure Article 5 compliance:

1. DM had a real opportunity to be heard: a safeguarder was appointed by the Sheriff Court to collect and convey his views, he was served with the renewal application, and he attended the hearing with his care team, so paragraph 19(3) of MCA 2005 Schedule 3 was not engaged.

[1] Note: Arianna did not contribute to this summary, having been involved in this matter.

2. The order itself contained an express power to review the continuing necessity of the deprivation of liberty annually or at DM's request.
3. The council put in place and funded an advocacy support plan under which an independent advocate meets DM every four to six weeks to ask whether he is content with the deprivation of liberty measures, whether he wishes to challenge the guardianship powers or how they are being used, to check whether he is unhappy with any aspect of his care or residence, to ensure he knows of his right to a review, and to ensure that any review he requests is actually undertaken.
4. As to access to court, the council confirmed that if DM wished to seek recall or termination under section 71 of the 2000 Act, either the Chief Social Work Officer or the independent advocate would instruct a solicitor – funded by the council, and irrespective of the council's own view as to whether the order should continue – with independent representation available in the Sheriff Court through a curator ad litem.

Theis J was satisfied that this "impressive and creative" framework was "real and not illusory", met the concerns expressed in *RF*, and that recognition was neither manifestly contrary to public policy nor inconsistent with a mandatory provision of the law of England and Wales.

Comment

The decision confirms that the Article 5 deficits identified in *SF* and *RF* = can be cured by practical, funded arrangements constructed around the order. One point merits watching. The sixth *RF* requirement is that reviews should not depend on the goodwill of the detaining authority, yet the machinery here is devised, funded and partly operated by the guardian authority itself. What carried it was the express commitment to fund advice and any section 71 application irrespective of the council's own position, coupled with the independence of the advocate and of any curator ad litem. Authorities seeking to replicate the model should ensure those commitments are equally concrete – and recorded in evidence – rather than gestured at. For cross-border placements, expect the 'Midlothian package' (a review provision on the face of the guardianship order, a funded advocacy plan with regular visits, and a guaranteed, funded route to the Sheriff Court) to become the de facto price for Schedule 3 recognition.

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PROPERTY AND AFFAIRS

Statutory wills and dispensing with service

Fairweather v AG & Anor [2026] EWCOP 24 (T1) (District Judge Ellington)

Best interests – statutory wills

Summary

AG is a young woman who has a substantial estate derived from an NHS compensation award. Her professional deputy sought the court's approval of a statutory will under which AG's whole estate would pass to her mother, AB, or her brother, GB. The concern driving the application was that, on AG's intestacy, her estranged father, CG, would be entitled to share equally with AB.

As part of that application, the deputy applied to dispense with service on CG, relying on AB's concern that contact would expose her to violence, supported by evidence that CG had received a police caution for assault in 2006.

District Judge Ellington dismissed the application to dispense with service. Applying *Re D* [2016] EWCOP 35, and notwithstanding CG's absence of some twenty years and the historical evidence of violence, she held that the evidence of a current risk of harm was insufficient to override CG's Article 6 right to participate in proceedings that would directly affect his inheritance. At [43] she stressed that the question before her was procedural, whether CG should be served, and not a best interests decision.

Comment

DJ Ellington's distinction at [43] between the procedural question of service and the substantive best interests decision about the will is central to the judgment: these two stages must not be run together.

The strength of the family's reasons for wanting CG to receive nothing is irrelevant to the earlier and separate question of whether he should be notified and given an opportunity to take part.

For practitioners, the key point is that dispensing with service where a third party has their own financial interests at stake requires clear, up-to-date evidence of risk. A single historic incident, or general concerns (even against a background of long estrangement) will not normally be enough to override that person's Article 6 right to participate. There may also be intermediate steps short of full non-service, such as an application to restrict the information disclosed to a particular family member if they are notified.

Charging for appointeeship: An article by Alex Cisneros

This guidance considers whether an appointee appointed under the Social Security (Claims and Payments) Regulations 1987 ("the 1987 Regulations") or the Universal Credit, Personal Independence Payment, Jobseeker's Allowance and Employment and Support Allowance (Claims and Payments) Regulations 2013 ("the 2013 Regulations") may lawfully charge for their services, and if so, on what legal basis.

1. The legal framework for remuneration in analogous roles

The default position

The starting point is the established common law principle that a trustee (or anyone acting in a fiduciary role) has no implied right to be paid for carrying out their role.[2]

[2] *Robinson v Pett* (1734) 3 P Wms 249

Because the default position is that the role is unpaid, any entitlement to remuneration must come from a specific legal source.

Deputies

For deputies, attorneys and trustees, that specific legal source is clear. Section 19(7) of the Mental Capacity Act 2005 provides:

> *The deputy is entitled— (a) to be reimbursed out of P's property for his reasonable expenses in discharging his functions, and (b) if the court so directs when appointing him, to remuneration out of P's property for discharging them.*

Remuneration is not automatic. It requires a positive direction from the Court of Protection at the time of appointment. As Hayden J said in Riddle v Parker Rhodes Hickmott Solicitors [2022] EWCOP 18 at para 8:

> *The MCA confers a right to remuneration of expenses, but it is the Court that provides legal authority for remuneration.*

Attorneys

An attorney under an LPA has no entitlement to remuneration unless the instrument expressly provides for it. The OPG's guidance is clear on this.

The donor must therefore have included a charging provision in the LPA instrument at the time of execution, while they had capacity to do so.[3]

Trustees

A trustee can only charge if one of the following applies:

- the document creating the trust expressly says they can;
- the court authorises it, using its inherent power to do so (Re Duke of Norfolk's Settlement Trusts [1982] Ch 61); or
- sections 28 and 29 of the Trustee Act 2000 allow professional trustees to charge in certain circumstances even without an express provision in the trust document.

2. The Regulations governing appointees

There are two sets of regulations that deal with a situation where someone is unable to manage their own benefits (the 1987 Regulations and the 2013 Regulations):

- **The 1987 Regulations:** Regulation 33 applies to legacy benefits such as Attendance Allowance, Disability Living Allowance, Employment and Support Allowance and State Pension.
- **The 2013 Regulations:** Regulation 57 applies to Universal Credit and PIP. It is in substantially the same terms as Regulation 33. It provides that the appointee's function includes "receiving and dealing on behalf of P with any sums payable to P".

Both regulations do the same thing: they authorise the appointee to act on the claimant's behalf and to handle their benefit income.

Neither regulation says anything about remuneration. Earlier DWP guidance is

[3] See for example *Re DP (Revocation of Lasting Power of Attorney)* [2014] EWCOP B4, where Senior Judge Lush held that an attorney "contravened his authority by awarding himself a salary" because the relevant section of the LPA had been left blank.

understood to have addressed the point and to have stated that an appointee should not charge for acting in that capacity.[4]

The DWP has since removed that clarity and recent guidance does not address the question of charging:

- The DWP's 2025 internal guidance about appointees is silent on charging.[5]
- The GOV.UK public-facing page is equally silent on the point.[6]

3. Proposed bases for charging

The legal basis on which an appointee may charge depends on two questions. The first is whether the person receiving the benefits ("P") has, or lacks, the mental capacity to agree both to the appointment and to being charged for it. The second is whether the appointee is a local authority or a private appointee (such as a family member, a company or another organisation).

(A) Where the benefits claimant has capacity

An appointee can only be appointed by the DWP where the person receiving the benefits is themselves "unable for the time being to act".[7] The regulations do not define what it means to be "unable to act", and they do not seek to import the statutory test for mental capacity under the Mental Capacity Act 2005. It is therefore possible for a person to be "unable to act" for the purposes of managing their own benefits while nonetheless retaining the mental capacity to decide to pay someone to manage those benefits on their behalf.

In those circumstances, the claimant may choose to pay their appointee for providing that service. However, any appointee seeking to charge for their services should take care to ensure that the claimant has the mental capacity to agree to those charges.

(B) Where the benefit claimant lacks capacity

Where P lacks the capacity to agree to the appointment or to being charged, consent is not available as a basis for charging, and the position is more difficult. The route to any lawful charge differs depending on the identity of the appointee.

Private appointee

Some companies and individuals are willing to act as a person's appointee but want to charge that person a fee for doing so. Where that person lacks the capacity to consent to paying such a fee, these appointees have sought other ways to justify the charge.

[4] Department for Work and Pensions: Agents, appointees, attorneys, deputies and third parties: staff guide Appendix 5 (last updated 5 June 2021 but withdrawn on 29 July 2022) says: 'You must not take a "fee" or "pay" for acting as an appointee.' https://webarchive.nationalarchives.gov.uk/ukgwa/20221103191458/https://www.gov.uk/government/publications/procedures-for-dealing-with-agents-appointees-attorneys-deputies-and-third-parties/appendix-4-aide-memoire-official-use

[5] https://data.parliament.uk/DepositedPapers/Files/DEP2025-0364/011._Appointees_PABs_and_CABs-Guidance_V15.0.pdf

[6] https://www.gov.uk/become-appointee-for-someone-claiming-benefits

[7] Regulation 33(1)(b) of the 1987 Regulations, under which an appointee may be appointed only where (among other conditions) the person "is unable for the time being to act". The equivalent provision is regulation 57 of the 2013 Regulations.

