NOTTINGHAM INQUIRY
EXPERT REPORT OF ALEX RUCK KEENE KC (HON)

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Introduction

1. I have been instructed to provide an expert report to the Nottingham Inquiry on a number of aspects of mental health and capacity law in England & Wales. I do so below, emphasising the following by way of scope:

    a. The report does not address the facts of Valdo Calocane's case.

    b. The report sets out a legal opinion, rather than a clinical opinion. There are certain questions which I can only answer by reference to guidance given by clinicians as to how they are to apply the law, but the views that I express are those of a lawyer, rather than a clinician.

    c. The report does not cover those under the age of 18.

    d. The report does not cover the position of those in Scotland or Northern Ireland.

2. The report is of necessity lengthy because of the number of questions that I have been asked. It does not, unfortunately, afford of an executive summary in consequence of the breadth of the terrain covered by the questions; the only executive summary that I could provide would be that the interface between mental health and mental capacity law is one that is, and will remain, complicated.

The basis upon which I am qualified to give this report

3. I am a barrister at 39 Essex Chambers in London, where I have been in practice since 2002 (taking tenancy in 2003). Prior to joining 39 Essex Chambers, I gained a First Class degree in History at Oxford, and a MA in International Relations at Johns Hopkins, subsequently converting to law via a Postgraduate Diploma in Law and then the Bar Vocational Course.

4. My practice at 39 Essex Chambers occupies roughly 1/3rd of my time. In my practice, I focus on mental capacity, mental health and healthcare ethics. I have appeared in cases involving all three areas before courts up to and including the Supreme Court and the European Court of Human Rights. I append a copy of my CV to this report which sets out cases I have been involved in more detail, but my experience in cases involving the Mental Health Act 1983 includes, most recently, appearing as one of the Counsel team for the NHS Trust in the *Lewis-Ranwell* case concerning the

application of the illegality defence in the context of a negligence claim brought by a person found not guilty by reason of insanity following the killing of three individuals.

5. Roughly 1/3rd of my time is spent on research and education. I am a Professor of Practice at the Dickson Poon School of Law, King's College London. In that capacity, I co-lead the Mental Health, Ethics and Law MSc programme, and teach Mental Health and Capacity Law: the Civil Context. I also train judges (as part of the Judicial College) on the Mental Capacity Act 2005, as well as social workers, doctors, nurses and other professionals who have cause to work with the Mental Capacity Act 2005 ('MCA 2005') and the Mental Health Act 1983 ('MHA 1983'). I am part of the roster of lawyers used by the Royal College of Psychiatrists for their induction / refresher training for psychiatrists (and in some cases other professionals) discharging functions under s.12 MHA 1983 and / or as Approved Clinicians under the MHA 1983.

6. The remaining 1/3rd of my time is spent on policy matters. In 2016-17, I was a consultant to the Law Commission's Mental Capacity and Deprivation Liberty project, which included working on the interface between the MHA 1983 and MCA 2005. Throughout 2018, I was the legal adviser to the Independent Review of the Mental Health Act 1983. I was specialist adviser to the Joint Committee on Human Rights for their 2021-2022 inquiry into human rights in the care setting. I sit on committees including the Royal College of Psychiatrists Special Human Rights Committee and the British Medical Association Medical Ethics Committee, as well as on the clinical ethics committees of two large trusts (one acute and one mental health). As a member of the Law Society of England & Wales's Mental Health and Disability Committee, I coordinated guidance on deprivation of liberty in a number of contexts (including the psychiatric setting, both inpatient community) in 2015, updated again in 2024. I was made an Honorary QC (now KC) in 2022, reflecting my contribution to the development of mental health and capacity law outside the courtroom.

Declarations of relevant interest / comments upon the case

7. I can confirm that I have had no dealings with Valdo Calocane, nor with those killed or injured by him on 13 June 2023. I am not currently employed by any core participant, although I should note:

   a. As noted above, I am on a regular basis paid by the Royal College of Psychiatrists in my capacity as a self-employed barrister to deliver training as part of their (mandatory) induction / refresher training for those seeking approval under s.12 MHA 1983 / as approved clinicians under the MHA 1983;

b. I was instructed and paid (as a self-employed barrister) by the Department of Health and Social Care to act as Sir Simon Wessely's legal adviser when he was chairing the independent Mental Health Review. I reported to, and advised, Sir Simon and his Vice Chairs, as opposed to the Department of Health and Social Care;

c. I have been employed – on a part-time basis – as a consultant to the Law Commission on two occasions (one the Mental Capacity and Deprivation of Liberty project noted above (my involvement running from May 2016 to March 2017), and the other the Disabled Children's Social Care project (my involvement running from October 2023-July 2025). The Law Commission is an advisory non-departmental body sponsored by the Ministry of Justice, so my employment arrangements were made by the Ministry of Justice. The Law Commission is, however, statutorily independent, and the Ministry of Justice had no say or direction over any of the matters that I was involved in at the Law Commission;

d. In my capacity as a practising barrister, I have advised national policing bodies, but not in relation to the specific issues raised by the Inquiry, and I have not advised at any stage advised or acted for East Midlands Police.

8. I have made no public comment or opinion directly addressing Valdo Calocane's case, although:

a. On my website, I did on a blog post[1] about the introduction of the Mental Health Bill into Parliament note the following:

> *The Bill now introduced is very similar to the draft Bill brought forward by the previous Government, which can be found here. A Joint Committee of both Houses of Parliament was convened to scrutinise the draft Bill published in 2022, and its report can be found here (together with my walkthrough of it). The previous Government responded to that report here.*
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> *No doubt reflecting recent high-profile cases such as that Valdo Calocane, the Bill now includes measures designed (in the words of the press release) to recognise that "safety is paramount" – including a requirement that the patient's responsible clinician consults with another person before discharging them; the press release also says that "[d]ischarge processes will be reviewed more broadly and will include a safety management plan for the patient, to keep themselves and others safe."*

b. The 39 Essex Chambers Mental Capacity Report has covered matters relating to the case on a number of occasions. However, whilst I have edited most editions, the articles in the Report

[1] https://www.mentalcapacitylawandpolicy.org.uk/mental-health-bill-introduced-into-parliament/.

relating to matters in England & Wales are not attributable by name, so they would not be identified as my public comments / opinions. I do not therefore set out the references here.

Overarching observations

The European Convention on Human Rights

9. So that I do not simply repeat myself and extend this Report longer than necessary, I set out at the outset some overarching observations about rights and obligations arising from the European Convention on Human Rights 1998. Via the Human Rights Act 1998,[2] the ECHR:

   a. Imposes a 'meta' set of obligations on professionals in the discharge of functions under the MHA 1983, an act which is striking in its absence of substantive duties. In other words, whilst the MHA 1983 sets out very detailed procedural safeguards as regards the admission and assessment of mental disorder, it says very little about when professionals should consider deploying the tools that the MHA 1983 contains. Even s.11, entitled "duty of approved mental health professionals to make applications for admission or guardianship," in fact contains a much lesser duty – a duty to consider the patient's case on behalf of a local authority where they have reason to think that an application may need to be made in respect of a patient within their area. Put another way, the driving forces behind consideration of the deployment of the MHA 1983 are primarily to be found outside the MHA 1983 itself, in the HRA 1998 (and, in turn, the ECHR);

   b. Provides the framework within which the MCA 2005 is applied – the MCA 2005 itself providing no powers or duties to act, as opposed to providing (in effect) a workaround for the situation where a person is unable to give the consent ordinarily required to an action being taken by someone else;

   c. Provides the framework within which local authorities apply the Care Act 2014 (in England) and the Social Services and Well-Being (Wales) Act 2014. Both Acts contain duties to assess and meet eligible needs, but in the situations of the kind with which the Inquiry is concerned, there may well be more than one potential response, and which one of those is 'right' is not a question that can be answered within the internal framework of the legislation. Rather, it is one that, in legal terms, is likely to be identified by reference to the external considerations

[2] Specifically, s.6(1). making it unlawful for a public authority to act in a way which is incompatible with a Convention right.

contained in the ECHR.

10. The obligations imposed by the ECHR are both positive and negative. Positive obligations are (crudely) obligations read into the ECHR by the courts (both domestic and that in Strasbourg) to make the rights protected by the Convention effective. This doctrine has been clearly enunciated in relation to Article 2 ECHR. Whilst on its face it solely imposes a 'negative' obligation on the state – i.e. not to deprive a person of their life intentionally – the courts have recognised that such a right would be empty if the state stood by and took no action to secure a person's life in the face of an imminent risk that they posed to themselves, or, conversely, if state agents stood by and did nothing to prevent a private individual taking the life or lives of others.[3] The approach under Article 2 has been applied by analogy in relation to Article 3 (the prohibition on torture or to inhuman or degrading treatment or punishment).[4] This means, for instance, that if the state stood by and did nothing to prevent a person with a mental health condition suffering at home in a situation of serious self-neglect, questions (at a minimum) would arise as to whether the state had satisfied the positive obligation to protect them against inhuman or degrading treatment.

11. More nuanced is the positive obligation under Article 8. Article 8, enshrining the right to respect for private and family life (including, it has been explained[5], the right to autonomy) is generally understood in the negative – i.e. a 'freedom from interference' provision. However, in some cases, it might be that the State is required to take positive steps to ensure that the person is actually able to enjoy the right to private and family life. The Strasbourg court has on occasion found that it mandates positive steps to ensure the "psychological integrity,"[6] of those within the state's borders. More broadly, actions by state agents are often motivated by a desire to secure a person's 'true' autonomy where it appears that their situation is compromised either by internal or external factors. That could be framed as seeking to discharge a positive duty under Article 8 ECHR, although it is a rather weaker obligation, not least as it requires much more of a 'gamble' that a step which might interfere with a person's currently expressed views is one which is, in fact, justified in their name of securing their 'true' autonomy, rather than one which is simply an interference with their right to private life.[7]

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[3] See, for an authoritative statement of this, the decision of the Grand Chamber of the European Court of Human Rights in *Valentin Câmpeanu v Romania* [2014] ECHR 972 at paragraph 130.
[4] See, for an authoritative statement of this, *O'Keeffe v Ireland* [2014] ECHR 96 at paragraph 144.
[5] *Pretty v United Kingdom* [2002] ECHR 427 at paragraph 61.
[6] *Botta v Italy* [1998] ECHR 12 at paragraph 32.
[7] These two conceptions of autonomy – sometimes described as 'thinner' and 'thicker' – can be seen, for instance, in the judgment of Swift J *Royal Bank of Scotland Plc v AB* [2020] UKEAT 0266_18_2702 at paragraph 26 discussed at paragraph 61 below.

12. Almost all of modern day mental health care can be seen as a balancing act between:

    a. The positive duties imposed by Article 2, Article 3 and (to a more limited extent) Article 8; and

    b. The obligations imposed by Article 5 (not to deprive a person of their liberty save on specified, limited, grounds, and by a procedure prescribed by law) and Article 8 (not to interfere with the right to private and family life save where the interference is justified, in particular by reference to the necessity and proportionality of the steps required).

13. The European Court of Human Rights has grappled with this balance in a number of important judgments over the past decade, including:

    a. *Bljakaj and Others v Croatia* (2014) [8] in which the Strasbourg court made clear that the so-called *Osman* duty[9] to take positive steps to secure against a risk to life posed by a specific person – in that case a "mentally disturbed" person who shot his wife's lawyer – can, in appropriate situations, arise even where the victim(s) had not been identifiable in advance. It did, however, reiterate that the obligation "*must be interpreted in a way which does not impose an impossible or disproportionate burden on the authorities, bearing in mind the difficulties involved in policing modern societies, the unpredictability of human conduct and the operational choices which must be made in terms of priorities and resources;*"[10]

    b. *Hiller v Austria* (2016) [11] in which Strasbourg emphasised that: "*today's paradigm in mental health care is to give persons with mental disabilities the greatest possible personal freedom in order to facilitate their re-integration into society. The Court considers that from a Convention point of view, it is not only permissible to grant hospitalised persons the maximum freedom of movement but also desirable in order to preserve as much as possible their dignity and their right to self-determination;*"[12]

    c. *Fernandes de Oliveira* (2019),[13] a Grand Chamber decision concerning the death by suicide

[8] [2014] ECHR 965.
[9] After *Osman v United Kingdom* [1998] ECHR 101.
[10] For the domestic application of this, see *Griffiths v Chief Constable of Suffolk* [2018] EWHC 2538 (QB). There can be some complex questions that arise in relation to Article 2 as regards the categorisation of the duty in play. I am concerned here, primarily, with the operational duty that arises 'in real time,' as opposed to questions of whether there are sufficient systems in play to address failures.
[11] [2016] ECHR 1028.
[12] Paragraph 54.
[13] [2019] ECHR 106. This case has been considered and applied by the domestic courts in *R (Morahan) v Her Majesty's Assistant Coroner For West London* [2021] EWHC 1603 (Admin), in which the High Court considered,

of a voluntary patient, and the positive obligations of the state in the presence of suicide risk, in which the court identified that the factors which it will take into account include: (a) whether the person had a history of mental health problems; (b) the gravity of the mental condition; (c) previous attempts by the person to take their own life or self-harm; (d) suicidal thoughts or threats; and (e) signs of physical or mental distress.[14] The Grand Chamber applied the *Osman* approach to risk and the steps required in the presence of risk where the risk was from the person to themselves, but "*reiterate*[d] *that the very essence of the Convention is respect for human dignity and human freedom. In this regard, the authorities must discharge their duties in a manner compatible with the rights and freedoms of the individual concerned and in such a way as to diminish the opportunities for self-harm, without infringing personal autonomy* [...]. *The Court has acknowledged that excessively restrictive measures may give rise to issues under Articles 3, 5 and 8 of the Convention;*"[15]

d. *Rooman v Belgium* (2019),[16] in which the Grand Chamber "*clarified*" and "*refined*"[17] its approach to deprivation of liberty under Article 5(1)(e) (i.e. detention on the basis of mental disorder). It made clear the need that there was a "*close link*" between the lawfulness of the detention and: (1) the provision of appropriate treatment; and (2) the treatment in an appropriate facility.[18] It emphasised that the "*detention of mentally ill persons must have a therapeutic purpose, aimed specifically, and in so far as possible, at curing or alleviating their mental-health condition, including, where appropriate, bringing about a reduction in or control over their dangerousness. The Court has stressed that, irrespective of the facility in which those persons are placed, they are entitled to be provided with a suitable medical environment accompanied by real therapeutic measures, with a view to preparing them for their eventual release;*"[19]

e. *Spivak v Ukraine* (2025),[20] concerning compulsory administration of medical treatment for mental disorder. The court observed that "*one of the fundamental principles in modern*

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and delineated, the scope of the Article 2 ECHR investigative obligation (and, by implication, the 'operational' duty under Article 2 ECHR to secure life) in relation to voluntary mental health patients at home in the community. *Morahan*, following *Fernandes*, represents a more nuanced approach to the positive obligation imposed by Article 2 ECHR in the case of voluntary patients than the Supreme Court (before *Fernandes*) had anticipated that Strasbourg would have taken in the case of *Rabone v Pennine Care NHS Foundation Trust* [2012] UKSC 2.