The proposed basis for charging in this situation is section 7 of the Mental Capacity Act 2005, which provides:

> *If **necessary** goods or services are supplied to a person who lacks capacity to contract for them, that person must pay a reasonable price for them.*

Section 7 is intended to strike a balance between two competing interests: protecting P's money from being unfairly reduced, and ensuring that people who provide necessary things to P in good faith are not left unable to recover payment simply because P lacked the capacity to enter into a binding contract.[8]

Appointeeship probably does count as a "service" to P. Whether that service is "necessary" will depend on whether (1) P genuinely cannot manage their own benefits, and (2) if no one else is willing or able to act as appointee.

If a private appointee does charge P for the service provided, this gives rise to an inherent conflict of interest. In charging P, the appointee is effectively deciding whether to charge, setting the level of the charge, and then authorising payment to themselves out of P's own funds.

The DWP should therefore issue guidance addressing how this conflict is to be managed, and establish safeguards to ensure that charges made by appointees are appropriate and properly scrutinised. No such guidance exists at present.

Local authority appointee

A local authority is not in the same position as a private organisation seeking to charge P. Unlike a private body, a local authority may charge for its services only where statute has given it a specific power to do so.

Section 7 MCA 2005 does not supply that power. What section 7 does is create a liability on P to pay a reasonable price for necessary goods and services supplied to them. A private appointee, not being a statutory body, can therefore supply the service and rely on section 7 to ground P's obligation to pay. A local authority cannot, because section 7 says nothing about a local authority's power to provide a service for a charge in the first place.

Various local authorities, when consulting on the introduction of charges, have considered their legal basis for charging for DWP appointeeship.[9][10][11] They have largely debated two legal frameworks:

- Section 1 of the Localism Act 2011; and
- Section 14 of the Care Act 2014.

Localism Act 2011

The Localism Act is unlikely to assist a local authority here. Since P cannot agree to the service being provided, condition (b) in section 3(2) cannot be met. In addition, where the authority is dealing with P's benefits as part of its duties towards P under the Care Act 2014, condition (a) may not be met either, because the service may be one the authority is required to provide.

[8] Mental Capacity Act 2005, Explanatory Notes, para 45.

[9] https://www.minutes.haringey.gov.uk/documents/s109453/DraftCharging Managed Accounts Questionnaire appendix 4.pdf

[10] https://northnorthants.citizenspace.com/asc-swp/appointeeship/

[11] https://cabinet.leicester.gov.uk/documents/s152493/Decision Notice - AAA March 2024.pdf

Care Act 2014

It has been argued that managing the benefits of a person who lacks capacity is itself part of a local authority's functions under the Care Act 2014, so that the cost of acting as P's appointee could be charged under section 14. Section 14 is not, however, a free-standing charging power.

By section 14(1)(a), a local authority "may make a charge for meeting needs under sections 18 to 20". The power to charge is therefore dependent on a prior decision to meet a need under one of those sections.

That decision is not confined to eligible needs. Section 18 imposes a *duty* to meet a person's eligible needs; section 19 confers a *discretionary power* to meet needs that are not eligible. A charge under section 14 may be made in either case.

But unless the authority has actually decided to meet the relevant need under sections 18 to 20, there is no power to charge for it under section 14 at all. The appointeeship argument therefore succeeds only if managing P's benefits can properly be characterised as a need the authority has decided to meet under those provisions. There does not appear to be a reported judgment squarely deciding that it can.

Two further points are relevant:

- The authority is free to set the price (that is, the cost) of the appointeeship service. However, what the person actually pays towards that cost is then governed by the financial assessment.
- In some cases the financial assessment can be waived, for example where it is already clear that the person falls above or below the relevant charging thresholds.

4. Conclusion

The common law starting point is that anyone managing another person's affairs does so without payment unless a specific legal authority says otherwise.

In every analogous role, that authority is identifiable: a court order, an express provision in the instrument, or a statute. For appointees, it is conspicuously absent. Neither the 1987 nor the 2013 Regulations says anything about remuneration, and the DWP, which is understood once to have stated that appointees should not charge, has allowed even that much clarity to lapse.

Whether an appointee may nevertheless charge turns on two questions: whether P has or lacks capacity, and whether the appointee is a local authority or a private appointee.

- Where P has capacity to decide to pay an appointee, charging rests on P's agreement: by ordinary contract for a private appointee, and under the general power in the Localism Act 2011 for a local authority.
- Where P lacks capacity to decide to pay an appointee, the position is markedly less secure: a private appointee's charge would have to be justified under section 7 of the Mental Capacity Act 2005 as a reasonable price for necessary services (a route available only if appointeeship is both a "service" and "necessary" on the facts), which does nothing to resolve the conflict of interest inherent in an appointee charging P out of P's own funds; while a local authority cannot use section 7 at all and must instead rely on section 14 of the Care Act 2014, which is available only where acting as appointee forms part of a need the authority has

> decided to meet under sections 18 to 20, with any charge then subject to a financial assessment of the person's ability to pay.

The overall picture is that there is no clear route to charging an incapacitous P.

The solution lies with the DWP, which should restore the clarity it previously provided by stating expressly whether, and in what circumstances, an appointee may charge. If charging is to be permitted, it cannot be left unregulated: at present, an appointee may decide whether to charge, set the level of any fee, and recover it directly from the claimant's funds, all without independent scrutiny.

Clear guidance is therefore needed on how this inherent conflict of interest should be managed, along with appropriate oversight to ensure that claimants who cannot protect their own interests are not exposed to overcharging.

Alex Cisneros

Assessing financial capacity: new guidance

The Association of Lifetime Lawyers has published new Professional Guidance on Financial Capacity (22 June 2026), aimed at those assessing a person's mental capacity to manage their property and financial affairs. The guidance is intended to support practitioners in approaching financial capacity assessments in a structured and defensible way, and is a useful companion to the issues canvassed above on appointeeship and charging. It can be downloaded from the Association's resources page.

PRACTICE AND PROCEDURE

Court of Protection and child deprivation of liberty statistics

The most recent (January to March 2026) statistics have been published for the Court of Protection. They will be of historical note as representing (we anticipate) the high water mark of deprivation of liberty applications (both s.21A and 'community DoL' applications) before the *AGNI* decision. Somewhat oddly, the note in the supporting table explaining the 2,264 applications does not relate to the reporting period, but, to give an indication, the 2,199 deprivation of liberty applications for the previous quarter (the end of 2025), broke down as follows: 276 for Section 16, 608 for Section 21A and 1,315 for the Re X process.

Separately, the Family Court statistics also show that there were 393 applications for authorisation of deprivation of liberty of a child in the same period (the most in any quarter for which broken-down records are available), 99 of which related to children aged 16 and 18 (and 40 to children under 10). Again, we will watch with interest to see whether there is an *AGNI* impact going forward.

Court of Protection fees rising

Subject to parliamentary approval and effective 13 July 2026, there will be increases to Court of Protection fees:

Description	Current	New
Application to start proceedings or application for permission to start proceedings	£421	£432
Filing an appeal	£265	£272
Hearing fees	£259	£266
Copy of a document fee	£5	£8

Capacity: the court and the expert, and the 'reasons burden'[12]

in *London Borough of Camden v BW & Anor (Capacity Decisions; Reasons)* [2026] EWCOP 26 (T3) (Lieven J)

Practice and Procedure (Court of Protection) - other

In one of what is likely to be one of her last decisions as a Tier 3 judge (having very recently been appointed a Court of Appeal judge), Lieven J considered a very complex situation in *London Borough of Camden v BW & Anor (Capacity Decisions; Reasons)* [2026] EWCOP 26 (T3). At its heart were two questions as to the capacity of the young woman, BW: (1) to make decisions about taking psychotropic medication;[13] and (2) about sharing information with her sister. Her case was, sadly, one which was not entirely

[12] Note: having appeared in this matter, Arianna has not contributed to the writing of this note.
[13] Note, the framing of the question at both first instance and on appeal was on the basis of 'consenting' to such medication, which likely reflects the realities of the situation, but is at interesting odds to conventional medical treatment cases, in which the decision is not about consent / refusal, but whether to have the specific procedure.

untypical of cases now appearing before the court, i.e. a young woman identified as vulnerable to sexual exploitation and abuse, with a history of contacting men on the internet and then being exploited. BW had also been arrested a number of times for assault, but had been assessed as unfit to plead or stand trial on at least one occasion.

Perhaps unsurprisingly in light of this history, the woman had been the subject of innumerable assessments. In 2023, she had been assessed for purposes of Court of Protection proceedings by Dr Ince, who held (in views accepted by the court, and not subsequently challenged) that BW lacked capacity to litigate; make decisions regarding her care, accommodation and support needs; contact with others; access to the internet and social media; and to manage her property and affairs. He subsequently also identified that she had capacity to engage in sexual relations. The court made orders as to her residence and care arrangements. In 2025, she had a series of mental health crises with delusional beliefs, and decreased functioning. Her behaviour was described as being extremely challenging, including assaulting staff and attempting to abscond. She refused to take her oral medication, save on one occasion. In August 2025, in the context of her sister and the Official Solicitor raising whether she should be put on psychotropic medication, her community psychiatrist expressed the view that BW had capacity to decide whether or not to take it. Between October and December 2025, BW was admitted to mental hospital, initially under s.2 MHA 1983, and then as a voluntary patient.[14]

A further expert, Dr Sheehan, identified that there was a "*a general acceptance that antipsychotic medication has been effective in reducing* [BW]*'s aggression and irritability*," but reached the conclusion that BW had capacity to decide whether or not to take it. He also concluded that she had capacity to decide whether or not to share information with her sister.

At first instance, at a hearing convened to consider BW's capacity, Senior Judge Hilder concluded that, contrary to the view of Dr Sheehan, BW lacked capacity in both regards. She also held that it was in BW's best interests for her to take psychotropic medication. The hearing was held in circumstances of some urgency, because the clinicians thought that BW needed her depot injection imminently.

Senior Judge Hilder's conclusions had been as follows (paragraph numbers being those in the underlying judgment, which had not been published, but extracts from which appear in the judgment of Lieven J):

21. Firstly, it is part of the information relevant to making a decision about depot medication that not having it and the consequential prospect for deterioration on BW's ability to avoid incidents of aggressive behaviour are likely to bring about the end of BW's current placement at [Address A]. That information was just wholly missing from Dr Sheehan's assessment. As the depot time approaches, incidents of aggression have increased. Insofar as Dr Sheehan said he was 'not sure' about the change of active level and medication as the depot time approaches, in my judgment his hesitant view must be considered in

[14] Parenthetically, it would be extremely interesting to know the basis on which this was considered to be lawful in circumstances where it is difficult to see how this could not have been a confinement, and (on the face of the judgment) it is not obvious how she could have capacity to consent to that confinement. Pre-*AGNI* it is very difficult to see how this could not have been seen to have been a deprivation of liberty requiring formal authority (the information in the judgment does not give enough material upon which to assess whether post-*AGNI* she would still be seen as deprived of her liberty)

the light of the prescribing clinician's view that another dose is required.

22. Secondly, it is part of the information relevant to making decisions about information sharing with AW that, without full information, her ability to support BW by input into the planning and delivery of the care arrangements which necessarily have to be made by others is likely to be adversely affected. It is relevant to the question of information sharing that BW's care arrangements have to be determined by others in her best interest. So when Dr Sheehan acknowledges, as he did orally, that he did not explore with BW her much-expressed view that she does not need anything like her current restrictive care arrangements to keep her safe, that amounts to a significant deficit in the process of assessment.

23. Ms Kelly asked the question: "What is it about BW's relationship with [AW] which gives rise to a distinction between her or others who have responsibility towards the care arrangements?" (I am conscious that that is a paraphrase of a whole line of questions, but I think that it captures the gist.) Dr Sheehan identified that relationships with family members may be different to relationships with professionals, but he did not identify how BW's wishes about the flow of information to AW are different from consideration of her capacity at the time

24. This is a very difficult case. BW's unique profile of abilities and capacities makes it very difficult for her to navigate life and also for others to assist her. Again, I am acutely conscious of the statutory assumption of capacity, of the need to avoid a protective imperative, of the need not to set a threshold unfairly high, but I am not satisfied that Dr Sheehan's conclusions adequately reflect the position. I agree with BW's own representatives that the assessment process is fatally undermined by superficiality in key respects.

25. Taking into account the full range of capacity assessments over time and the evidence presently of BW's carers as set out in the social worker's statement and indeed by AW, it is my judgment that BW does not understand the relevant information for either of the decisions currently under consideration, and is not able to use or weigh those relevant factors; and that both of those factors are due to the impairment attributable to her current diagnosis of autism.

26. Accordingly, today, I make a declaration that BW lacks capacity in each of the domains which I have been considering.

Senior Judge Hilder went on to hold that it was in BW's best interests to have the medication (it is unclear what her determination was as regards the sharing of information). As can be seen, Senior Judge Hilder's reasons were relatively short form. A central plank of the appeal brought against her decision by the local authority was on the basis that those reasons were inadequate. The appeal was also brought on the basis that it had been procedurally unfair to reach a conclusion about best interests when the hearing had been listed for determination of capacity; that ground was, however, abandoned at the hearing before Lieven J, and it was acceptable on BW's behalf that, if she lacked capacity to take psychotropic medication, it was in her best interests to have it.

Dealing with the reasons challenge first, Lieven J noted that:

60. […] *The standard of reasons is that encapsulated by Lord Brown at [36] in South Bucks v Porter (no 2). The reasons must explain to a reasonably informed reader why the Judge considered BW did not have capacity. In doing so they must cover the principal issues, here the statutory requirements of the MCA, and they must show why the Judge departed from the view of the expert, Dr Sheehan. However, they are addressed*

to the parties who are familiar with the case; they do not have to be lengthy; and they do not have to recite all or even large parts of the evidence.

61. Mr Hadden in effect submits that there was an enhanced duty in respect of reasons because of the presumption in favour of capacity. His argument is that if the Judge was going to find that BW did not have capacity, then given the statutory presumption she had to explain her reasons particularly clearly. In my view, this argument is not correct. The Judge obviously has to apply the law correctly, but there is no suggestion that she did not do so, and no such argument was advanced by Mr Hadden.

62. I note that the Skeleton Argument says: "the Judge displaced the presumption of capacity…" However, Mr Hadden did not pursue this argument, and it is in my view hopeless, particularly given that at J24 the Judge expressly referred to the statutory assumption of capacity. Plainly the Judge was well aware of the statutory presumption and applied it to the case.

63. The standard of reasons remains the same whatever the issue, or where the burden lies, it remains to provide clear and intelligible reasons for the conclusions reached.

Lieven J considered that:

64. The reasons here achieved those requirements. At the heart of the issue in the case was whether BW understood and could weigh up the information which was relevant to the decisions about medication and sharing information, see s.3(1)(a) and (c) of the MCA. Central to the Judge's decision was the requirement in s.3(4) that a person needs to be able to understand the "reasonably foreseeable consequences" of making the decision. A reasonably foreseeable consequence of BW not taking the medication was, in the Judge's view, that she would lose her current placement, see J21. The Judge was correct to take this into account and give it considerable weight. The placement had expressly stated that if there was another incident of aggression to staff BW would be asked to leave.

65. I do not accept that this consequence was too remote for it to be relevant to the conclusion that BW did not have capacity. Firstly, that was a decision for the Judge, who heard the evidence, subject only to appeal if her judgement was wrong. Secondly, in my view, the likely loss of the placement was an obvious, direct and reasonably foreseeable consequence of BW stopping the medication, becoming aggressive and being required to leave her current placement. Further, such a consequence was likely to have disastrous consequences for BW given her history of homelessness, periods in prison and periods of compulsory detention under the MHA. The words of Lord Stephens in JB at [74] are particularly pertinent here because the loss of accommodation was a serious and grave consequence that it was important that BW could understand. The same was true of the potential loss of support/advocacy by AW if she did not have all the relevant information.

With particular reference to the report of Dr Sheehan, Lieven J considered that:

66. The Judge was correct to say that Dr Sheehan had not considered the potential consequence of the loss of the placement in his report and had not asked BW about it. He had therefore failed to weigh up a highly material matter when reaching his conclusion on capacity. For the matter to be relevant, for it to be open to the Judge to rely on it, it was not necessary that it be referred to in the letter of instruction. Dr Sheehan was instructed to assess capacity, and he needed to consider what were the reasonably foreseeable consequences of the decision in question.

67. Although the Judge's reasons are short, she dealt with the important critical issue, whether BW could weigh up the information relevant to the decision about her medication, including the likely consequence of her deciding not to take it.

68. The same analysis applies to the decision about sharing information with AW. Dr Sheehan did not explore with BW the likely consequences of AW not being able to advocate on her behalf, and what the Judge plainly viewed as the lack of realism around BW's view that she did not need the current care arrangements. This was an entirely valid concern given that BW had been found not to have capacity in respect of assessing her care needs. Again, this amounts to failing to consider and weigh up the likely consequences of the decision not to share information with AW, and the impact on the provision of the care she undoubtedly needed.

69. There was a lack of assessment in Dr Sheehan's report, as the Judge states at J23, as to how BW's lack of capacity in relation to decisions about her care, which was not disputed, related to a finding that she had capacity to decide AW should not have information shared with her. With all respect to Dr Sheehan, the statement that relationships with family members may be different to those with professionals, misses the point that the history strongly suggested that BW's family, and AW in particular, had been critical in ensuring that BW received the care support she needed and was entitled to. BW was adamant that she did not want AW to be given information about her care, but the Judge was entitled to conclude that BW was unable to weigh up the consequences of that decision.

Perhaps ambitiously, it was submitted by the local authority that Senior Judge Hilder had acted pursuant to the 'protective imperative,' rather than considering BW's capacity to make decisions, even if unwise. Lieven J had little truck with this:

70. The Judge is the Senior Court of Protection judge, and extremely experienced in this jurisdiction. There is nothing in the judgment to suggest that she has confused an unwise decision with a finding of lack of capacity. It is clear from the judgment that she found BW not to have capacity because she concluded that BW did not understand the reasonably foreseeable consequences of her decisions.