[14] Paragraph 115.

[15] Paragraph 112, the last sentence citing *Hiller*.

[16] [2019] ECHR 105. *Rooman* has been considered and applied domestically by the Upper Tribunal in *SF v Avon and Wiltshire Mental Health Partnership* [2023] UKUT 205 (AAC) (see paragraphs 53 to 54)

[17] Paragraph 205.

[18] See paragraphs 208 and 210.

[19] Paragraph 208.

[20] [2025] ECHR 136.

medical ethics and international human rights law - as widely emphasised across various international instruments, […] *is that no medical intervention may take place without the patient's free and informed consent* […]. *This principle is a cornerstone of personal autonomy, as it ensures that individuals maintain control over decisions regarding their medical treatment, with a full understanding of the associated risks, benefits, and alternatives. This principle holds particular significance in the field of mental healthcare, where patients are often in vulnerable situations and at heightened risk of treatments being administered without their full understanding or agreement.*" The court went on to acknowledge that "*the issue of informed consent becomes more complex in cases involving compulsory medical measures imposed by court order.*[21] *The very concept of 'compulsory medical measures' appears to conflict with the principle of personal autonomy. At the same time, the justification for such measures often lies in the need to protect either the individual's health or public safety - considerations that are seen as outweighing and overriding the usual requirement for free and informed consent." It reconciled the tension by emphasising the need for "rigorous oversight to prevent potential abuse and to ensure that the interference with personal autonomy is proportionate and justified. In particular, it is essential that the treatment provided is appropriate and necessary. Without such safeguards, the automatic authorisation of treatment without consent risks undermining the individual's rights in a manner that may be incompatible with the rule of law in a democratic society.*"[22]

14. It can be seen from these that:

a. Strasbourg recognises that there are rarely absolutes, even when it comes to the discharge of apparently absolute obligations such as that imposed by Article 2, and is also willing to take into account that resources are not unlimited;

b. Strasbourg continues to place very considerable weight on the exercise of professional judgment by clinicians, with the ECHR providing a framework for the exercise of judgment. The converse is that Strasbourg expects: (1) careful consideration of the balance; and (2) careful explanation of the conclusion reached;

c. The landscape is shifting at the ECtHR level such that the room for compulsory measures might appear to be increasingly limited. It was, in part, the shifts in this landscape which led

[21] Note: this being the relevant mechanism in *Ukraine*. The same logic applies in relation to the MHA 1983, which – as set out further below – provides an administrative mechanism for the imposition of such treatment.
[22] Paragraph 176.

to the proposals from the Independent Review of the Mental Health Act 1983 (addressed below). However, I need to emphasise that, contrary to the position advocated by the Committee on the Rights of Persons with Disabilities (the treaty body overseeing the UN Convention on the Rights of Persons with Disabilities), the European Court of Human Rights has made clear that it considers that, subject to appropriate safeguards, compulsory admission and treatment for mental disorder is still compatible with international human rights norms. It has further made clear that it considers that a functional concept of capacity such as that contained in the MCA 2005 is equally compatible with international human rights norms.[23]

Primary legislation vs Codes of Practice

15. One other important observation I need to make at the outset is as to the interaction between primary legislation and Codes of Practice. Both the MHA 1983 and the MCA 2005 are accompanied by statutory Codes of Practice.[24] In practice, I am aware (but the Inquiry is likely to wish to investigate for itself) many professionals and others look first to the Codes of Practice, rather than the legislation, because they are often written in more user-friendly English. The Codes of Practice are both statutory, in the sense that the relevant statute requires them to be prepared,[25] which means, in turn, that they have been laid before Parliament.[26] Relevant professionals must have regard to the guidance given in the relevant Code.[27] The MCA 2005 contains (in effect) a sanction for failure to have such regard;[28] the equivalent does not appear in the MHA 1983 but has been read in by the courts.

16. Both Codes – but in particular that accompanying the Code of Practice to the MHA 1983 – contain very 'directive' language as regards the operation of the legislation. That can give the impression that they form a source of law. However, that is incorrect. In the context of the Code of Practice to the MHA 1983, the House of Lords held that it was:

[23] These issues are addressed in detail in Annex B to the Report of the Independent Review of the MHA 1983 (which I drafted). Whilst the report dates from 2018, the fundamental position of Strasbourg has not changed thereafter, as can be seen from the decision in *Spivak v Ukraine* noted above.
[24] There are, in fact, two for both. The MHA 1983 has a Code of Practice for England, most recently updated in 2015 and a Code of Practice for Wales, most recently updated in 2016. The MCA 2005 is accompanied by a Code of Practice to the main body of the legislation (published in 2007, and not updated thereafter), and a Code of Practice accompanying the so-called Deprivation of Liberty Safeguards (published in 2009, and not updated thereafter). The then-Department of Health also published a (non-statutory) Reference Guide to the MHA 1983 in 2015 (it has not been updated thereafter).
[25] Section 118 MHA 1983; s.42 MCA 2005.
[26] Section 118(4) MHA 1983; s.43 MCA 2005. The purpose of such 'laying' is to give the opportunity for scrutiny; this very rarely happens, and did not happen in the case of any of the Codes referred to here.
[27] Section 118(2D) MHA 1983; s.42(4) MCA 2005.
[28] Section 42 (5) provides that "[if it appears to a court or tribunal conducting any criminal or civil proceedings that – (a) a provision of a code, or (b)a failure to comply with a code, is relevant to a question arising in the proceedings, the provision or failure must be taken into account in deciding the question."

> *plain that the Code does not have the binding effect which a statutory provision or a statutory instrument would have. It is what it purports to be, guidance and not instruction.*[29]

17. In the context of the MCA Code of Practice, the Supreme Court has made clear in *NHS Trust v Y*[30] that a Code cannot create a legal obligation where none in fact exists; as the then-Vice President of the Court of Protection, Hayden J, put it subsequently:

> *It is axiomatic that the Code of Practice is not a statute. It is an aid to the interpretation of the law, not a primary source of law.* […] *where a conflict arises between the Act or the* [Court of Protection Rules 2017] *or, indeed existing authority, and the Codes of Practice; it is the MCA 2005 (or as the case may be, the COPR 2017 or case law) which must be taken as representing the law.*[31]

18. However, the picture is made more complicated because, as the House of Lords said in relation to the MHA 1983 Code of Practice:

> *It is not instruction, but it is much more than mere advice which an addressee is free to follow or not as it chooses. It is guidance which any hospital should consider with great care, and from which it should depart only if it has cogent reasons for doing so.* […] *In reviewing any challenge to a departure from the Code, the court should scrutinise the reasons given by the hospital for departure with the intensity which the importance and sensitivity of the subject matter requires.*[32]

19. Given the status of the Codes, in my answers below I focus primarily on the statutory provisions, rather than the Codes. I will highlight relevant places where the Codes go further than the statute and / or are incorrect.

20. For completeness whilst in the context of Codes, I note that:

    a. At Third Reading of the Mental Health Bill on 14 October 2025, the Minister for Care,

[29] *R (Munjaz) v Ashworth Hospital Authority* [2005] UKHL 58 at paragraph 21.
[30] [2018] UKSC 46 at paragraph 46.
[31] *Re Lawson, Mottram and Hopton (appointment of personal welfare deputies)* [2019] EWCOP 22 at paragraph 46.
[32] *R (Munjaz) v Ashworth Hospital Authority* [2005] UKHL 58 at paragraph 21.

Stephen Kinnock MP, stated that "[t]he first *priority once the Bill gets Royal Assent will be to draft and consult on the code of practice. We will engage closely with people with lived experience and their families and carers and with commissioners, providers, clinicians and others to do that.*"[33]

b. The Department of Health and Social Care announced on 18 October 2025 that there was to be a consultation "*in the first half of* [2026]" on the Liberty Protection Safeguards (i.e. the replacement for the Deprivation of Liberty Safeguards), and that responses from the consultation "*will be used to inform a final Mental Capacity Act (2005) Code of Practice which will be laid in Parliament.*"[34] At the time of drafting this Report, there is no further detail as to the timeframe for the completion of this process.

Question 1: please set out the powers under which mental health clinicians can provide clinically indicated mental health treatment on a non-voluntary basis. Please specifically consider admission for assessment or treatment under the MHA 1983 (s.2 or s.3), the general authority under s.5 MCA 2005 and the interplay of these powers.

Preliminary

21. In answering this question, it is worth starting with the basic premise that, in general, the law only allows adults to be treated on the basis of their voluntary, capacitous and informed consent; treatment absent such consent will amount to both a criminal and a civil wrong. However, there may be circumstances in which this is not possible. For present purposes, there are two key ones:

    a. The person has the mental capacity to make the decision whether or not to have the treatment,[35] and decides that they do not wish it.

    b. The person is unable to give the necessary consent because they lack the mental capacity to decide whether or not to have the treatment.

22. In the first case, the only way in which it is possible to provide medical treatment for mental disorder in the absent of consent is to invoke the provisions of the MHA 1983.

[33] *Hansard*, HC, 14 October 2025, col 341.
[34] https://www.gov.uk/government/news/improved-safeguarding-and-protections-for-vulnerable-people.
[35] I put it this way because this is the test which is applied by the Court of Protection in situations in which it is called upon to decide upon a person's decision-making capacity in relation to medical treatment; sometimes abstruse arguments arise as to whether a different test applies to determine a person's capacity to consent to that which applies to their test to refuse. The better way of looking at it is that it is the same test, with the relevant information including the consequences of refusal.

23. In the second case, it is in principle possible to apply either the provisions of the MHA 1983 or the MCA 2005.

The Mental Health Act 1983: medical treatment for mental disorder

24. Medical treatment for mental disorder is defined in s.145 MHA 1983. It goes beyond medication, to include nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care; the purpose of such treatment must be to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations.[36]

25. Complicated questions sometimes arise as to whether a specific treatment represents treatment for mental disorder or physical disorder,[37] but for purposes of this Report these questions can be put to one side. Further, for purposes of this question, I proceed on the basis that the medical treatment in question is both clinically indicated and considered to be appropriate applying the test in s.3(4) MHA 1983, namely that it is appropriate taking into account the nature and degree of the mental disorder and all other circumstances of the person's case.

26. The MHA 1983 is best thought of as hospital-based legislation. In other words, it is predicated upon admission, followed by assessment and / or treatment. It does not provide a standalone framework for the administration of treatment for mental disorder for patients who have not been admitted to hospital. As discussed at paragraphs 49 to 52 below, the framework for such treatment is the MCA 2005.

Admission to mental health hospital

27. A factor that has increasingly come to be recognised in recent years[38] is that admission to a mental health hospital[39] should be regarded as (at a minimum) giving rise to the potential for confinement,

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[36] Section 154(4).
[37] For instance, in many cases, nasogastric feeding could represent medical treatment for mental disorder if (for instance) the person's decision not to eat represents a manifestation of their mental disorder; in other cases, it might not: see *A NHS Trust v Dr A* [2013] EWCOP 2442.
[38] In part in consequence of the decision of the ECtHR in *HL v United Kingdom* [2004] ECHR 720, and then the decision of the Supreme Court in *P v Cheshire West and Chester Council* [2014] UKSC 19.
[39] I am conscious in saying this that there is no statutory definition of 'mental health hospital' (there is a definition of 'hospital' in the MHA 1983: see ss. 34 and 145: there is also a definition (in England) of 'mental health units' in s.1(1) Mental Health Units (Use of Force) Act 2018. However, the vast majority of acute hospitals are registered with the Care Quality Commission / Health Inspectorate Wales to deliver mental health services as regulated activities to cater (amongst other things) for the potential that a patient may be admitted for physical health treatment but undergo a mental health crisis. I am therefore not using 'mental health hospital' as a term of art, but to cover hospitals who are primarily dedicated to the assessment and treatment of mental disorder.

because any person who is admitted as a patient can be prevented from leaving by invoking the holding powers in s.5 MHA 1983 (which apply to give a time-limited power[40] to complete the process for formal admission). It is, however, still possible to be admitted as an informal patient under s.131 MHA 1983 where the patient has capacity to and agrees to enter the hospital.[41]

28. A person can also be compulsorily admitted to hospital for assessment and/or treatment for mental disorder under the provisions of the MHA 1983.[42] This can take place either directly from the community or from hospital (for instance where it becomes clear that it is not appropriate for them to be continue to be treated as an informal patient).