Lieven J was also underwhelmed by the suggestion that Senior Judge Hilder was wrong to place reliance on the earlier capacity evidence of Dr Ince, and also as regards the challenge that she had not given adequate reasons for departing from the report of Dr Sheehan:

74. Ground 4 focuses on the Judge's alleged lack of reasons for departing from Dr Sheehan's recommendation. Mr Hadden submits where the Judge was disagreeing with the expert on capacity, she had to give further and more detailed reasons. The Skeleton says that if the Judge was to depart from the expert "this required the clearest of bases and explanations". I note that there is no authority given for this proposition and Mr Hadden could not point me to one. Mr Hadden relies on Hemachandran where the Court of Appeal overturned a first instance decision where the Judge had determined capacity contrary to the consensus view of all the experts. It is relevant in that case that there was such a consensus view, whereas here there was one expert, who as the Judge explained, had not taken into account some of the key considerations that were relevant under the tests in the MCA.

75. There is no doubt that the decision as to capacity is one for the Judge, and the Judge is fully entitled to depart from the capacity assessment, whoever it is undertaken by.

76. As Ms Kelly submits it was not the Judge's job to critique Dr Sheehan's report. She had to reach a decision on capacity taking into account all the

relevant evidence, including her own knowledge of BW. A fair reading of the judgment makes it perfectly clear why the Judge departed from Dr Sheehan's views and what factors she took into account.

Comment

This case is a useful reminder that judges are entitled to depart from the reports of experts instructed to assist on capacity, and also that there is no difference in the 'reasons burden' by virtue of the presumption of capacity. The judge needs to have before them sufficient evidence to establish (on the balance of probabilities) that the person lacks capacity to make the relevant decision. However, that is a different question to the question of the nature and extent of the reasons that they have to give. Given that the consequences for a person of being found to have capacity can be just as serious as being found to lack it (here, potentially, not taking medication recognised as being of assistance), it can readily be seen why there is an equivalent duty on a judge to explain their conclusions either way.

The discussion of the capacity issue in relation to the sharing of information is also relevant and important in a context where the conclusion can sometimes too readily be reached that a person has capacity to make such a decision on the basis (1) of desires to uphold patient confidentiality; and (2) failures to probe the extent to which the person recognises and is able to process that they may have others in their life who provide a support network.

Timing and procedure in Serious Medical Treatment applications

University Hospitals Birmingham NHS Foundation Trust v EN [2025] EWCOP 59 (T3) (McKendrick J)

In a cri de coeur from McKendrick J (which was heard in 2025, but only recently reported), practitioners are reminded that those making urgent medical treatment applications must reflect on the practical realities of the court and Official Solicitor to deal with those applications on short notice. In *University Hospitals Birmingham NHS Foundation Trust v EN* [2025] EWCOP 59 (T3), the applicant had made an application for orders to compulsorily treat 'EN' by way of a caesarean section under a general anaesthetic and with the use of restraint if necessary. At the time of judgment, EN was detained under s.3 MHA with a diagnosis of schizophrenia, and was 40 weeks + 3 days pregnant. The child was her third child, and her previous child had required delivery by emergency caesarean section. The background to the application is set out at [7]: *'While she was initially compliant with her care, her mental health and her presentation have deteriorated. Essentially the background is that she has been refusing to co-operate with staff, is often dysregulated in mood and behaviour and there is significant concern that she will not co-operate with the necessary obstetric care required to be delivered of her baby. She could give birth imminently.'* EN was expressing wishes to both hospital staff and her representative via the Official Solicitor that she wished to have a vaginal delivery, and the matter was listed for a hearing the day after it was filed, hearing evidence from EN's consultant obstetrician and gynaecologist. After identifying that further evidence was required from an anaesthetist on the risk of a general anaesthetic and obtaining the evidence, neither the Official Solicitor nor the court appeared to have great difficulty in agreeing that EN lacked capacity and the Trust's plan to proceed with a caesarean section was in her best interests.

We highlight this case in the Practice and Procedure section due to McKendrick J's setting out his concerns about the manner in which the application was brought:

> 4. *I am giving this judgment ex tempore under challenging circumstances. The application was purportedly issued around 10 past 4 yesterday afternoon. I say purportedly as it was issued by way of an email with 12 separate attachments, each of which was password protected. I was supposed to be dealing with other matters today but it was the applicant trust's position that the matter had to be dealt with today…*
>
> > 60. *…I have considered this matter as carefully as I possibly can in the rushed, unsatisfactory circumstances that have led up to this hearing. I repeat, there has been no question of the Official Solicitor or this court acting as some form of rubber stamp. There has been questioning, and testing of the evidence. For those reasons, I will make the orders…*
> > 61. *I will add a postscript to the judgment as follows. The circumstances of how this application was brought to court are unacceptable. It was clear to the applicant trust that Ms EN was a woman with psychiatric challenges. It was clear from 29 June 2025 that she was detained pursuant to Section 3 of the Mental Health Act. As I understand the chronology, she was assessed on Monday of this week and whilst in the morning it was considered she was engaging and had capacity, it was clear by the middle of Monday that she was not. The application was issued at 10 past 4 yesterday afternoon, seeking a four-hour hearing the next day.*
> > 62. *I have received an email from a highly experienced solicitor explaining the delay. It has been approved by the applicant trust's team. They say on the various occasions when the obstetricians and Ms EN met they felt Ms EN was able to understand and agree to the birth plan as discussed. They accept she was seen as high risk because of her mental health and a plan was drawn up at 34 weeks gestation. They say that when she was seen in clinic on 1 July she was still capable of making decisions and an MDT meeting took place on 3 July and it considered the question of fluctuating capacity. Legal advice was sought by the obstetrician from the legal department of the trust on 3 July 2025 and was informed there was a substantial risk of a patient becoming so unwell as to lose capacity which means that the treatment might have to be forced on her. The Court of Protection was in a position to make a declaration.*
> > 63. *It then appears that there was discussion between that Trust and the psychiatric Trust. There was another MDT meeting on 7 July and it was felt that she lacked capacity to make the decisions about her care. As I say, on 8 July she seemed to accept induction of labour but again deteriorated quickly thereafter and I am told the obstetric team were not aware of the guidance set out by Keehan J in NHS Trust v FG and it was not appreciated, as it should have been last week, that an application to court was likely.*
> > 64. *The reference to NHS Trust v FG is a reference to Keehan J's decision called NHS Trust 1 v G Practice Note [2014] EWCOP 30. In an annex to*

that judgment, Mr Justice Keehan set out clearly what should happen in these types of cases. He emphasised in particular that early identification of an individual in respect to whom an application might have to be made is essential. He set out that late applications must be avoided absent genuine emergencies and set out the very undesirable consequences.

65. *I have had to deal with matters at a pace this morning, but it seems to me on a summary analysis of what I have been told that this application should have been made easily last week because there was a risk that this vulnerable woman who is detained may have significant challenges. It does not seem to me that the aggressive, guarded, difficult behaviours blew out of nowhere yesterday. Indeed on the obstetric Trust's own evidence, that was the position at the start of this week.*
66. *To compound matters, it is unacceptable that this very urgent application was sent into court by way of an email with 12 separate attachments, each of which were password protected. I do not understand why solicitors are sending into the court password protected documents. To further compound matters the application was sent to the wrong email address. This urgent application was sent to the wrong email address. This created unnecessary delay. It is further unacceptable that no bundle was sent to me until 23 minutes past 10 this morning.*
67. *This is not simply a judge venting spleen regarding procedures and rules. This is because the application I have been required to deal with this morning is of the utmost gravity for Ms EN. Whilst I am satisfied I have received the assistance and evidence necessary to make decisions on capacity and best interests, that may not be the case in every scenario. It was not acceptable at the outset of this hearing there was no proper evidence on anaesthesia. That further delayed determination of matters.*
68. *There may come a time when a mistake is made and grave harm or death befalls a patient before the Court of Protection, because of the unacceptable procedural steps that lead up to hearings.*
69. *It is also unacceptable that the matter I should have been dealing with today has had to be put off. Other litigants who need determination of their litigation now have to wait. I do not see that there are any good reasons for any of this.*
70. *The Official Solicitor has not sought an application for her costs. If she had made an application I would have granted a costs order against the Trust in full. In the exercise of my discretion, applying Court of Protection rule 19.5, I would not have accepted any resistance from the Trust that I should not depart from the general rule in personal welfare proceedings. I would have accepted, applying 19.5(1), that the conduct of the party has merited a cost order against the Trust in the full amount. I would have been prepared to have heard submissions as to whether that costs order should have been paid pursuant to the Civil Procedure Rules on an indemnity basis, applying the general principles of CPR 44.3.*

> 71. *However, I am not asked to make any costs order and therefore I simply make those obiter observations so that if other Trusts bring these urgent applications in respect of caesarean sections they understand the time has come that cost orders will have to be more routinely made to ensure applications are brought in a timely fashion to ensure that vulnerable women like Ms EN's care is not jeopardised by late applications being brought to court.*

Comment

McKendrick J's points on the impacts of late applications on the court and other court users are clear and require no interpretation (though the query of why password-protected documents would be filed with the court is worthy of amplification). We would, however, note this case in concert with the next piece on making robust attempts to resolve healthcare disputes without the personal and financial costs inherent in having recourse to the Court of Protection. We consider that while in this case, it appears that the need for an application was well-established, there are many other healthcare disputes in which the approach of trying to work with the patient is a successful one and avoids unnecessary applications being made to court.