29. The procedure for detention for assessment under s.2 MHA 1983 (which provides for detention for up to 28 days) requires an application to be made by an Approved Mental Health Professional ('AMHP') or the patient's Nearest Relative. The application must be supported by written recommendations by two doctors, confirming that the patient is "*suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period*" and "*he*[43] *ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons.*"

30. An application for detention for treatment under s.3 MHA 1983 may be made on the grounds that that the person "*is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital,*" "*it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under this section*" and "*appropriate medical treatment is available for him.*" Written recommendations from registered medical practitioners supporting the application must additionally include a statement of reasons for their opinion and any particulars relating to the conditions.

31. The question of whether the patient has the capacity to agree to an informal admission is relevant to the question of whether it is necessary to invoke the compulsory powers under ss.2 / 3 MHA 1983. However, ultimately, and despite what sometimes appears to be understood by health and

[40] The time limit depending upon whether it is invoked by a nurse or a registered medical practitioner / approved clinician.
[41] On the basis, amongst other things, that they are aware that if they try to leave and it is considered that the conditions that s.5 are met, that power will be invoked.
[42] In this section, and given the terms of the question, I am not addressing the situation where a patient is 'diverted' from the criminal justice under the provisions of Part 3 MHA 1983.
[43] The MHA 1983 reflects the date when it was drafted, and refers solely to 'he'; modern drafting is gender neutral.

social professionals,[44] the MHA 1983 is not capacity-based as regards the question of admission.

32. Where a person lacks capacity to agree to admission to hospital, then it is extremely unlikely that it would be appropriate for them to be admitted informally. This is because admission to hospital (as noted above) will be very likely to amount to confinement, and a person who lacks the capacity to consent to confinement will be viewed as deprived of their liberty.[45] Deprivation of liberty requires formal authorisation so as to comply with the provisions of Article 5 of the European Convention on Human Rights; at present, there are three routes to obtain such authorisation: (1) admission under the MHA 1983; (2) authorisation by way of the Deprivation of Liberty Safeguards provided for in Schedule A1 to the MCA 2005; and (3) (exceptionally) a court order.

33. The interaction between the MHA 1983 and the Deprivation of Liberty Safeguards ('DoLS') is notoriously complex,[46] but for present purposes, and in headline terms:

    a. Both frameworks provide a mechanism lawfully to deprive a person lacking capacity to consent to admission;

    b. Where a person objects to admission and /or any part of the treatment for mental disorder, the DoLS regime cannot be used, and the MHA 1983 must be used; and

    c. The frameworks for treatment are different, as I address further at paragraphs 35 to 44 below.

34. I note, finally, that it is possible that the admission to hospital may be authorised by way of court order:

    a. If the person lacks capacity to consent to their admission, the Court of Protection has jurisdiction both to decide on their behalf to be admitted, and to authorise any deprivation of liberty to which they may be subject.[47] Whilst the statutory framework provided for by DoLS should be used wherever possible in preference to a court order,[48] there is no statutory bar to

[44] For a good 'worked example' of this misunderstanding in practice, see *Lukes v Kent & Medway NHS & Social Care Partnership Trust & Anor* [2024] EWHC 753 (KB).
[45] The clearest domestic statement of this is in the Supreme Court decision in *P v Cheshire West and Chester Council* [2014] UKSC 19. I note that, at the time of preparing this report, the Supreme Court is considering the question of whether all people who lack capacity to consent to confinement are automatically to be viewed as deprived of their liberty. The hearing took place on 20-22 October, and judgment is awaited.
[46] The statutory interface is set down in Schedule 1A to the MCA 2005; it is explained, most recently, in the judgment in *Manchester University Hospitals NHS Foundation Trust v JS & Anor (Schedule 1A Mental Capacity Act 2005)* [2023] EWCOP 33.
[47] Under ss.4A and 16 MCA 2005.
[48] See *A Local Authority v PB & Anor* [2011] EWCOP 2675 at paragraph 64(iii).

a court order being used save and to the extent that it purports to authorise deprivation of liberty for purposes of admission / treatment for mental disorder to which the person objects. At that point, the Court of Protection cannot purport to authorise any deprivation of liberty.[49]

b. It is theoretically possible that the High Court could authorise any deprivation of liberty to which the person is subject upon admission under its inherent jurisdiction.[50] However, it is in practice difficult to think of a situation in relation to adults which is not covered by statute (either the MHA 1983 or the MCA 2005), and the inherent jurisdiction can only operate where there is a statutory gap.[51]

Non-voluntary treatment for mental disorder: in hospital

Informal patients

35. An informal patient cannot be subjected to compulsory treatment under the provisions of Part 4 MHA 1983, discussed below. Their medical treatment for mental disorder must either take place on the basis of their capacitous consent or on the basis of the 'general authority' in s.5 MCA 2005. It would, however, be unusual, and problematic, for a patient to be treated on the basis of s.5 MCA 2005 on anything other than a very short term basis pending their formal admission under s.2 or s.3 MHA 1983. One of the reasons for this is that a patient who lacks capacity to make decisions about their medical treatment for mental disorder would also be very likely to lack capacity to make decisions about their continued presence at the hospital in circumstances giving rise to confinement. At that point, and as set out at paragraph 32 above, a formal framework would be required for authorisation of the deprivation of their liberty. They would therefore no longer be classified as an informal patient.

Patients detained under the MHA 1983

36. Where the patient is detained under the MHA 1983, the vast majority of decisions made about

[49] Section 16A MCA 2005.
[50] See *Mazhar v Birmingham Community Healthcare Foundation NHS Trust & Ors* [2020] EWCA Civ 1377 at paragraph 52 (the person would need to have a mental disorder of sufficient gravity justifying detention so as to satisfy Article 5(1)(e) ECHR). The case of *A NHS Trust v Dr A* [2013] EWCOP 2442, in which the High Court used its inherent jurisdiction to authorise deprivation of liberty in the context of a patient detained under the MHA 1983, addressed a different situation – namely the authorisation of the deprivation of the 'residual liberty' of the patient for purposes of addressing physical health matters.
[51] See the case law summarised in *A Local Authority v KP* [2023] EWHC 3102 (Fam) at paragraph 33.

medical treatment for mental disorder will be made under the provisions of Part 4 MHA 1983.[52] (Note, this is sometimes written Part IV, reflecting the age of the MHA 1983). Again, it is important to start by noting that, whilst Part 4 provides for non-voluntary treatment, it does not mandate it. It is entirely possible for a detained patient's treatment throughout their period of admission to be based solely on their capacitous consent.[53] However, the critical feature of Part 4 is that it provides a framework within which it is possible to proceed without that consent.

37. General authority to give medical treatment for mental disorder without consent for detained patients is provided by s.63 MHA 1983, which provides that the consent of the patient is not required to give medical treatment for mental disorder. This is subject to the following four exceptions:

    a. Serious treatment for mental disorder, currently limited solely to neurosurgery and surgical implantation of hormones to reduce male sex drive. A patient who does not have capacity to consent to such treatment can never be administered this treatment.[54]

    b. Specified forms of treatment that can be given after three months of being liable to detention under the Act either with the patient's capacitous consent or, where the capacitous patient refuses or is not capable of consent, only subject to a second opinion from a Second Opinion Appointed Doctor ('SOAD').[55] It is in practice this provision which governs the administration of most medications (such as antipsychotic medication) where the person is detained for three months or more.

    c. Treatment (currently limited to electro-convulsive therapy (ECT)) that can only be administered to a patient capable of (and in fact) consenting or to an incapable patient subject to a second opinion, so long as the delivery of such treatment does not conflict with: (1) a valid and applicable advance decision to refuse ECT; (2) the decision of a donee or court appointed deputy; or a decision of the Court of Protection.[56]

    d. Treatment in an emergency. This will primarily be of relevance in the case of ECT, which can

[52] The exceptions are 'short-term' patients, i.e. those brought into hospital by the police as a place of safety under s.136 MHA 1983, patients in respect of whom an emergency application has been made under s.4 MHA 1983, or patients detained using the holding powers under s.5 MHA 1983.
[53] Note, as discussed further below in relation to the answer to question 2, the precise test may be one of 'capability' rather than capacity, depending on context; in practical terms, there is no difference at present, and in due course will be no difference in statutory terms given the changes to be introduced by the Mental Health Bill.
[54] The combined effect of ss.28 and 57 MHA 1983, s.57 and s.28; see also the (English) *Mental Health Act 1983 Code of Practice*, fig. 12 (the Welsh Code addresses this at pp.165-6).
[55] Section 58 MHA 1983.
[56] Section 58A MHA 1983.

be administered without the protections set out above where it is immediately necessary to save the patient's life or prevent serious deterioration of their condition.[57] A shortage of SOADs and the administrative delay in seeking a second opinion approval has also led to the need for the emergency procedure to be invoked following a change of consent status (loss of capacity or withdrawal of consent) pending the obtaining of the requisite second opinion. Here, one of the statutory justifications to use s.62, "*(not being irreversible) is immediately necessary to prevent a serious deterioration of his condition*,"[58] is in practice easily met.

38. Whilst Part 4 MHA 1983 does not specifically provide authority to restrain the patient in order to secure the administration of medical treatment, the courts have read in the ability to use restraint, including, potentially physical force.[59] For completeness, I note in this regard that the Mental Health Units (Use of Force) Act 2018 (which is not fully in force) does not give clinicians any power to restrain, as opposed to setting out provisions in relation to the monitoring and reporting of such force.

39. It is important to note that where the provisions of Part 4 MHA 1983 are invoked, as they will be almost invariably be in relation to any patient detained under that Act, s.28 MCA 2005 makes clear that nothing in the MCA 2005 authorises anyone to give the person treatment for mental disorder; or consent to the person being given treatment for mental disorder. On its face, therefore, there is a bright line between the MHA 1983 and the MCA 2005 in terms of the psychiatric treatment of those detained in hospital. It is, in particular, clear that a clinician could not seek to rely upon the provisions of the 'general authority' in s.5 MCA (see further paragraph 42 below) to provide medical treatment for mental disorder to a patient detained under the MHA 1983 who falls within the framework of Part 4 MHA 1983.

40. The picture is, however, made more complicated in two respects:

    a. By case law which makes clear that the presence of an advance decision to refuse medical treatment for mental disorder should weigh very heavily in the balance where consideration

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[57] Section 62 MHA 1983. Treatments falling within ss.57 and 58 MHA 1983, could, theoretically, also be delivered on the same emergency basis, but by the nature of the treatments in question, it is very unlikely in practice that s.62 could ever properly be invoked in relation to such treatments. In relation to neuro-surgery, it is also difficult to see how this could be said to be anything other than irreversible, a further reason why s.62 would not apply.

[58] Section 62(1)(b) MHA 1983.

[59] For instance, in *Tameside v Glossop Acute Services Health Trust* v *CH* [1996] 1 FLR 762, the court held that restraint may lawfully be used, so long as reasonably required and clinically necessary, to administer treatment under s.63. In *R (B) v Dr SS (Responsible Medical Officer)* [2006] EWCA Civ 28, the Court of Appeal expressly envisaged the "distress that will be caused to the patient if the treatment has to be imposed by force" as a factor going to whether the treatment is appropriate (see paragraph 62).

is given to whether to use the compulsory treatment provisions of the MHA 1983 to administer treatment contrary to that decision.[60] Such an advance decision cannot serve to prevent treatment being administered under Part 4 MHA 1983.[61] However, at least where the medical treatment for mental disorder would be capable of being life-saving, the courts have made clear that the relevant treating body would be "*well advised*"[62] to consider putting the matter before a court to determine whether the use of compulsory powers is appropriate.

b. Where the patient lacks capacity to make the decision about the relevant medical treatment, we are increasingly seeing treating Trusts placing the question of whether medical treatment for mental disorder is in the patient's best interests before the Court of Protection. This phenomenon is particularly identifiable in the case of detained patients with anorexia; whilst it is possible to ensure that they are fed under restraint (if necessary) under the terms of Part 4 MHA 1983, treating bodies now quite regularly place the case for determination before the Court of Protection.[63] In some ways, this sits quite uneasily with the terms of s.28 MCA 2005; this tension has not perhaps come to the fore because the cases have all concerned situations where the treating Trust consider that continued compulsory treatment is not in the patient's best interests. In formal terms, therefore, the Court of Protection has only been asked to refuse treatment on the patient's behalf (under s.16 MCA 2005), rather than to consent, which would arguably directly conflict with the terms of s.28 MHA 1983.