Resolving health disputes out of court: a policy paper

In Resolving Health Disputes Out of Court: A Policy Paper by Jamie Lindsay and Margaret Doyle, the authors focus on 'on out-of-court resolution of disputes between healthcare professionals, patients, and family members in the context of medical care and treatment for adults and children.' It draws on discussions from a symposium held in March 2026 at the University of Oxford to consider how policy and practice in this area might be developed. The paper notes the personal and financial costs for people and healthcare professionals who end up in court, and 'sets out a series of recommendations aimed at supporting earlier and more effective management of disputes before cases reach the Family Court (for children) or Court of Protection (for adults). The recommendations include:

- The development of online resources around dispute resolution and signposting;
- Protocols for access to medical records;
- Access to independent advocacy by families to challenge medical decisions;
- 'Family members should have a right to obtain an independent second opinion where there is a best interests disagreement, funded by the relevant NHS body. This right could be implemented based on a similar principle to Martha's Rule and DHSC should investigate this option.' It is also recommended that a standard commissioning process should be developed for second opinions, and a standard expert declaration for them;
- Further funding and development of protocols for Clinical Ethics Committees should be developed, and families and healthcare professionals should be supported to engage with them;
- *NHS Trusts and families should consider use of independent mediation before proceeding to litigation, except in emergencies. There should be no*

requirement on family members or HCPs to mediate, only the requirement to consider mediation…Commissioners should fund independent mediation and should include funded legal and advocacy advice for families taking part in mediation….Independent mediation should generally be attempted before proceedings are issued.'

MENTAL HEALTH MATTERS

EU Recommendation of the Committee of Ministers to member States on respect for autonomy in mental healthcare

Recommendation CM/Rec(2026)8 of the EU Committee of Ministers to member States on respect for autonomy in mental healthcare was published on 17 June 2026, and may signify a turning point on the influence of the UNCRPD. A recommendation was given that the governments of member states implement a number of recommendations on autonomy in mental healthcare in the next five years:

…Chapter II – General principles

Article 3 – General rule

1. Mental healthcare should only be provided with the free and informed consent of the person concerned or, where according to law the person does not have the capacity to consent, by respecting their will and preferences.

2. Any exception to the general rule laid down in the preceding paragraph should be subject to strict legal safeguards that respect human dignity.

Article 4 – Access to mental healthcare

Persons with mental health problems should have equitable access to mental healthcare, including community-based care. They should have access to mental healthcare as early as possible.

Chapter III – Policies and practices

Article 5 – Guiding principles

Policies and practices should reflect the goal of ensuring respect for the autonomy of the persons concerned in mental healthcare. Responsibilities for achieving this goal should be defined at all levels.

Article 6 – Involvement of persons with lived experience

Persons with lived experience of mental healthcare should be involved, individually or via representative organisations, in developing laws, policies and practices relevant to mental health and in their monitoring and evaluation. Their involvement should be appropriately resourced.

Chapter IV – Mental healthcare

Article 7 – Information about rights and how to exercise them

The persons concerned should be individually informed of their rights in respect of mental healthcare and have access to assistance to enable them to understand and exercise such rights, including to express their will and preferences and make decisions about their care.

Article 8 – Advance care planning

The persons concerned should be encouraged to express their will and preferences for their future care and these should be documented.

Article 9 – Environment of mental healthcare facilities

The physical and social environment of mental healthcare facilities should be reviewed and, if necessary, adapted, taking

into account the need to respect the autonomy of the persons concerned.

Article 10 – Service networks

Mental healthcare services should have close links with other services that can contribute to the promotion of and respect for the autonomy of the persons concerned.

Article 11 – Family and social network

Subject to respecting the confidentiality, privacy and autonomy of the person concerned, the potential benefits of involving the person's family and social network in their care should be taken into account.

Article 12 – Complaints procedure

1. The persons concerned should have effective access to a complaints procedure. They should be informed of this procedure and should receive an appropriate and timely response to any complaint.

2. Information arising from complaints should be used to improve care in the future.

3. Such information should be made available, subject to appropriate protection of the privacy and confidentiality of the person concerned, to bodies responsible for quality assurance and monitoring.

Chapter V – Public understanding and prevention of stigma

Article 13 – Public understanding

Public understanding should be promoted in relation to:

a. the importance of respect for autonomy as a human rights principle;

b. the prevention and care of mental health problems, and the potential for recovery; and

c. the benefits of early access to mental healthcare.

Article 14 – Non-stigmatisation and non-discrimination

Measures should be taken to address the stigma and prejudice associated with mental health problems, and to prevent and eliminate discrimination against persons with such problems and to promote their inclusion in society.

Chapter VI – Education and training

Article 15 – Education and training

1. All staff involved in mental healthcare and those who, in their professional capacity, come into contact with persons with mental health problems, should receive, as appropriate to their role:

a. education on respect for autonomy as a human rights principle; and

b. training in practices that respect the autonomy of such persons.

2. Healthcare professionals in primary care should receive appropriate training in the early identification of mental health problems and initiation of appropriate care that respects autonomy.

Chapter VII – Research and sharing of good practice

Article 16 – Research

Research aiming to promote respect for autonomy in mental healthcare should be supported.

Article 17 – Sharing of good practice

Mental healthcare services should share good practice in view of ensuring respect for autonomy in mental healthcare.

Chapter VIII – Review of practices and monitoring

Article 18 – Review of practices

Those providing mental healthcare should regularly review their practices, with a view to ensuring respect for the autonomy of the persons concerned.

Article 19 – Monitoring

1. There should be systems for monitoring compliance with the principles set out in this Recommendation.

2. The results of such monitoring should be made publicly available.

CHILDREN'S CAPACITY

Deprivation of Liberty or Initiation of Institutionalisation? A view from CAMHS Psychiatrist, Dr Girish Vaidya[15]

Whilst Deprivation of Liberty is necessary, it is often not inevitable

As a Consultant Child and Adolescent Psychiatrist, I predominantly work with young people often identified as 'Complex Needs' in professional jargon. In clinical practice, it often indicates needs that are usually difficult to safely 'categorise' within existing legal, educational and social services' frameworks.

Let us examine the story of Jess – a 16-year-old who came into care following an adoption breakdown. The adoption breakdown was preceded by multiple requests for assistance from child and adolescent mental health services (CAMHS) and from children's social services. Jess came to be adopted after the courts accepted that she had been neglected by her alcoholic mother who had separated from her birth father who had a long career in crime. Jess' two half-siblings from other fathers lived in their fathers' families.

Assessments focussed on her trauma, not her neurodiversity. Solutions proposed were a failure since the diagnosis was rational – but flawed. Jess moved rapidly from foster families to residential care to secure care. A return to the community did not last long. Lack of spaces in secure children's homes meant that a bespoke placement authorised in which her deprivation of liberty was authorised under the inherent jurisdiction was the only option left.

Speak to Jess and she tells you that she actually '*loves*' the bespoke placement. It enables her to feel 'wanted'. She can't see herself living in the community since there is now no-one 'left' for her. She is without roots having moved so frequently that she barely got to know the building she was living in. She is without anchors since those who she had thought of her had long 'disconnected' from her. She never returned to her mother who is now sadly dead. Her adoptive parents are scarred from their experience of parenting her, have separated and have new families where she does not have a place. She had a string of social workers – too many to remember. She never had any school friends or friends in the 'community' since she was never part of either.

As her Deprivation of Liberty order was in the process of being renewed, Jess absconded – stabbed a random person and was convicted for murder. She is expected to spend a majority of her life in prison.[16]

There are a number of Jess' in prison. Yet, the ending need not be so stark.

In this article, I will analyse five aspects where interventions may have yet changed the trajectory.

1. Disability and distress vs diagnosis: Clinicians often focus on getting the 'diagnosis' right. Unfortunately, in clinical practice, it is at the cost of not recognising the distress and disability that accompanies clinical presentations. *Diagnosis in mental health is dimensional, not categorical*. A focus on defining categories accurately, can sometimes miss the subtle dimensions that may yet contribute to the disability and resulting distress. Psychiatry is not alone in taking a 'dimensional' approach. Indeed, most of medicine (excluding infectious diseases and trauma) takes a dimensional approach where disability or distress underpin the need for treatment. For

15 https://www.expertwitness.co.uk/expert/67da97a1bc96b45a97508122

16 Details have been changed to protect confidentiality.

example, a shepherd in a developing country may not experience the disability arising from his deteriorating vision for a long time. Yet, a lawyer would notice the impairment associated with deteriorating vision much earlier due to the nature of the work undertaken. The reluctance to embrace a diagnosis despite evidence of distress and/or disability does more harm to the child in the short, medium and long-term.