Patients deprived of their liberty under the provisions of the Deprivation of Liberty Safeguards

41. Where a patient is in hospital, and authority for their deprivation of liberty stems from the DoLS, the basis upon which they are provided with medical treatment for mental disorder could, in theory, be their capacitous consent (as capacity is decision-specific it is possible, but unlikely, that they would lack capacity to consent to their admission in circumstances of confinement, but have capacity to decide whether or not to accept the relevant medication).

42. It is much more likely that a person whose deprivation of liberty in hospital is authorised by way

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[60] *Nottinghamshire Healthcare NHS Trust* v *RC* [2014] EWCOP 1317 (a case concerning refusal of blood required after the patient self-harmed). The court in that case was the High Court, rather than the Court of Protection, because the patient in question was considered to have the capacity to make the relevant decision, and the Trust was seeking a determination that their decision not to require the patient to undergo a compulsory blood transfusion was lawful. On advance decisions, see also the (English) *Mental Health Act 1983 Code of Practice* at paragraph 24.6: an equivalent statement does not appear in the Welsh version.

[61] Contemporaneous refusal is no bar, as set out above; advance refusal is therefore no bar either.

[62] *Nottinghamshire Healthcare NHS Trust* v *RC* [2014] EWCOP 1317 at paragraph 21.

[63] See, for a recent example, and also a discussion of the interaction between the jurisdiction of the Court of Protection and the High Court, *Leeds and York Partnership NHS Foundation Trust v FF & Anor* [2025] EWCOP 26 (T3).

of DoLS will lack capacity to consent to treatment. At that point, consent could theoretically be given on their behalf by a health and welfare Lasting Power of Attorney, a welfare deputy or a Court of Protection judge. In practice, it is more likely, however, that the basis upon which non-voluntary treatment will be given will be s.5 MCA 2005. This provision is often referred to as a general authority (and was referred to as such by Baroness Hale in *N v ACCG* [2017] UKSC 22), but in fact is a defence to the civil and criminal liability which would otherwise arise where a person is touched in the course of provision of care and treatment without giving their consent. The defence relies upon the relevant actor: (a) taking reasonable steps to establish whether the person lacks capacity in relation to the matter; (b) the actor having a reasonable belief that the person lacks capacity to consent to the relevant act; and (c) a reasonable belief that the act done is in their best interests.[64]

43. For present purposes, what is most important is that, by contrast to the position in relation to treatment under Part 4 MHA 1983:

a. The test is not whether the treatment is appropriate, but whether it is in the person's best interests, applying the statutory test in s.4 MCA 2005. That statutory test has been interpreted by the courts as incorporating a very significant element of substituted judgment: i.e. the starting point being what the person would have decided if they were able to do so. "Best interests" here is usually interpreted by reference to the person's own interests. However, the courts have shown themselves willing on occasion to interpret "best interests" as incorporating the interests of others, either (a) where it is clear that the person themselves would wish those interests to be taken into account; or (b) where it is clear that following the person's wishes and, in consequence, putting others at risk, could lead to 'blowback' risks for the person themselves. To give an example of (b), the courts have considered on occasion that it is in a person's best interests not to harm a small child if the consequences are likely to be harmed by the parent of the child and /or to face criminal proceedings.[65]

b. There are no express procedural safeguards (for instance, a requirement to consult a Second Opinion Appointed Doctor ('SOAD')). The courts have taken some steps to read in implied safeguards,[66] but the drafting of s.5 MCA 2005 represents a very different philosophical

[64] Note, it does not depend on the actor formally stating that they are relying upon s.5, so long as they are complying in substance with its provisions: see *ZH v Commissioner for the Police for the Metropolis* [2013] EWCA Civ 69.
[65] See *DY v A City Council & Anor* [2022] EWCOP 51.
[66] For instance, in *ZH v Commissioner for the Police for the Metropolis* [2013] EWCA Civ 69, the Court of Appeal recognised the force of the submission that a failure to comply with the best interests 'checklist' set out in s.4 MCA 2005 would prevent reliance upon s.5 (see paragraph 41); and in *Winspear v City Hospitals Sunderland NHS Foundation Trust* [2015] EWHC 3250 (QB), the court found that it had been practicable and appropriate to

starting place to the provisions of Part 4 MHA 1983;

c. Reflecting that different philosophical starting point, treatment cannot be given in reliance upon s.5 MCA 2005 where it conflicts with a valid and applicable advance decision to refuse such treatment.[67] Nor (although these are in practice less likely) could it be given in face of a refusal by a lasting power of attorney with the relevant decision-making authority, a Court of Protection appointed deputy with the relevant authority, or a Court of Protection judge on the person's behalf.[68]

44. Alongside s.5 must also be considered s.6. This provides a defence against liability (and hence a form of authority) where restraint is required to give effect to an act which is the person's best interests, and where that restraint is: (1) reasonably believed by the actor to be necessary to prevent harm to the person; and (2) the restraint is a proportionate response to the likelihood of the person suffering harm, and the seriousness of that harm. Restraint is defined in s.6(4) as: (1) the use of force and the threat of the use of force to secure the doing of an act which the person resists, or (2) a restriction on the person's liberty of movement, whether or not they resist. Complicated legal questions can arise as to the point at which restraint tips over into deprivation of liberty; the former does not require formal authorisation;[69] the latter does. For present purposes, however, it is important to note that s.6 is regularly relied upon in the context of patients deprived of their liberty in hospital under DoLS to secure the administration of medication considered to be in their best interests. In this regard, I should perhaps, finally, note that there is an issue – as yet unresolved – as to whether it is possible to rely upon s.6 MCA 2005 where the risk is not to the person, but to

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consult with the mother of a young man with learning disability before placing a DNACPR recommendation on his medical records, such that there had been a duty to consult with her for purposes of considering his best interests under s.4. and that the failure to consult therefore meant that there was no defence available (there, to a claim under Article 8 ECHR) under s.5 MCA 2005. The Supreme Court has also made observations about the scope of s.5 in the context of the withdrawal of life-sustaining treatment (*NHS Trust v Y* [2018] UKSS 46, but that is a somewhat different context. Guidance issued subsequently by the (then) Vice-President of the Court of Protection relating to serious medical treatment, Hayden J (2020] EWCOP 2), emphasised (at paragraph 10) that in in any case involving a serious interference with the person's Article 8 ECHR rights, it was "highly probable" that an application to the Court of Protection should be made; this guidance was applied by the (subsequent) Vice-President, Theis J. in *An NHS Trust v XB* [2020] EWCOP 71 in relation to the administration of covert hypertensive medication to a patient detained under the MHA 1983, holding that given the anxiety expressed by the man's' siblings about the administration of the medication, and the serious nature of the interference with his rights under Article 8 ECHR involved in administering covert medication, this was a case where there should have been no reticence in involving the court (paragraph 74).

[67] This flows by operation of ss.24-6 MCA 2005, which has the effect of creating the fiction that the person is contemporaneously refusing the relevant intervention at the point it is being proposed.

[68] By operation of section 6(6) (which does not refer to the Court of Protection itself, but this flows as a matter of logic from the primacy of the Court of Protection's powers as regards determination of capacity and best interests under ss.15-6 MCA 2005).

[69] Note, though, that it may well be required to be recorded as a use of force for purposes of the Mental Health Units (Use of Force) Act 2018 when this is fully in force.

others. By parity of reasoning with the approach set out in relation to best interests above, a sufficient 'blowback' risk of harm to the person might be said to fall within the scope of s.6.

Non-voluntary treatment for mental disorder: outside hospital

The Mental Health Act 1983

45. Part 4 MHA 1983 applies to patients who are actually detained in hospital. It also applies to patients who are on leave under s.17 MHA 1983, as (perhaps slightly counter-intuitively, especially given that such leave can be very extended) they are considered 'liable to be detained' (s.17(1)).[70] This is by contrast to the position in relation to patients who are on a Community Treatment Order ('CTO') under the provisions of ss.17A-G MHA 1983. At that point, the provisions of Part 4 do not apply; rather, the provisions of Part 4A apply.

46. Part 4A MHA 1983, perhaps reflecting the fact that CTOs represent a rather later addition to the MHA 1983 (being introduced in the Mental Health Act 2007), is much more clearly focused upon the patient's capacity than Part 4:

    a. Patients who are subject to Community Treatment Orders (CTOs) and who have capacity[71] to decide whether or not to agree to the proposed medical treatment for mental disorder can only be given treatment in the community with their consent. Those who refuse must be recalled to hospital in order to be given treatment without their consent,[72] although I note that the clinician in exercising the power of recall has to be satisfied that there would be a risk of harm to the person or others if the relevant treatment in hospital were not provided (in other words, a mere refusal alone is not sufficient).[73]

    b. CTO patients who lack the capacity to decide whether or not to agree to the proposed treatment can (in theory) be given treatment in the community if an attorney with the requisite authority under a health and welfare Lasting Power of Attorney, a Court of Protection appointed deputy, or a Court of Protection judge consents on their behalf.[74] I say 'in theory' because, in practice,

[70] The Supreme Court made clear that patients under s.17 are still to be considered 'detained' in *Secretary of State for Justice v MM* [2018] UKSC 60, in contradistinction to a patient released under a CTO: see paragraph 18.
[71] Applying the test in the MCA 2005: s.64(2) and (3).
[72] The treatment then being given subject to the (complex) provisions of s.62A MHA 1983. A patient on a CTO (if they have the requisite capacity) can also agree to being admitted informally to hospital without the recall procedure being used, in which case the treatment of their mental disorder is governed by Part 4A MCA 1983.
[73] See s.17(E)(1) MHA 1983; see also *Welsh Ministers v PJ* [2018] UKSC 66.
[74] Section 64C(2)(b) MHA 1983

this is unlikely to happen.[75] Much more likely in reality is that there is no legal fiction that consent is being given on their behalf by one of these categories of people. Rather, s.64D MHA 1983 allows for treatment to be given by or under the direction of the approved clinician in charge of the treatment unless:[76] (a) the treatment would be contrary to a valid and applicable advance decision made by the patient or the treatment would be against the decision of someone with the authority under MCA 2005 to refuse it on the patient's behalf (i.e. a health and welfare Lasting Power of attorney, a deputy or the Court of Protection);[77] or (b) the person objects to the treatment and physical force needs to be used in order to administer the treatment.[78]

47. There are also emergency provisions which apply in certain strictly defined circumstances so as to give authority to treat a community patient who has not been recalled and who lacks the material decision-making capacity.[79] They hinge, in particular, on the treatment being judged to be "immediately necessary," which means: (1) immediately necessary to save the patient's life; (2) immediately necessary to prevent a serious deterioration of the patient's condition and is not irreversible; (3) immediately necessary to alleviate serious suffering by the patient and is not irreversible or hazardous; or (4) it is immediately necessary, represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to himself or others and is not irreversible or hazardous.[80] If the treatment is 'immediately necessary,' then force may be used to give it if (1) the treatment needs to be given in order to prevent harm to the patient; and (b) the use of such force is a proportionate response to the likelihood of the patient's suffering harm, and to the seriousness of that harm.[81]

48. For completeness, I note that guardianship under the MHA 1983 provides no authority to treat. If treatment is to be delivered to one of the (very few) people subject to guardianship, it has to be delivered either on the basis of their capacitous consent, or the provisions of the MCA 2005.

The Mental Capacity Act 2005

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[75] I am aware of two (linked) unreported cases in which a Court of Protection judge did exercise such a power of consent, alongside authorisation to deprive the person of their liberty to receive medication, so as to enable the person to remain in the community. See the article entitled "CTOs and the Court of Protection" in the October 2018 edition of the 39 Essex Chambers Mental Capacity Report, available here: https://www.39essex.com/sites/default/files/Mental-Capacity-Report-October-2018-Compendium-Screen-Friendly.pdf.
[76] Section 64D MHA 1983.
[77] Section 64D(6) MHA 1983.
[78] Section 64D(4) MHA 1983.
[79] Section 64G MHA 1983.
[80] Section 64G(5)(a)-(d). Further criteria apply in relation to ECT, but I do not address these here.
[81] Section 64G(3).

49. Where the person is not in hospital, and is not subject to the MHA 1983, then the most obvious basis upon which non-voluntary treatment for mental disorder can be administered is under the provisions of s.5 MCA 2005. I have discussed s.5 at paragraph 42 above. It is, perhaps, though, worth flagging two further points here:

    a. It is not commonly understood that the MHA 1983 does not apply in prison, so prisoners experiencing mental health crisis will be administered medical treatment to address that crisis on the basis of s.5 MCA 2005 (if they cannot at that point consent to the treatment);

    b. Section 6 MCA 2005 is likely to be of particular relevance where it appears that there may be any resistance on the part of the person to the administration of the medication, because there will be no other formal powers in play which could give a springboard to justify force. I note that the courts have demonstrated an increasing willingness to identify the relevance of the person's own views in determining how 'robust' steps can be under s.6. In *Leicestershire County Council v P & Anor* [2024] EWCOP 53 (T3), Theis J took account of the fact that the subject of the proceedings wished (in effect) to be protected against herself when she was at point when she was dissociating and therefore lacking capacity to make the relevant decisions (see paragraph 138(3)).

50. It is possible, but in practice unlikely, that medical treatment for mental disorder could be given on the basis of the consent of a health and welfare attorney under a Lasting Power of Attorney. I say 'unlikely' simply because of the circumstances under which most LPAs are granted and used. If it does arise, then the attorney could only give consent: (1) where the person lacks the capacity to make the specific decision about the medication in question; and (2) after considering their best interests. I discuss capacity at paragraphs 60 to 75 below, and best interests at paragraph 43(a) above.

51. It is also possible, but in practice even less likely, that medical treatment for mental disorder could be given on the basis of the consent of a health and welfare deputy. I say 'even less likely' because the Court of Protection is reluctant to appoint such deputies unless the conventional operation of s.5 MCA 2005 has broken down.[82] If the conventional operation has broken down, the likelihood is that the person's circumstances are such that a deputy would not be able to operate effectively.

52. Finally, it would be possible for medical treatment for mental disorder to be delivered on the basis

[82] See *Re Lawson, Mottram and Hopton (appointment of personal welfare deputies)* [2019] EWCOP 22.

of a decision by a Court of Protection judge to consent on behalf of the person if: (1) they lacked the capacity to decide whether to consent to or refuse such treatment; and (2) it the judge concluded it was in their best interests. I discuss capacity at paragraphs 60 to 75 below, and best interests at paragraph 43(a) above. I note that Court of Protection judges relatively regularly authorise plans for the delivery of care and treatment to people in the community (including those which give rise to deprivation of liberty[83]). It is fair to say that in my experience these sorts of plans tend to involve individuals with cognitive impairments such as learning disability, autism or dementia, as opposed to serious mental health conditions such as schizophrenia. There is, however, no reason in principle for a care plan not to be authorised to provide for the delivery of such treatment to a person with such a condition. Practical questions will arise to how such treatment is to be delivered, and by whom, but at a legal level the position is clear.

Court order

53. Finally, I note that there is a possibility that a person who has capacity applying the MCA 2005 to make the decision whether or not to accept medical treatment for mental disorder, but is in some way 'vulnerable,' might be the subject of an order under the High Court's inherent jurisdiction. The precise extent of this jurisdiction is controversial, and at least one judge has made clear that they considered unacceptable the idea that an order be made directing a capacitous person to accept treatment.[84] There are, however, examples of other judges making orders directed against the person;[85] further, where the apparent refusal stems from the influence of another, it is conceivable that a court might find that there was, in fact, no 'refusal' to override.[86]

Summary

54. The picture set out above is complicated. It can be summarised in the following tables.

Admission to mental health hospital

[83] Under the so-called *Re X* procedure. For further details, see this guidance note: https://www.39essex.com/sites/default/files/Judicial-Authorisations-of-Deprivation-of-Liberty-July-2022v1.pdf.
[84] See *JK v A Local Health Board* [2019] EWHC 67 (Fam).
[85] *Southend-On-Sea Borough Council v Meyers* [2019] EWHC 399 (Fam), which did not concern treatment but requiring a (capacitous) person to live at a place away from their son.
[86] The pre-MCA 2005 case of *Re T* [1993] Fam 95 was such a case, where the court found that the refusal by a young woman to accept blood did not prevent the doctors administering it, as her decision was the result of the influence of her Jehovah's Witness mother. However, at the time, the High Court's inherent jurisdiction was deployed both in relation to those who would now be looked at through the prism of the MCA 2005 and those who are said to be capacitous but vulnerable: it might now be said that, on the facts, T in fact lacked capacity applying the MCA 2005.

	Mental Health Act 1983	**Mental Capacity Act 2005**	**Court order**
Has capacity to decide whether or not to be admitted to mental health hospital	Y	N	Theoretically possible but very unlikely
Lacks capacity to decide or not to be admitted to mental health hospital	Y	Y (unless objecting to admission or all / part of proposed medical treatment for mental disorder)	Y (unless objecting to admission or all / part of proposed medical treatment for mental disorder)[87]

Provision of non-voluntary medical treatment for mental disorder

	Hospital	**Not in hospital but subject to MHA 1983**	**Not in hospital and not subject to MHA 1983**
Has capacity to decide whether or not to have medical treatment for mental disorder	1. If informal: no power to treat. 2. If detained under MHA 1983, Part 4 MHA 1983	1. Part 4 MHA 1983 if on s.17 leave 2. Cannot be treated in the community if on a CTO, but could be recalled to hospital and treatment provided. 3. Otherwise no power to treat absent (theoretical) invocation of High Court inherent	No power to treat absent (theoretical) invocation of High Court inherent jurisdiction

[87] Albeit that a Court of Protection judge would be likely to wish to understand why the provisions of the MHA 1983 were not being used in such a case.

	Hospital	**Not in hospital but subject to MHA 1983**	**Not in hospital and not subject to MHA 1983**
		jurisdiction	
Lacks capacity to decide whether or not to have medical treatment for mental disorder	1. If informal, s.5 MCA 2005 (but questionable whether appropriate to rely on this) 2. If detained under the MHA 1983, Part 4 MHA 1983. 3. In either situation, order of the Court of Protection (although, in respect of a detained patient, questionable whether the Court of Protection can properly authorise treatment directly covered by Part 4 MHA 1983)	1. Part 4 MHA 1983 if on s.17 leave 2. If on CTO, Part 4A where no restraint required, or where emergency.	1. Section 5 MCA 2. Lasting Power of Attorney (health and welfare) 3. Deputyship (health and welfare) 4. Order of the Court of Protection

Question 2: As regards assessing a patient's capacity to make a decision as to mental health treatment - (i) treatment generally; and (ii) depot medication in particular - please explain how such assessment should take place? When should the assessment be done and repeated? Who

should do the assessment? What are the principles that apply?

Preliminary

55. In answering this question, which I take to refer to medical treatment for mental disorder,[88] I need to make two matters clear at the outset:

    a. I am providing an opinion as to the requirements of the law, in particular the MCA 2005. The inquiry will no doubt wish to consider guidance from relevant bodies such as the General Medical Council and / or the Royal College of Psychiatrists as regards the expectations from a clinical perspective. I will note such guidance where relevant, but only insofar as the inquiry may wish to consider its relevance in determining 'reasonableness,' which is a core feature of the MCA 2005's approach to considering capacity.

    b. I am providing an opinion on the basis of the law as it stands in 2025. The statutory law is the same at the time of the events under consideration, albeit that, as I note at paragraphs 91-99 below, the meaning of that law was subject to important clarifications in 2024 and 2025 as regards how to consider the concepts of 'belief' and 'insight' within the scope of the MCA 2005.

56. There are two different scenarios which need considering. The first is where the person is subject to either Part 4 or Part 4A MHA 1983, i.e. the treatment frameworks considered in the answer to question 1 above. The second is where the person is not so subject but the question of whether they have capacity to make decisions as to mental health treatment arises.

Part 4/Part 4A MHA 1983

57. There is no difference between mental health treatment in general and depot medication in particular. In terms of the principles, and how assessment is to be done it is, strictly, necessary to differentiate between situations in which the test is one of 'capability' and one of 'capacity.' Some older parts of the MHA 1983 talk of capability: the test in ss.58 and 58A MHA 1983 being whether the patient is "capable of understanding the nature, purpose and likely effects of the treatment;"

[88] In other words, rather than broader questions such as whether the person has capacity to make decisions as to whether to seek assistance from mental health professionals. I note that this is not, in fact, a legally meaningful question, because the capacity is only relevant where relevant professionals have a power or duty to act in some way, and need to know whether they are engaging with the person on the basis that they have capacity to agree to what they are proposing (where statute provides a role for capacity).

conversely, the test of capacity is used expressly in the provisions regarding treatment on a CTO.[89] The Code of Practice to the MHA 1983 suggests that the test is the same as the statutory test that applies under s.2 MCA 2005.[90] The caselaw relating to these provisions pre-date the MCA 2005,[91] but I consider it very likely that a court if asked to consider the interpretation of the test in s.58 would follow the test set out in s.2 MCA 2005. I also consider it very likely that the court would also read into the relevant provision of the MHA 1983 the principles contained in ss.1(2)-(4) MCA 2005 which strictly apply only to the assessment of capacity for purposes of the MCA 2005.[92] I note that, in due course, the changes to be introduced by the Mental Health Bill will replace the concept of 'capability' with that of capacity.

58. I therefore proceed on the basis that the same approach applies in terms of the mechanics of considering the person's capability / capacity to make decisions about medical treatment for mental disorder under Part 4 MHA 1983.

59. This means, first, that the assessor has to consider the three principles set out in ss.1(2)-(4) MCA 2005. I set these out together with commentary, as they are frequently misunderstood.

The presumption of capacity

60. Section 1(2) MCA 2005 provides that a person must be assumed to have capacity unless it is established that they lack capacity. This is regularly referred to as the 'presumption' of capacity. It is often viewed solely by reference to the question of when the presumption is displaced. For instance, the Code of Practice to the MCA 2005 says that the principle "*states that every adult has the right to make their own decisions – unless there is proof that they lack the capacity to make a particular decision when it needs to be made.*"[93] This is both:

    a. Strictly legally incorrect: as set out at paragraph 42 above the test in relation to the use of s.5 MCA 2005 is whether there is a reasonable belief that the person lacks capacity. In that case, the individual relying on the defence has not 'proved' that the person lacks capacity; and

    b. Incomplete, because it does not address the prior question of the point at which it is necessary

[89] See s.64K.
[90] See the (English) Mental Health Act 1983 Code of Practice, paras.24.30–23.32: the Welsh Code addresses this at paras 24.28 to 24.39.
[91] In particular *R (B) v Dr SS* [2006] EWCA Civ 28.
[92] Again, this is the position suggested by the Code of Practice: see para 24.31 (English) and para 24.38 (Welsh).
[93] Paragraph 2.3. Paragraph 2.4 then provides that "It is important to balance people's right to make a decision with their right to safety and protection when they can't make decisions to protect themselves. But the starting assumption must always be that an individual has the capacity, until there is proof that they do not."

to consider whether or not the person has capacity to make the decision.

61. The proper approach to this second issue is as set out by Swift J as follows:

> *The presumption of capacity is important; it ensures proper respect for personal autonomy by requiring any decision as to a lack of capacity to be based on evidence. Yet the section 1(2) presumption like any other, has logical limits. When there is good reason for cause for concern, where there is legitimate doubt as to capacity* [to make the relevant decision], *the presumption cannot be used to avoid taking responsibility for assessing and determining capacity. To do that would be to fail to respect personal autonomy in a different way.*[94]

62. The important question, not provided for in the MCA 2005, is as to the point at which there are, or should be 'good reason for cause for concern,' or 'legitimate doubt.' None of the Codes of Practice address this question. I note for the Inquiry's reference that the General Medical Council's guidance on decision-making and consent provides in its 2020 iteration provides that:

> *You should be alert to signs that patients may lack capacity and must give them all reasonable help and support to make a decision.*
>
> [...]
>
> *If you believe that a patient may lack capacity to make a decision, you must assess their capacity using the test set out in the relevant legislation, taking account of the advice in the relevant guidance. If you find it difficult to judge whether a patient has capacity to make a decision, you should seek support from someone who knows the patient well, for example, another member of the healthcare team or someone close to the patient.*[95]

63. The Chair of the Inquiry may wish to investigate whether there is a specific guidance issued by the Royal College of Psychiatrists on this issue; I am not aware of any such current guidance.

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[94] *Royal Bank Of Scotland Plc v AB* [2020] UKEAT 0266_18_2702 at paragraph 26. The decision was taken in the context of proceedings before the Employment Appeal Tribunal, but is of wider relevance, as it was interpreting the provisions of s.1(2) MCA 2005.

[95] General Medical Council, *Decision Making and Consent* (paragraphs 82 and 84). 'Must' in this context constitutes 'an overriding duty or principle' (see the Terminology section at the start of the guidance).

The support principle

64. Section 1(3) MCA 2005 provides that a person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success. The Supreme Court has made clear that the operation of this principle "ensures that the interference with article 8 [European Convention on Human Rights], if it is engaged, is proportionate."[96] It is perhaps important to note that the requirement is not that all possible steps are taken, but rather all practicable steps. Practicability would be judged by reference (amongst others) to the nature of the decision and the urgency of the situation.[97] The courts have also made clear that it is necessary to be clear-eyed at which point the line between a decision made with the person (with support) becomes a decision for the person. As one judge has put it:

> *if the process* [in that case, of supporting the person to make decisions in relation to accessing the internet] *could only really occur with the degree of supervision and prompting suggested then that would, in truth, be a fiction rather than a genuine exercise in autonomy.*[98]

The unwise decisions principle

65. Section 1(4) MCA 2005 provides that a person is not be treated as lacking capacity merely because they make an unwise decision. This is often said to constitute a 'right to make unwise decisions.' It is, important, however, to be clear that there is no such right within the MCA 2005 itself; s.1(4) enshrines a different right, namely not to be held as lacking capacity on the sole ground that the purported decision is unwise. Lord Stephens has authoritatively interpreted the provision thus:

> *Legal capacity depends on the application of sections 2 and 3 of the MCA together with the principles in section 1. It does not depend on the wisdom of the decision. Furthermore, an important purpose of the MCA is to promote autonomy. That purpose aids the interpretation of sections 2 and 3 of the MCA. If P has capacity to make a decision then he or she has the right to make an unwise decision and to suffer the consequences if and when things go wrong. In this way P can learn from mistakes*

[96] *A Local Authority v JB* [2021] UKSC 52 at paragraph 118. Lord Stephens holding in consequence that he considered the MCA 2005 to be compatible with Article 8 ECHR.
[97] Chapter 3 of the MCA 2005 sets out guidance on such steps.
[98] *Re C (capacity to access the internet and social media)* [2020] EWCOP 73 at paragraph 41 per IIHJ Mark Rogers.

and thus attain a greater degree of independence. (emphasis added)[99]

The test for capacity

66. The test for capacity is set out in s.2 MCA 2005, amplified by s.3.[100] Section 2(1) MCA 2005 requires it to be shown that the person is unable to make the decision in question because of an impairment of, or disturbance in the functioning of, the person's mind or brain. Section 3(1) MCA 2005, in turn, sets out the test for assessing whether a person is unable to make a decision for themselves, namely that they are unable: (a) to understand the information relevant to the decision; (b) to retain that information; (c) to use or weigh that information as part of the process of making the decision, or to communicate his decision (whether by talking, using sign language or any other means).