2. Medications treat symptoms – not the underlying cause: A reluctance to use medication – alongside other psychological interventions – is another factor that can impair a child's ability to sustain and succeed in school. Medication – particularly for ADHD, a common neurodevelopmental disorder – is known to be effective across numerous studies. Folkins and colleagues [17] reported on the use of long-acting stimulant (LAS) medications in school children. They found '*LAS treatment was associated with improved report card and provincial assessment exam scores among grades 9 to 12, reduced absences among grades K-12 and increased likelihood of graduation and transition to post-secondary education.*' Concerns over substance abuse associated with stimulant medication is not borne by research. Baweja and colleagues [18] analysed the impact of ADHD medication on those abusing substances. They concluded '*stimulant treatment was associated with fewer hospitalizations, accidental overdoses, and suicidal ideation/attempts. Overall, ADHD treatment was associated with a 30% lower risk of mortality.*' Conversely, lack of treatment for ADHD is associated with increased criminality [19] and an early death [20] . In summary – long acting stimulant medication has a strong evidence basis for improved outcomes in those with ADHD. Denying treatment or, at the very least, a therapeutic trial, does deserving patients a great disservice.

3. Loss of 'institutional memory [21] ': In children living within families, it is the families themselves, the schools and the community which provide an ongoing repository of the child's information. For children who come into care, it is the State that is expected to hold the child in its mind – the 'institutional memory'. Yet, multiple placement breakdowns often lead to changes in therapeutic teams and systems. Each new CAMHS team is

[17] Chris Folkins et al., 'Academic Outcomes in Primary and Secondary School Students Prescribed Long-Acting Stimulants for ADHD Management', *Journal of Attention Disorders* 30, no. 4 (2026): 493–505, https://doi.org/10.1177/10870547251378169.
[18] Raman Baweja et al., 'Attention-Deficit/Hyperactivity Disorder Treatment Patterns and Association With Clinical Outcomes in Adolescents and Young Adults with Co-Occurring Attention-Deficit/Hyperactivity Disorder and Substance Use Disorder: A Retrospective Analysis', *Journal of the American Academy of Child & Adolescent Psychiatry*, December 2025, S0890856725022324, https://doi.org/10.1016/j.jaac.2025.12.003.
[19] Martina Nicole Modesti et al., 'ADHD in Adults and Criminal Behavior: The Role of Psychiatric Comorbidities and Clinical and Sociodemographic Factors in a Clinical Sample', *International Journal of Law and Psychiatry* 101 (July 2025): 102088, https://doi.org/10.1016/j.ijlp.2025.102088.
[20] Søren Dalsgaard et al., 'Mortality in Children, Adolescents, and Adults with Attention Deficit Hyperactivity Disorder: A Nationwide Cohort Study', *The Lancet* 385, no. 9983 (2015): 2190–96, https://doi.org/10.1016/S0140-6736(14)61684-6.
[21] t.ly/aaWFv

typically unaware of the young person's prior experience in care to the same extent as someone who has known the person over the years. Every new social worker is a new leaf in the child's memory book, but is not able to hold the narrative of the child in the same way that a parent/grandparent does. Such loss of institutional memory leaves the system around the child repeating errors from the child's past.

4. Absence of an Always Available Adult: Children in care are often surrounded by adults. For those who are violent or abusive or absconding, the number of adults is higher. It is not uncommon to come across a child being on 3:1 continuous observations due to their risks. Yet, none of these adults could be understood as being always available for the child. An always available adult is not someone who needs to be physically close to the child. It is usually an adult who the child regards as being supportive *despite* their physical separation. It is typically an adult who has believed in the child's potential or seen a positive aspect of their emerging personality which has got buried in the multiple incident reports and risk assessments. Yet – and this is an important *yet,* research[22] shows that a child requires one – just one – adult to believe in their potential to succeed. Such belief is often able to help the child overcome the most severe adverse childhood experiences. Such an adult can have positive consequences not just for mental health but also physical health.

5. *ACEs to PACES [23] – from deficit to strengths*: Most of the professional conversations around 'complex' young people is around their deficits. This also involves an understandable emphasis on 'trauma' and the need for healing the trauma. An increasingly restrictive regime however tends to simply reinforce the trauma. In clinical practice, within multiprofessional meetings, it is often interesting to observe the response from professionals when the issue of a child's strengths is brought up. Well meaning professionals frequently overlook the child's strengths to the detriment of the child. In some cases, it may be due to the ignorance of those strengths on behalf of the workforce [24] or the paucity of information on supporting an autistic young person's obvious tech talent [25]. Frustrated at being forced to communicate through the spoken word, these young people – often on the autistic spectrum – are then subject to Deprivation of Liberty Orders with escalating restrictions. Their ACEs (Adverse Childhood Experiences) are then amplified. Services should start to focus on a child's strengths – the PACES (Positive Assessment of Childhood Experiences and Strengths) approach. Doing so helps to reduce the trauma of ACEs, presents children with tools for recovery, helps them to identify their Always Available Adult (AAA) and thereby also discover their ability to monetise their skills.

[22] Mark A. Bellis et al., 'Does Continuous Trusted Adult Support in Childhood Impart Life-Course Resilience against Adverse Childhood Experiences - a Retrospective Study on Adult Health-Harming Behaviours and Mental Well-Being', *BMC Psychiatry* 17, no. 1 (2017): 110, https://doi.org/10.1186/s12888-017-1260-z.

[23] https://www.linkedin.com/pulse/paces-aces-rethinking-childhood-girish-vaidya/

[24] https://www.linkedin.com/feed/update/urn:li:activity:7468176303054225408/

[25] https://www.linkedin.com/pulse/from-self-taught-coder-tech-visionary-what-can-support-girish-vaidya-owhef/

To contextualise for Jess, a focus on her impulsivity, distractibility and hyperactivity would have been accurately identified as ADHD. It would have led to treatment with methylphenidate which would have allowed her to stay in one placement. Being in a single placement would have helped develop institutional memory. It would have also facilitated developing relationships which could have identified her match with an Always Available Adult. The latter would have facilitated developing her strengths in sports (she was an excellent footballer) which would have led to a career in coaching.

Jess needed to ascend the 'Virtuous Spiral' wherein those around her identified her strengths and enabled her to take risks with activities that would have gained positive attention. Such positive attention would have further cemented her self-esteem leading to self-belief. Unfortunately, Jess ended up in a 'Vicious Spiral' where her traumas were the main focus, leading her to feel a passive recipient of support that was transitional since she would be moving placements rapidly. As people around her stopped believing in her possibilities, Jess did so too ending up in behavioural dysregulation that spiralled downwards into a long prison sentence. With a reported million children referred for anxiety[26], the need for a different approach is all the more crucial.

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[26] https://www.bbc.co.uk/news/articles/cwyd1l0lge8o

THE WIDER CONTEXT

Adult Social Care Reform

On 22 June 2026, DHSC wrote to Baroness Casey (who is chairing the Independent Commission on Adult Social Care) to update her on progress against the recommendations that she set out in her letter on 3 March 2026 (echoed in a speech to the Nuffield Foundation on 5 March 2026.) DHSC highlighted:

- The establishment of a new national adult safeguarding board 'chaired by the Chief Social Worker, Sarah McClinton, reporting directly into Minister Kinnock, as the Minister of State for Care. It has a broad membership, with the seniority and experience required to drive change - including sector leaders, people with lived experience, experts and innovators.' The board's priorities are to
    - *'…update the Care Act statutory guidance on adult safeguarding to drive better implementation and practice across a wide range of issues, including homelessness, drugs and alcohol, and transitional safeguarding…'*
    - *'…oversee an urgent review of the legal framework for safeguarding. This will:*
        - *identify any improvements needed to ensure that the legal framework is robust enough to respond to serious safeguarding risks*
        - *examine the current mechanism for escalating local safeguarding concerns to national level*
        - *identify what statutory powers the board might need to operate most effectively*
    - *the board will work to strengthen national oversight of local Safeguarding Adults Boards and improve the quality of adult safeguarding practice'*

- The creation of '*a new modern service framework for dementia and frailty, published by the end of the year…Progress will be championed and accelerated by a new dementia tsar. They will work within and alongside the system, to catalyse progress. We will begin recruitment shortly.*
    - *In parallel, we will review how we approach dementia within the Department of Health and Social Care (DHSC) and its arm's length bodies (ALBs) - so that we have one coherent strategy, that spans from research to practice and brings together the right capability and capacity to make progress, and the full ambition of the modern service framework, a reality.*
    - *We agree with your call for urgent investment in dementia trials. That's why I'm pleased to confirm we have adopted the recommended target to scale participation in UK dementia trials to 2,000 people within the next 5 years, up from 377 in 2025 to 2026…'*

- Speeding up and improving coordination of care and support for people with Motor Neurone Disease.