67. The Code of Practice to the MCA 2005 advised that there was a two stage test to be adopted to the test,[101] namely that:

    a. it must, first, be established that there is an impairment of, or disturbance in the functioning of, the person's mind or brain (the so-called 'diagnostic test'[102]); and

    b. it must be established that the impairment or disturbance is sufficient to render the person unable to make that particular decision at the relevant time (the 'functional test'[2]).

68. However, in 2021, in *A Local Authority v JB*, the first case concerning the approach to capacity in the MCA 2005 to come before the Supreme Court, Lord Stephens (giving the judgment of the court) made clear that it is necessary to start with the question of whether the person is functionally capable of making the decision in question, and only if they are not, to then move on to consider why that is the case.[103] In doing so, he also emphasised the importance of the 'causative nexus' between the two aspects: i.e. establishing why the person's inability (for instance) to understand

[99] *A Local Authority v JB* [2021] UKSC 52 at paragraph 51.
[100] As Lord Stephens put it in *JB* (at paragraph 65): "[t]*he core determinative provision within the statutory scheme for the assessment of whether P lacks capacity is section 2(1). The remaining provisions of sections 2 and 3, including the specific elements within the decision-making process set out in section 3(1), are statutory descriptions and explanations which support the core provision in section 2(1). Those additional provisions do not establish a series of additional, freestanding tests of capacity. Section 2(1) is the single test, albeit that it falls to be interpreted by applying the more detailed description given around it in sections 2 and 3…*"
[101] Mental Capacity Act 2005: Code of Practice, pp 44–45.
[102] There is, however, no requirement that there be a formal diagnosis in order to satisfy this test: see *Hemachandran & Anor v Thirumalesh & Anor* [2024] EWCA Civ 896 at paragraph 140(i).
[103] [2021] UKSC 52, [2022] AC 1322, at paragraph 79 per Lord Stephens. See in this regard also the earlier decisions of *PC & Anor v City of York Council* [2013] EWCA Civ 478 and *Kings College Hospital NHS Trust v C and V* [2015] EWCOP 80.

the relevant information was caused by the identified impairment.[104]

69. In *Re EO*, the Court of Appeal noted:

> *that the MCA 2005 Code of Practice at para. 4.11 is in direct contradiction to the judgment in Re JB and stipulates the two-stage test of capacity should be approached with the first stage being to establish whether someone has an impairment (i.e. the diagnostic test) and only then to move onto the functional test. A new draft Code dated June 2022 but yet to be implemented, adopts the Re JB approach. Regardless of the fact that the new Code has not yet been implemented, all assessments should comply with the Supreme Court approach (see Hemachandran v University Hospitals Birmingham NHS Foundation Trust [2024] EWCA Civ 896 para.[140](iii)).*[105]

70. It is unfortunate that the MCA 2005 Code of Practice does not just go beyond what the primary legislation requires, but is in flat contradiction to it. The Chair of the Inquiry may wish to consider the practicalities of how a medical professional might be expected to be aware of the clear edict from the Court of Appeal as to how assessments are to be conducted so that they can be aware that there is a "*cogent reason*"[106] to depart from the Code.

71. The Supreme Court's decision in *JB* is also helpful for emphasising two further points:

> *68. As the assessment of capacity is decision-specific, the court is required to identify the correct formulation of "the matter" in respect of which it must evaluate whether P is unable to make a decision for himself: see York City Council v C at paras 19, 35 and 40.*
>
> *69. The correct formulation of "the matter" then leads to a requirement to identify "the information relevant to the decision" under section 3(1)(a) which includes information about the reasonably foreseeable consequences of deciding one way or another or of failing to make the decision: see section 3(4).*

72. As regards 'reasonably foreseeable consequences,' and perhaps contrary to the popular perception

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[104] *Re JB* at paragraph 78.
[105] *Re EO (by her litigation friend)* [2024] EWCA Civ 1579 at paragraph 36.
[106] To use the language relating to the Mental Health Act Code of Practice in *Munjaz*: see paragraph 16 above.

of the MCA 2005, Lord Stephens made clear that these consequences are not just those for the person themselves. At paragraph 92, he identified that:

> *The information relevant to the decision includes information about the "reasonably foreseeable consequences" of a decision, or of failing to make a decision, which consequences are not limited to the consequences for P: see para 73 above. The consequences for other persons or for members of the public are therefore a part of the information relevant to the decision. Furthermore, I agree with the Court of Appeal, at para 6, that:*
>
> > *"as a public authority, the Court of Protection has an obligation under section 6 of the Human Rights Act 1998 not to act in a way which is incompatible with a right under the European Convention of Human Rights, as set out in Schedule 1 to the Act. Within the court, that obligation usually arises when considering the human rights of P, but it also extends to the rights of others."*
>
> *In this way the court as a public authority, in determining what information is relevant to the decision, must include reasonably foreseeable adverse consequences for P and for members of the public. In practice, by doing so, the court under the MCA protects members of the public. As the Court of Appeal observed, at para 98:*
>
> > *"Although the Court of Protection's principal responsibility is towards P, it is part of the wider system of justice which exists to protect society as a whole."*

73. Lord Stephens was considering the position of a determination of capacity by the Court of Protection; however, logically, his analysis would apply equally to any person discharging functions as a public authority bound by s.6 Human Rights Act 1998. It is fair to say that the implications of this aspect of the judgment of the Supreme Court have yet to be fully explored; they will no doubt be the subject of guidance in any future draft Code.

74. A final important observation of the Supreme Court in *JB* in relation to the assessment of capacity was in relation to the relevance of the gravity of the consequences. There is no 'sliding scale' of capacity, such that there is no requirement that a person have 'greater capacity' to make a more

serious decision.[107] However, if the decision could have serious or grave consequences, it is "even more important" that they understand (and can retain, use and weigh) that information.[108]

The standard of proof

75. It is regularly asserted that the standard of proof in determining capacity under the MCA 2005 is the balance of probabilities. This is true when a matter is before a court: see s.2(4) MCA 2005. However, outside the court room setting, and in any situation where the person is relying upon the defence under s.5 MCA 2005 (as to which see further paragraph 42 above), the question is whether they have a reasonable belief[109] that the person lacks capacity, having taken reasonable steps to establish whether this the case. This has two consequences:

    a. It should not automatically be assumed that a person can only be said to have a reasonable belief in the other's lack of capacity if they have directed themselves by reference to the civil standard of proof. Rather, they simply must be able to point to objective reasons to justify why they hold that belief. Given the time-specific nature of capacity, further, the fact that a person may not subsequently be able to establish before a court that the other now lacks capacity to make a relevant decision does not mean that they did not have, at an earlier time, a reasonable belief that they lacked it;

    b. Section 5 applies where steps will be taken on the basis that the person lacks capacity to make the relevant decision. It does not on its face having anything to say about the situation where steps will be taken (or not taken) on the basis that the person has capacity. However, in practice, the courts would be likely to look to whether the belief that the person had capacity at the relevant time through the same prism – i.e. whether it was reasonable based upon the steps taken, and the circumstances. As noted at paragraph 74 above, the more serious the potential consequences of the decision, the more intently the court will look at whether the belief that the person had the requisite capacity was reasonable.[110]

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[107] This is a common misunderstanding: to give a recent example, Professor Sir Chris Whitty had to write to Kim Leadbeater MP to correct evidence that he had given to the Bill Committee considering the Terminally Ill Adults (End of Life) Bill that "the more serious the decision, the greater the level of capacity that someone needs to have" (Hansard, PPBC (Bill 012) 2024 – 2025, 28 January 2025, p 30).

[108] *JB* at paragraph 74, referring to paragraph 4.19 of the MCA 2005 Code of Practice.

[109] In *Barnet Enfield and Haringey Mental Health NHS Trust and another v Mr K and others* [2023] EWCOP 35, John McKendrick KC (sitting as a Tier 3 Judge), considering the analogous position in relation to exercise of the Court of Protection's interim jurisdiction under s.48 MCA 2005, which requires that there be "*reason to believe*" that the person lacks capacity in relation to the matter, noted that "[b]*elief is different from proof*" (see paragraph 57).

[110] See also in this regard *Pindo Mulla v Spain* [2024] ECHR 753 at paragraph 148, balancing the state's positive obligations under Article 2 to secure life and under Article 8 to respect the person's (true) autonomy.

Capacity in context

76. I should note that I have been addressing solely the question of capacity. Consent is not based solely on the person's capacitous ability to give it (or refuse it) but also on that consent being given on the basis of that appropriate information has been given to them,[111] and also that it is given voluntarily. The Mental Health Act Code of Practice emphasises these points at paragraphs 24.34 to 24.39.[112] The short observation that I would make it is that it is not necessarily as easy to comply with these principles in the context (in particular) of Part 4 MHA 1983 as it is in other contexts.

Outside Part 4/Part 4A MHA 1983

77. The second scenario is where the person is not subject to Part 4 / 4A MHA 1983 but the question of whether they have capacity to make decisions as to mental health treatment arises. The approach is identical to that set out to the consideration of capacity under Parts 4 / 4A, with two caveats.

78. The first that more rides on the outcome, as there is no way in which treatment can be imposed absent either: (1) the person's capacitous consent; (2) one of the mechanisms provided for under the MCA 2005 (most obviously, the defence in s.5 MCA 2005).

79. The second is that, as a matter of logic, outside the MHA 1983 framework, it may be more difficult to see the person to consider their capacity to make decisions about medication treatment. I frame this somewhat broadly, because those difficulties could be self-imposed (for instance, resource pressures could mean that a member of (say) the Community Mental Health Team does not have time to visit the person). They could also be imposed by a third party (for instance a person barring access to the individual in their own home).[113] They could also arise because the person does not engage with the relevant medical professionals.

80. In this regard, it is important to note that there is a difference between the MCA 2005 and the MHA 1983. It is absolutely clear that decisions about assessment for admission under the MHA 1983 cannot be made without personal examination.[114] However, there is no statutory requirement for such 'personal examination' before a conclusion is reached as to their capacity to make relevant

[111] See, in particular, the case of *Montgomery v Lanarkshire Health Board* [2015] UKSC 11.
[112] The Welsh Code addresses these issues at paragraphs 24.29 to 24.37.
[113] If there are proper grounds to believe that the person's refusal to undergo the assessment is due to the influence of a third party, then it may be possible to invoke the inherent jurisdiction of the High Court to seek injunctions requiring that third party to allow access to the person.
[114] *Devon Partnership NHS Trust v Secretary of State for Health and Social Care* [2021] EWHC 101 (Admin); the same also applies to renewing authority for detention (and, parasitic, for a CTO) *Derbyshire Healthcare NHS Foundation Trust v Secretary of State for Health and Social Care* [2023] EWHC 3182 (Admin).

decisions applying the MCA 2005. This means that it is entirely lawful for capacity assessments to be carried out remotely,[115] although the Senior Judge of the Court of Protection has emphasised that:

> *remote assessment is not the optimal way for P to be seen. If a virtual assessment is undertaken, an explanation must be provided as to why and as to what support measures were provided to P. An explanation based simply on 'stretched resources' is unlikely to be persuasive.*[116]

81. The law, therefore, does not prevent the carrying out of remote capacity assessment where the person does not wish to see the relevant professionals face to face but is willing to engage virtually.

82. The engagement challenge may, however, be more fundamental. At that point, it is important to distinguish between the situation where the person is unwilling to take part in the assessment, and the one where they are unable to take part. As Hayden J emphasised in *QJ v A Local Authority and Anor*: "[i]*t is important to emphasise that lack of capacity cannot be established merely by reference to a person's condition or an aspect of his behaviour which might lead others to make unjustified assumptions about capacity (s 2(3) MCA).* [In this case, a]*n aspect of* [the person's] *behaviour included his reluctance to answer certain questions. It should not be construed from this that he is unable to. There is a good deal of evidence which suggests this is a choice.*"[117]

83. Conversely, Poole J has made clear that:

> *If on assessment P does not engage with the expert, then the expert is not required mechanically to ask P about each and every piece of relevant information if to do so would be obviously futile or even aggravating. However, the report should record what attempts were made to assist P to engage and what alternative strategies were used. If an expert hits a "brick wall" with P then they might want to liaise with others to formulate alternative strategies to engage P. The expert might consider what further bespoke education or support can be given to P to promote P's capacity or P's engagement in the decisions which may have to be taken on their*

[115] *BP v A Council and another* [2020] EWCOP 17 (in the context of DoLS during the COVID-19 pandemic).
[116] Court of Protection Court Users Group (Property and Affairs) Minutes of meeting of 9 July 2025, available at https://www.mentalcapacitylawandpolicy.org.uk/wp-content/uploads/2025/09/COP-Court-User-Group-PA-09.07.25-Final-Minutes-.pdf. There will be some people, however, people for whom proceeding remotely constitutes precisely such a step: for instance, an autistic person who is more comfortable talking by video than face to face. The draft Code of Practice to the MCA 2005 published for consultation in March 2022 suggested (at paragraph 4.83) that provision would be made in the final Code for remote assessments where it was not possible to visit the person or where doing so would constitute a practicable step to support their decision-making ability.
[117] *QJ v A Local Authority and another* [2020] EWCOP 7 at paragraph 24.

> *behalf. Failure to take steps to assist P to engage and to support her in her decision-making would be contrary to the fundamental principles of the Mental Capacity Act 2005 ss 1(3) and 3(2).*[118]

84. The logic of Poole J's analysis applies equally to any other situation where a decision needs to be reached as to the person's capacity to make decisions by the relevant medical professionals.

85. Ultimately, no one can be forced to undergo an assessment of capacity in the face of an outright refusal. At that point, the relevant medical professionals will have to consider:

    a. Whether they have sufficient circumstantial evidence to enable a conclusion to be reached one way or another as to the person's capacity;

    b. (Arguably more relevantly and more importantly) what the refusal by the person to engage with them for purposes of assessing capacity is suggesting about their situation more broadly. A refusal to undergo a capacity assessment could not, itself, serve as grounds to initiate assessment for admission under the MHA 1983. However, it could, when combined with other evidence, suggest there are, or should be, concerns about the person's mental state requiring further investigation and further steps.

<u>When and who should consider capacity</u>

86. In relation to both scenarios set out above, the 'when' and 'who' questions are perhaps most easily answered by way of a table.[119]

Situation	**When should capacity be considered**	**Why should it be considered**	**Who should consider it**
Part 4			
First three months of any inpatient admission	At the point of proposing a particular treatment.	No express statutory requirement, as s.63 MHA 1983 is not capacity based, but Code of Practice emphasises that "the patient's consent should still be	The approved clinician in charge of the patient's care

[118] AMDC v AG & Anor [2020] EWCOP 58 at paragraph 28(h).
[119] I do not address in this table the very limited class of treatment falling under s.57 – neurosurgery and surgical implantation of hormones to reduce male sex drive, as these are so unusual.

Situation	When should capacity be considered	Why should it be considered	Who should consider it
		sought before any medication is administered, wherever practicable. The patient's consent, refusal to consent, or a lack of capacity to give consent should be recorded in the case notes."[120]	
Treatment after three months since medication was first given to the patient during an unbroken period of compulsion (as detained patient or under CTO)[121]	At the point of proposing a particular treatment, and at the review of such medication.	Section 58 MHA 1983 Need to know whether treatment is on the basis of capacitous consent or otherwise.	The approved clinician in charge of the patient's care. If treatment is to be otherwise than on the basis of capacitous consent, a SOAD
Urgent treatment whilst an inpatient	At the point of proposing a particular treatment, and at the review of such medication.	No express statutory requirement, as s.62 MHA 1983 is not capacity based, but Code of Practice and good medical practice	The clinician in charge of the patient's care
Part 4A: Community Treatment Order			
Patient on community treatment order	At the point of proposing a particular treatment, and at the review of such medication.	Section 64A. Capacity must be recorded in form CTO12.	The clinician in charge of the patient's care

[120] Paragraph 24.41. The Welsh Code of Practice deals with this at paragraph 24.41.
[121] Nb, the three month period runs from the first administration of any medication for mental disorder, not only the medication in question. It does not matter whether that medication was given with the patient's consent or by using the powers in the MHA 1983 to give treatment without consent.

Situation	**When should capacity be considered**	**Why should it be considered**	**Who should consider it**
Outside the scope of the MHA 1983			
Medical treatment for mental disorder	If there is appropriate[122] reason to doubt the person's capacity to give consent.	As otherwise the doctor (and anyone acting under their direction) would have no defence to the criminal or civil liability that would arise from touching the person without their consent. The defence under s.5 MCA 2005 is only available where reasonable steps have been taken to ascertain capacity and the belief that the person lacks capacity is reasonable. [123]	The doctor prescribing the treatment[124] Note, if the person actually administering the treatment is not the doctor, they will only be able to rely upon the s.5 MCA 2005 if they also reasonably believe the person lacks capacity.

Recording capacity

87. It is perhaps important to highlight for the Inquiry that there are statutory forms for recording the capacity of a person to make relevant decisions about medical treatment under Parts 4 and 4A MHA 1983. There is no statutory form for recording the capacity of a patient to make relevant decisions under the MCA 2005.

[122] See paragraphs 60 to 63 above.
[123] There may also be regulatory requirements which are in play as regards the operation of the service on whose behalf the doctor is acting: I note, for instance, that Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations made under the Health and Social Care Act 2008 provides as follows:
"*(1) Care and treatment of service users must only be provided with the consent of the relevant person.*
(2) Paragraph (1) is subject to paragraphs (3) and (4).
(3) If the service user is 16 or over and is unable to give such consent because they lack capacity to do so, the registered person must act in accordance with the 2005 Act.
(4) But if Part 4 or 4A of the 1983 Act applies to a service user, the registered person must act in accordance with the provisions of that Act.
(5) Nothing in this regulation affects the operation of section 5 of the 2005 Act, as read with section 6 of that Act (acts in connection with care or treatment)."
[124] Note, the MCA 2005 does not say that only doctors can consider capacity, and the Court of Protection regularly relies upon those from other disciplines, including psychology and social work; rather, this flows from the fact that it is the doctor who would need to rely upon the defence in s.5 MCA 2005.

Question 3: Further to 2, please discuss the implications if:

a. a patient with a diagnosis of schizophrenia does not recognise that they have a mental illness;

b. a patient with a diagnosis of schizophrenia does not recognise that depot medication would be of any benefit to them;

b. a patient declines depot medication because they have paranoid delusions as to what the purpose and outcome of taking the medication would be?

88. Again, there are two different scenarios which need considering. The first is where the person is subject to either Part 4 or Part 4A MHA 1983, i.e. the treatment frameworks considered in the answer to question 1 above. The second is where the person is not so subject but the question of whether they have capacity to make decisions as to mental health treatment arise.

Part 4/Part 4A MHA 1983

89. As explained at paragraphs 36 to 48 above, neither Part 4 nor Part 4A MHA 1983 are ultimately dependent upon the consent of the patient to treatment. It is therefore, strictly, irrelevant, whether the patient does not recognise that taking the depot medication would benefit them, or declines it on the basis of paranoid delusions. The test is whether the depot medication is appropriate; Part 4 and Part 4A contain (as described above) different routes to ensuring that, if this is the case (determined, where relevant, by reference also to the view of a SOAD), then the depot medication can be administered.

90. I have, though, noted above how the Code of Practice to the MHA 1983 (in both England & Wales) steer clinicians towards seeking to provide medication on the basis of capacitous consent wherever possible. Further, securing treatment in the face of a refusal by a patient on a CTO is likely to require recall of the patient to hospital; logistical considerations may well arise at that point as to the mechanics of that recall.

91. Given the importance placed by the Code of Practice on seeking capacitous consent, it is perhaps important to highlight that the courts have recently considered the questions of belief and insight in the assessment of capacity; both of these are issues lurking in the background of question 3.

92. In a case decided that the MCA 2005 came into force, Munby J (as he then was) identified that:

> […] *if one does not believe a particular piece of information then one does not, in truth, comprehend or understand it, nor can it be said that one is able to use or weigh it." In other words, the specific requirement of belief is subsumed into the more general requirements of understanding and the ability to use and weigh information.*[125]

93. In *An NHS Trust v ST and Anor*,[126] concerned with medical treatment for physical disorder, Roberts J considered that this proposition remained good law. However, on appeal, the Court of Appeal confirmed that, not only did it not remain good law, it had, in fact, never been law at all, and that:

> *The proper application of the statutory test does no more than reflect that, where there is an objectively verifiable medical consensus as to the consequences of having or not having medical treatment, if the patient does not believe or accept that information to be true, it may be that they are unable to understand and or use and weigh the information in question.*[127]

94. Put another way, a view that the patient may not believe relevant medical information (including as to the benefits of a particular medication) cannot, itself, serve as the reasoning to explain their lack of capacity to make the decision about medication. Rather, it should be a trigger for further consideration of whether:

    a. They <u>can</u> understand, use and weigh the fact that there are benefits, but do not agree with the doctors about the benefits in their case, at which point there is a disagreement which cannot be resolved through the prism of capacity.

    b. They <u>cannot</u> understand, use or weigh the fact that the doctors consider that there are benefits, at which point (and assuming that the reason they cannot do this is a disturbance or impairment of the mind or brain) they lack capacity to make the decision.

95. A similar issue arises in respect of the concept of 'insight,' and was addressed in *CT v London Borough of Lambeth & Anor*.[128] The question of capacity there arose in the context of care needs.

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[125] *Re MM; Local Authority X v MM* [2007] EWHC 2003 (Fam) at paragraph 81.
[126] [2023] EWCOP 40.
[127] *Re Thirumalesh (dec'd)* [2024] EWCA Civ 896 at paragraph 129.
[128] [2025] EWCOP 6 (T3).

At first instance the judge had reached the conclusion (as summarised on appeal) that:

> *The Judge concludes CT cannot use or weigh 'the fact that he has mental impairments and that these lead to specific care needs and impact on his wider decision-making ability' [33], 'his own impulsivity, lack of planning ability and lack of foresight when he is making decisions about his care needs' [34], 'the knowledge of his mental impairments' [35], 'the impact of [CT's] mental impairment [39], that CT is unaware that the impact of his mental impairment 'leads to a lack of foresight when weighing the consequences of refusing treatment' [40] and 'on his impulsivity means he is unable to weigh that impulsivity when making decisions' [40], the inability to weigh the likely outcome of the refusal of care [43] and the impact that 'his mental impairment has on his acceptance of care provision explains the history of admission to and self-discharge from previous placements' [45].*

96. One of the grounds of appeal was that the judge erred in including the need for CT "*to have insight into the effect of his mental impairment*" to the information that he needed to be able to be understand, retain, use and weigh for purposes of satisfying the functional test under the MCA 2005.[129] The Vice-President of the Court of Protection, Theis J, having already allowed the appeal on another ground, also made clear that she considered that this ground of appeal, also, was made out:

> *The two stage test in JB is clear. The approach in this case of including insight into his mental impairment had the effect that the Judge did not conduct the functional test in accordance with the requirements of the MCA 2005. By taking that into account the Judge conflated and risked blurring the two distinct tests. This was caused by not taking the structured approach of going through the list of information identified as being relevant, resolving the relevant issues in the written and oral evidence and setting out the Judge's assessment of whether CT can use/weigh the information. In effect, the Judge's conclusion on the first stage was determined by CT's mental impairment and not by resolving the key evidential dispute in respect of the functional test.*[130]

97. Two of the barristers involved in the case provided a checklist for those assessing capacity. Theis J "[w]h*list not wanting to add to the growing industry of checklists*," recognised "*they may be*

[129] See paragraph 38.
[130] Paragraph 57.

useful," and adapted them as follows:

(1) The first three statutory principles in s 1 MCA 2005 must be applied in a non-discriminatory manner to ensure those with mental impairments are not deprived of their equal right to make decisions where they can be supported to do so.

(2) In respect of the third principle regarding unwise decisions, particular care must be taken to avoid the protection imperative and the risk of pathologising disagreements.

(3) As set out in A Local Authority v JB [2021] UKSC 52, whether the person is able to make the decisions must first be addressed. Only if it is proven that one or more of the statutory criteria are not satisfied should the assessor then proceed to consider whether such inability is because of a mental impairment.

(4) Those assessing capacity must vigilantly ensure that the assessment is evidence-based, person-centred, criteria-focussed and non-judgmental, and not made to depend, implicitly or explicitly, upon the identification of a so-called unwise outcome.

(5) Insight is a clinical concept, whereas decision making capacity is a legal concept. Capacity assessors must be aware of the conceptual distinction and that, depending on the evidence, a person may be able to make a particular decision even if they are described as lacking insight into their general condition.

(6) In some cases, a lack of insight may be relevant to, but not determinative of, whether the person has a mental impairment for the purposes of s2 MCA 2005.

(7) When assessing and determining the legal test for mental capacity, all that is required is the application of the statutory words in ss2-3 MCA 2005 without any gloss; having 'insight' into mental impairment is not part of that test.

(8) Relevant information will be different in each case but will include the nature of the decisions, the reason why the decision is needed, and the likely effects of deciding one way or another, or making no decision at all.

> *(9) The relevant information is to be shared with the individual and the individual should be supported to understand the relevant information. The individual is not required to identify relevant information him/herself.*
>
> *(10) If a lack of insight is considered to be relevant to the assessment of capacity, the assessor must clearly record what they mean by a lack of insight in this context and how they believe it affects, or does not affect, the person's ability to make the decision as defined by the statutory criteria, for example to use/weigh relevant information.*[131]

98. It can be seen from the way in which the judge handled the concept of 'insight,' in particular in the checklist, that it is similar to belief – i.e. a view of lack of insight (either into a condition, or the need for treatment) is not, itself, a basis for a conclusion that the person lacks capacity, but a trigger for further examination.