The Muckamore Abbey Hospital Public Inquiry Reports

In a tragically familiar account to the findings of the inquiries into Ely Hospital, Longcare, Whorlton Hall and Winterbourne View, and Yew Tree Hospital (among other inquiries and safeguarding reports chronicled at length in the report), the lengthy, in-depth and harrowing report of the Muckamore Abbey Hospital Public Inquiry was published on 18 June 2026. Muckamore Abbey Hospital is a large hospital in Northern Ireland which treats people with learning disabilities and mental illnesses. Following evidence inquiry was established in 2020 and '[i]n total the Inquiry heard from 235 witnesses including a number of service users and over 90 relatives of service users. Approximately 40,000 documents were provided and considered by the inquiry.' The inquiry found that:

> *Patients were abused at Muckamore Abbey Hospital (MAH). It is important to state that bold and simple fact. The abuse did not involve every patient nor every member of staff, nor a majority of the staff. But many patients had their lives made miserable by systematic bullying by certain members of staff whose job it was to look after them. It also appears that some patients suffered a high number of incidents, others very few or none. It is also important to state, however, that no adjudication is made by the Panel in this report in respect of individual incidents in relation to which evidence was heard.*
>
> *Institutions caring for people with learning disabilities and autistic people are known to be high-risk environments. Across the United Kingdom and Northern Ireland, abuse of people with learning disabilities has recurred in institutional, hospital and community settings over many decades. There have been numerous well-publicised Serious Case Reviews and Inquiries into such abuse. The Inquiry found that many of the conditions found in previous abuse inquiries, both in Northern Ireland and in Great Britain, existed at MAH, yet were not identified as signals of heightened risk, despite the setting itself and the patient cadre being at obviously high risk….*
>
> *The patients were vulnerable in the sense that the vast majority of them had learning disabilities and/or were autistic people, which made it far easier for them to be abused. Many of the patients were non-verbal. They were easy targets for those with malign intent. It would however be too easy simply to blame the individuals involved and to say, where there are those with bad intent it is practically impossible to stop them acting on it. The reality is that there were multiple contributory factors allowing the circumstances that put the patients in this position and that contributed to the reason why some staff acted as they did.*
>
> *It is perhaps obvious that the factors that allow for a situation in which a member of staff chooses to abuse a patient, and that set the culture in which such abuse is witnessed by others but not prevented or reported by them, are many and complex. We examine those factors with care in this report. We examine the management systems in place, the staffing of the hospital, the training of those staff, the*

governance of the hospital and the Belfast Trust that managed it, as well as the external agencies that might have spotted what was going on but did not.

The investigation of abuse of patients at MAH was triggered by the discovery of CCTV footage that had retained recordings of public parts of the hospital between March and September 2017. Examination of that footage led first to an internal investigation and shortly thereafter to the involvement of the Police Service of Northern Ireland (PSNI)…

Every Public Inquiry has its complexities but, in addition, this Inquiry faced the significant issue of contemporaneous criminal proceedings. By the time I was appointed to Chair this Inquiry in June 2021, the PSNI had already been investigating allegations of abuse of patients at Muckamore for some three years. Those investigations have continued as the Inquiry proceeded. We were told that it was the largest adult safeguarding investigation ever conducted in this jurisdiction and possibly in the UK. We understand that there are five committed trials waiting to start in the Crown Court here in Belfast, and there may be other trials thereafter. But no Crown Court trial has yet been held and none of the committed trials currently has a start date; that is, eight years after the investigations began and five years after this Inquiry was announced. The reality may be that criminal trials will not conclude either this year or quite possibly next year.

The inquiry made over 100 recommendations for the Northern Irish government; the progress of these recommendations will certainly be worth watching.

How far does a solicitor's duty to assess a client's mental capacity extend?

How far does a solicitor's duty to assess a client's mental capacity extend? This was a question the Court of Appeal pondered in *R(Aina Khan Law Ltd) v Legal Ombudsman* [2026] EWCA Civ 773 – the conclusion being: far enough to protect them from themselves.

In this case, Aina Khan Law Ltd, an experienced and well-respected one-woman-band practice, was instructed by CXV to assist in divorce proceedings including child arrangements for the two children of the marriage, and a freezing injunction against her husband's assets.

The firm's original notes of the case included that CXV had mental health issues; that she was 'emotionally raw' and would need a good deal of support. In addition, *'she has to be careful to keep an eye on the costs and make sure that they are proportionate to what she is seeking to achieve.'* [2].

Proceedings ensued and quickly became complex and fraught, with CXV accusing her husband of grooming and sexually abusing their six-year-old daughter and of drugging or poisoning both her and the child and using electronic surveillance on them. The allegations were denied by the father who argued that CXV was having a mental health breakdown following a diagnosis of ADHD and prescribed treatment by way of amphetamines. The father applied for an occupation order of the family home and sole custody of the children; CXV applied for an occupation order in turn, plus a non-molestation order and sole custody.

A court ordered psychiatric assessment concluded that CXV was indeed suffering from paranoid psychosis and that her allegations were in fact part of her paranoid delusional system, likely precipitated by the prescribed amphetamine use. The expert advised the court that he did not consider CXV could properly engage with the proceedings as a result of her

delusions. Following these findings, the Family Court declared CXV to lack capacity in relation to the proceedings [7] and CXV's sister was proposed as her litigation friend.

Solicitors then wrote to the litigation friend, advising them of likely costs estimates going forward. Having said that it would maintain costs reviews throughout proceedings, CXV's solicitors had, by this point, already charged her a total of £113,963 including VAT – having originally estimated a cost of £43,500.

CXV's sister complained to the firm, and then to the legal ombudsman on the grounds that the firm had 'failed to adequately assess CXV's litigation capacity' [10] and that it had charged excessive costs for the work completed.

The Ombudsman upheld the complaint and proposed compensation of £51,192.60 arising out of what were effectively two complaints.

Aina Khan Law challenged the ombudsman's decision by way of judicial review. It claimed the ombudsman had exceeded her "remit" and had made a disproportionate and thus discriminatory award against such a small firm; it also issued an irrationality challenge - The ombudsman made a decision that was "so fundamentally flawed and unreasonable that no regulator should be allowed to impose such judgments, particularly when there is no right of appeal".

The court at first instance rejected the discrimination complaints and the complaints on costs so one element of the award of costs - £35,500 – remained unchallenged; the judge accepted the rationality challenge regarding litigation capacity however, and thus set aside the £15,692.60 element of the costs award.

The appeal to the Court of Appeal was heard on the basis that the court had imposed an *"excessively legalistic and … unduly onerous obligation on the ombudsman to give reasons in relation to each of the matters identified in his judgment"* and that the judge had *"erred by reviewing the ombudsman's decision as if: (i) the ombudsman had purported to apply the legal concept of "capacity", alternatively (ii) the ombudsman had been obliged to apply that legal concept, but failed to do so."* [19]. A third ground, that the award of compensation was tainted by irrationality, was also considered as well as a fourth ground concerning costs.

The Court of Appeal in its reasoning (which is delivered in a leading judgment by Lord Justice Holgate rather than Lord Justice Baker, who also sat on the bench) did not consider it necessary to delve into the law on incapacity to resolve the issues in the appeal [41]; it did, however, look closely at the SRA code of conduct, and in particular the Guidance regarding meeting the needs of vulnerable clients. It noted in particular:

> *44. In the section dealing with the first group, "Identifying vulnerable clients", the Guidance gives a list of 25 different indicators of vulnerability which range widely from advanced age to young age and include "mental health problems" and "psychological or emotional factors, such as stress":*
>
> *"One or more of these risk factors may mean that your client is vulnerable and may need your help to express their wishes, understand relevant advice and give you instructions, or that they may lack capacity to make relevant decisions and to give your instructions."*
> *This passage relates the risk factors to the same two broad groups, vulnerable clients and clients who may lack capacity. Where a solicitor is aware of "risk factors" he or she should help their client inter alia to "overcome any difficulties to understand relevant advice" and "give valid instructions". The Guidance indicates that family members may be able to assist.*
> *45. Under the heading "clients who may lack mental capacity", the Guidance states:*

"Under paragraph 3.4 of the SRA's Code of Conduct for Solicitors, RELs and RFLs, you must consider and take account of your client's attributes, needs and circumstances. As such you must satisfy yourself about their capacity if you have any doubts about whether your client has the capacity to give instructions.
This is also important as it can enable the client to make decisions or protect them from making a decision when they lack capacity, and reduces the risk of any subsequent complaint or challenge." (emphasis added)

46. Thus the Guidance makes it clear that a person who begins to instruct a solicitor may have mental health issues making them "vulnerable" in the broad sense explained in that document, but without lacking mental capacity, and that such a person may need assistance e.g. from a relative or friend. It is well-recognised that mental capacity is both issue-specific and time-specific. It may fluctuate over time. A person may lack mental capacity at one point in time and be in the broader sense "vulnerable" at another. In other words mental health issues may relate to a spectrum of conditions and problems

The Court of Appeal noted that while the Ombudsman's decision referred in part to mental capacity, it was also clear that it was looking more broadly at the issue of vulnerability and that, on that basis, it was rational for the ombudsman to consider whether or not CXV might have required assistance from a relative [55]. It held: *"the ombudsman examined whether, from September 2020 onwards, AKLL ought to have considered not only whether CXV lacked mental capacity but also whether she was a "vulnerable client" with mental health problems. This was in the context of a person who, viewed objectively, suffered from paranoid psychosis involving a complex delusional system and lacked litigation capacity from August 2020 onwards. In addition, CXV was facing complex and costly litigation where she needed to be able to understand the issues involved in order to make decisions and give instructions. The ombudsman rightly had regard to the Law Society's Guidance that a solicitor should consider whether a vulnerable client requires support, for example from family members, even if she does not lack litigation capacity and require a litigation friend."* [76]

Comment

This judgment does not have anything much to say on capacity – and in fact the Court of Appeal is quite careful to resist any suggestions of its having raised any issues *"which are either new or of wide-ranging importance"* [22]. It does, however, reiterate the importance, for both solicitors and counsel, to consider issues of both capacity and vulnerability throughout proceedings, particularly where costs estimates are exceeded.

Terminally Ill Adults (End of Life) Bill returns

On 14 June 2026, Lauren Roberts MP announced that she would use her position (second) in the Private Members Ballot to re-introduce the Terminally Ill Adults (End of Life) Bill. It appears from her announcement that she intends to bring back the Bill introduced by Kim Leadbeater MP. Alex maintains a full page of resources on the bill and its predecessor, which is available here.

SCOTLAND

Circumvention and undue influence

A helpful re-statement of the requirements to establish facility and circumvention, and to establish undue influence, has been provided by Sheriff A F Deutsch in the case *Allan Scott v Lorna Reeves and others*, [2026] SC GLA 57.

Mrs Ruby Scott, a widow, died on 14th March 2021, aged 77, survived by five adult children. She had subscribed an "original Will" on 14th October 2011. It left her estate equally among her son Allan, her daughter Lorna, and her daughter Jacqueline. It is narrated that she was diagnosed with vascular dementia in September 2018. On 21st February 2019 she subscribed a power of attorney conferring welfare and continuing powers upon her daughter Lorna Reeves. Following Mrs Scott's death, Allan commenced his action seeking production and reduction of a second Will. As the sheriff put it: "*The second Will bears to have been signed on 25 April 2019. It could not have been attested any earlier than November 2019.*" The significance of that difference would appear to be that Mrs Scott's capabilities were declining markedly and rapidly. Having heard and considered evidence, Sheriff Deutsch concluded that: "*The second Will was obtained from the deceased [Mrs Scott] by the first defender [Lorna] through circumvention and undue influence for the first defender's own benefit*". He ordered production and reduction of the Will.

Beyond the specific facts of the case, Sheriff Deutsch's judgment is interesting for the passage on pages 6 – 8 (paragraphs [3] – [9] of the note to the judgment). That passage does not develop the law. It is however a helpful statement of the current law on facility and circumvention, and on undue influence. The deceased's capacity was not put in issue. One might surmise that the advice to Allan as pursuer may have taken account of the adage that it is easier to prove a positive than to prove a negative – in this case, to prove the positives that there was facility and circumvention, and also undue influence, such as to warrant reducing the second Will; than to prove the negative that Mrs Scott lacked adequate capacity to grant it. Such categorisations can however overlap: for example, the Mental Welfare Commission pointed out that a person may lack capacity to recognise and/or resist exercise of undue influence, in its report on "An investigation into the response by statutory services and professionals to concerns raised in respect of Mr and Mrs D" (published 13th February 2012). Where lack of adequate capacity can be, and is, established, the outcome is clearcut: in Scots law, the purported act or transaction in question is void. Potentially vitiating factors such as facility and circumvention, or undue influence, render the act or transaction voidable, necessitating careful enquiry not only into whether such factors existed, but as to their consequences: in the present case, the question was whether Mrs Scott subscribed a second Will which she would not otherwise have subscribed.

Facility and circumvention

Sheriff Deutsch summarised the requirements at [5]:

> "*To succeed with his plea of facility and circumvention the pursuer must establish three elements. Firstly, that the deceased was facile, secondly that she was pressurised to make the new will by circumvention and thirdly lesion, which simply means harm or loss. These elements are to be looked at together, not compartmentalised. The strength of the evidence in relation to one matter may compensate for the weakness of proof upon other matters. (Mackay v Campbell 1967 SC 53 at 61). In a case such as the present, there is no requirement for any separate proof of harm having been*

> *caused, the very fact that a new will was granted would be sufficient (Pascoe-Watson v Brock's Executor 1998 SLT 40 at 47; Smyth v Romanes's Executors 2014 CSOH 150).*"

Sheriff Deutsch quoted from *Smyth* that improper pressure and undue circumvention could be "*direct, forceful and overpowering*" or "*more subtle and insidious, working by solicitation or importuning*". Possible, but not individually necessary, elements in circumvention could be fraud, bullying or browbeating. Facility is a spectrum. "*If a person with a weak and pliable mind … is pushed or led by fraud, force or solicitation to do what he would, or might, otherwise have resisted doing had his mind been stronger, then his act can be reduced by the court.*"

Where "facility or weakness of mind" is proven at the time when a person acts or transacts in favour of the alleged perpetrator, fraud or circumvention may be assumed "*without the need to prove any specific types of circumvention*".

The sheriff addressed the requirement for lesion (harm) later in the judgment, at [40]: "*In the present case there is no requirement for proof of lesion; the very fact that a new will was granted is sufficient evidence of harm.*"

Undue influence

Sheriff Deutsch quotes selectively from authorities as to the essential nature of undue influence, though this commentator would tend to favour the dictum of Lord Guthrie in *Forbes v Forbes' Trustees*, 1957 SC 325 at 333, that there must be proof of "a fiduciary or quasi-fiduciary relationship" between the parties, enabling one to exert a dominant influence over the other. In assessing alleged undue influence, Sheriff Deutsch made two significant points. Firstly, in the present case, Mrs Scott had not received independent advice:

> "*Independent advice is important because, if independent advice was not made available, undue influence will be inferred unless the defender can show that the position of the granter was as good as if he had received independent advice Smyth v Romanes's Executors.*" [8]

Secondly:

> "*Once it has been proven that there existed a relationship in which one party had the dominant or ascendant influence, the pursuer must go on to prove that the party in the position of trust and influence has abused his position or the power that the position gives him (Broadway v Clydesdale Bank plc (No 2) 2003 SLT [26]).*" [9]

Certification of the power of attorney

There appears to be an unexplained gap in the narrative provided by the sheriff's Findings in Fact. In Finding (21), on page 4 of the judgment, the sheriff found that:

> "*In the period from the beginning of 2018 until the death of the deceased [Mrs Scott] the first defender [Lorna] was in a position of dominance over her both in relation to her finances and her physical and medical care.*"

That was therefore the position when the power of attorney in favour of Lorna was subscribed on 21st February 2019. In terms of Finding (15):

> "*Annexed to the power of attorney is a certificate given by the deceased's consultant psychiatrist to the effect that he was satisfied that the deceased understood the nature and effect of the power of attorney.*"

It seems reasonable to conclude that the certificate referred to must have been the "single certificate" incorporated in the power of attorney document in accordance with section 16A of the

Adults with Incapacity (Scotland) Act 2000 certifying the matters set out in sections 15(3)(c) and 16(3)(c) of that Act. As well as certifying capacity, as narrated in Finding (15), the consultant psychiatrist must also have certified that he had no reason to believe that Mrs Scott was "acting under undue influence or that any other factor vitiated the granting of the power". Given that no party called the consultant psychiatrist to give evidence, and that no written record was produced as to the basis on which the consultant psychiatrist considered that he could properly certify absence of undue influence or any other vitiating factor (which would encompass *inter alia* facility and circumvention), it is surprising that the judgment does not explain why the court neither enquired about the existence of such a record, and required it to be produced, nor sought attendance of the consultant psychiatrist so that the consultant psychiatrist could be examined (or cross-examined) as to the basis on which the consultant psychiatrist considered that the certificate could properly be granted.

UN CRPD

The UN Convention on the Rights of Persons with Disabilities ("CRPD") is not mentioned or discussed in the judgment. Article 12.4 could be said to accommodate circumstances such as arose in this case, in the generalised wording appropriate for international instruments, in that Article 12.4 requires respect for "the rights, will and preferences of the person" but protection from "conflict of interest and undue influence".

In a future similar case, a court might consider it appropriate to explain its conclusions not only by reference to the long-established criteria explained by Sheriff Deutsch, but also in relation to the intersection of the CRPD requirements for respect and protection. In the case of Mrs Scott, was her subscription of the second Will not an exercise of her will at all? If so, was the second Will void rather than voidable? Did the outcome equate to a finding of incapacity? If subscription was an exercise of her will, is the outcome to be explained on the basis that where principles are in conflict, it is for the court to strike a balance in the light of the circumstances of each individual case, as they might be found by the court to be proven; so that no one principle can be allowed to prevail in any absolute way?

Adrian D Ward

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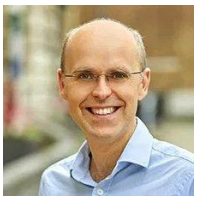

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Conferences

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.

Neil's training dates are available on his website.

Advertising conferences and training events

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

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

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