99. It is perhaps important that I note that the two decisions discussed above post-dated the events under examination in the Inquiry (the Court of Appeal decision in *Thirumalesh* dating from 2024, and the decision in *CT* from 2025). However, the approach to insight in the *CT* is consistent with the (somewhat less worked up) approach taken to insight in the NICE clinical guidelines on capacity assessment produced in 2018.[132] Those guidelines provided at paragraph 1.1.71 that:

> *Practitioners should be aware that a person may have decision-making capacity even if they are described as lacking 'insight' into their condition. Capacity and insight are 2 distinct concepts. If a practitioner believes a person's insight/lack of insight is relevant to their assessment of the person's capacity, they must clearly record what they mean by insight/lack of insight in this context and how they believe it affects/does not affect the person's capacity.*

100. I have set out the legal framework here. I do not consider it to be appropriate for me to venture into commenting on what good clinical practice dictates in such situations, as that is a matter for the Inquiry Chair to address with relevant clinical witnesses. The Inquiry Chair may well wish, in particular, to investigate further clinical understandings of 'insight' in this context, and reactions to the *CT* judgment.

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[131] Paragraph 60.
[132] NICE Guideline 108, '*Decision-making and mental capacity*,' published October 2018, available at https://www.nice.org.uk/guidance/ng108.

Outside Part 4/Part 4A MHA 1983

101. All the same considerations apply as set out in relation to the scenario of the patient subject to Part 4 / Part 4A MHA 1983, although more rides on the outcome as there is no ability to provide treatment in the face of capacitous refusal.

Question 4: Please provide an opinion on the relevant legal powers, rights and obligations as regards the provision of mental health treatment in the following scenarios:

a. **A schizophrenic patient in the community, without capacity as regards medical treatment, declines to (i) engage with mental health services; or (ii) take depot medication, and who poses a risk of imminent harm to the public or themselves if they do not take the medication.**

b. **A schizophrenic patient in the community, without capacity as regards medical treatment, declines to (i) engage with mental health services; or (ii) take depot medication, and who poses a risk of future but not imminent harm (ie: a number of weeks or months away) to the public or themselves if they do not take the medication now or consistently.**

c. **A schizophrenic patient in the community, with capacity as regards medical treatment, that declines to (i) engage with mental health services; or (ii) take depot medication, and who poses a risk of imminent harm to the public or themselves if they do not take the medication.**

d. **A schizophrenic patient in the community, with capacity as regards medical treatment, that declines to (i) engage with mental health services; or (ii) take depot medication, and who poses a risk of future but not imminent harm (ie: a number of weeks or months away) to the public or themselves if they do not take their medication now or consistently.**

e. **A schizophrenic patient in the community, with capacity as regards medical treatment whilst taking oral medication but who has a history of not taking oral medication and losing capacity, who declines to take depot medication.**

Question 5: Please consider the above five scenarios in (i) circumstances where a patient was being detained and discharged under the MHA 1983 in 2021-2023 (and, if pursuant to Part II, whether pursuant to s.2 or s.3) and (ii) as would be the case considering the amendments proposed by the Mental Health Bill. In particular, please comment upon the powers and use of a Community Treatment Order.

102. I take these questions together. I address them first on the basis of the position in 2021-2023 (and, indeed, at present), and then note the impact of the changes proposed by the Mental Health Bill 2025.

103. As a preliminary note, I will use the term 'schizophrenic patient' here as this is the term used in the question, but it is perhaps important to note that the preferred term now would be patient with schizophrenia. I also note that a person will only be a patient if they are (or should be) subject to the MHA 1983. If they are not subject to the MHA 1983 then 'person' would be the better term.

104. I also understand each of these scenarios should be addressed by reference to the permutations that: (a) the person has never been subject to the MHA 1983; (2) the person remains subject to the MHA 1983, but is not currently in hospital (whether they are on s.17 leave or discharged under a CTO); and (3) the person is to be discharged both from hospital and the MHA 1983. I will do so, first, by reference to the position in 2021-23, and then by reference to the position as it would be if and when the amendments proposed in the Mental Health Bill come into effect.

105. For the avoidance of doubt, in this section, I focus on the position of patients who are, or may be, subject to Part II MHA 1983. I address the position of patients subject to Part III in answer to question 10.

106. In giving my opinion, I focus on those actually seeking to discharge functions towards the patient. I say this because complex issues can arise in relation to Articles 2 and 3 ECHR as to whether the state has in place an appropriate legislative, administrative and regulatory framework to protect the right to life and the right not to be subject to torture, inhuman or degrading treatment. Those raise important, but distinct, issues to the question of what particular professionals should do in relation to the scenarios posed.

107. I also proceed on the basis that:

a. The relevant professionals have knowledge of the person;

b. The analysis of the harm and the risk of the harm complies both with the positive obligations imposed by the ECHR (via the HRA 1998),[133] and with relevant clinical guidelines;

c. The conclusions as to capacity have been reached after appropriate consideration;

[133] I.e. in particular, that the professionals have reached defensible conclusions as to (1) the nature of the harm; (2) the risk of the harm eventuating (3) the imminence of the risk.

d. The medical treatment proposed for the mental disorder is appropriate, and, to the extent that the medication is proposed to be administered by way of depot, rather than oral medication, this is clinically appropriate.

a. A schizophrenic patient in the community, without capacity as regards medical treatment, declines to (i) engage with mental health services; or (ii) take depot medication, and who poses a risk of imminent harm to the public or themselves if they do not take the medication.

Person not previously detained under the MHA 1983

108. The only bases upon which treatment could be delivered would be on the basis: (1) of the defence under s.5 MCA 2005; or (2) on the basis of a decision of the Court of Protection under s.16 MCA 2005 to consent on behalf of the patient.

109. Whilst this would be a matter for clinical judgment, I anticipate that it would be highly likely that the provision of treatment would be in the person's best interests if they pose a risk of harm to themselves. As noted at paragraph 43(a) above, it may well also be possible to frame it as being in their best interests to provide treatment where they pose a risk of harm to others, if there is 'blowback' risk of harm to them. It would, in turn, be highly likely that it would be justified to restrain them for purposes of securing that they take the relevant medication, so that the defence under s.6 MCA 2005 could be relied upon.

110. In practical terms, however, if the patient does not engage with mental health services, the real issue is not about delivery of treatment but securing access to them. Sections 5 and 6 MCA 2005 undoubtedly give the power to professionals to be robust in their interactions with the patient as regards the taking of medication. However, and whilst there is no case which has decided this point, I consider it be highly questionable whether s.5 MCA 2005 gives sufficient authority to (for instance) force entry into the person's home, especially in the face of the person's likely objections.[134]

111. The Court of Protection could, however, be invited to make decisions and declarations enabling access to the person's place of residence and the provision of treatment. The Court of Protection

[134] For further discussion of this issue, see this paper: https://www.mentalcapacitylawandpolicy.org.uk/wp-content/uploads/2016/11/Section-5-Article.pdf. A central reason for concern here is as to the adequacy of the protection afforded the person's Article 8 rights given the absence of any structured approach to justifying the interference with their rights when relying upon s.5 MCA 2005. See also paragraphs 14.22 to 14.42 of the Law Commission's Mental Capacity and Deprivation of Liberty report.

would need to have evidence that the person not only lacked capacity to make decisions about medical treatment, but about the arrangements for securing that treatment (i.e. not merely about whether or not to have the medication, but whether, if necessary, that the medication be provided by someone else coming into their place of residence and carrying out the injection). Some complicated questions may arise as to the enforcement of such orders, but the legal fiction will be that the person, themselves, is inviting the team in to provide them with the medication.

112. In reality, however, I suspect that the Court of Protection route is less relevant than consideration of whether the person requires admission to hospital for the treatment of their mental disorder.[135] In this regard:

a. The local authority would be likely to be under the duty imposed by s.13 MHA 1983 to make arrangements for an approved mental health professional ('AMHP') to consider the patient's case on their behalf;

b. It may be possible for the AMHP to rely upon s.115 MHA 1983 to seek to enter person's place of residence. However, this power does not give the ability to enter by force, or to override the refusal by the owner of a property to give permission to enter and is really more directed to the situation where there is a third party in play (the statutory language talking in s.115(1) about a person 'not being under proper care.');

c. In practice, most relevant will be as to whether consideration of whether steps need to be taken to obtain a warrant from the Magistrate's Court to enable the police to enter the property under s.135 MHA 1983.[136]

113. The important point to emphasise, perhaps, is that there are clear tools that could be used, most likely involving a court, to bring about either: (1) treatment in the community; or (2) the admission of the person to hospital.

The person remains subject to the MHA 1983, but is not currently in hospital (whether they are on s.17 leave or discharged under a CTO)

[135] I.e. under s.3 MHA 1983. Given that the patient's condition in this scenario appears to be known, and the medication framework established, having recourse to s.2 MHA 1983 would appear to be more difficult to justify, as that is intended for circumstances where the primary goal is assessment of the person's mental disorder.
[136] In my experience, and not least because of the clearer mechanism for enforcement of a warrant under s.135 MHA 1983, the Court of Protection would want to understand why such a route was not possible before going down the route of making decisions and declarations under the MCA 2005.

114. The legal position here is clear as regards the treatment framework – either Part 4 MHA 1983 for a patient on s.17 leave, or Part 4A for a patient on a CTO (assuming that they have been subject to s.3 MHA 1983). If the patient is not engaging and not taking medication, then:

a. For the patient on s.17 leave, it would be legally possible to use force in their place of residence (the fiction being that they are still a detained patient), although whether this would be appropriate is primarily a matter for clinical judgment.[137]

b. For the patient on a CTO, much would turn on the clinical judgment on whether the criteria in s.64G MHA 1983 for the administration of 'emergency' treatment are met:

i. If the risk of harm to others is imminent, then it would appear likely that it could be said that the treatment was immediately necessary for purposes of s.64G (the concept being discussed at paragraph 47 above). If it is immediately necessary, force could be used to administer the treatment if it needs to be given to prevent harm to the patient, and the use of force is a proportionate response to the likelihood of that harm. I note in this regard that, if the real risk is not to the patient, but others, force could not be used absent a clinical explanation as to how there was 'blowback' risk of harm to them if the treatment was not to be given.[138] I also note that s.64G does not give a power of entry.

ii. If the clinical view is that the criteria under s.64G are not met, then treatment could be provided, but not by force (s.64D).

c. In reality, however, in the scenario described, the real issue is likely to be access to the person's place of residence. Neither s.17 nor s.64G empower the use of force to enter a property. The real question is likely therefore to be whether it is necessary for them to be returned to hospital. In the case of a patient on s.17 leave, revoking the leave would mean that they were now to be seen as absent without leave, thereby giving rise to the powers available under s.18 MHA 1983 to address the situation of such patients. Similarly, for a patient on a CTO, if it is not possible to secure access or that the patient takes the medication, it is likely that the conditions for recall under s.17E(1) would be met.[139] At that point, a failure to comply with recall would mean that the powers available under s.18 MHA 1983 would

[137] Assuming that the conditions are met including, importantly, that the time limits set in out s.18 (which vary depending upon the underlying section of the MHA 1983 upon which they are detained).
[138] But, depending upon the circumstances, 'harm' could include (for instance) a return to hospital.
[139] I.e. that (a) the patient requires medical treatment in hospital for his mental disorder; and (b) there would be a risk of harm to the health or safety of the patient or to other persons if the patient were not recalled to hospital for that purpose.

apply as if they were absent without leave from the hospital to which they have been recalled.[140]

The patient is to be discharged from hospital and the MHA 1983

115. As a matter of law, if the patient is discharged from both hospital and any underlying detention under the MHA 1983 then, with one exception, they revert to exactly the position as set out in the first permutation above. The exception is that, if they have been detained under s.3 MHA 1983, they will be owed the after-care duty set out in s.117 MHA 1983.

116. I am duty-bound to say, however, that it is somewhat difficult to see the basis upon which a patient could properly be discharged both from hospital and the MHA 1983 if they are not engaging with mental health services in circumstances where professionals are aware that they are not taking the medication that is required to prevent a risk of imminent harm to themselves or others. In legal terms, the effect would be to deprive professionals of an important tool (in the form of the MHA 1983) to secure that such medication continues to be taken.

b. A schizophrenic patient in the community, without capacity as regards medical treatment, declines to (i) engage with mental health services; or (ii) take depot medication, and who poses a risk of future but not imminent harm (ie: a number of weeks or months away) to the public or themselves if they do not take the medication now or consistently.

Person not previously detained under the MHA 1983

117. The same considerations as set out at paragraphs 108 to 113 apply, save that:

a. It may be more difficult to justify the use of restraint to secure the provision of medication under the MCA 2005 if the risk that is in play is not imminent. As set out at paragraph 44 above, the test for whether restraint is justified is the reasonableness of the belief that the restraint is necessary to prevent harm to the person, and that the restraint is a proportionate response to a likelihood of the person suffering that harm, and the seriousness of that harm. Self-evidently, the further off the potential for harm, the less obvious it is that restraint can be justified. That having been said, I note that the Vice President of the Court of Protection, Theis J, reaffirmed in 2024 that the framework provided by ss.5 and MCA 2005 is not limited solely

[140] See s.18(2A).

to emergency situations.[141] The courts (if asked) would therefore look in deciding whether the requirements of s.6 were made out to the evidence upon which the clinicians formed the view that the use of restraint was justified to forestall a risk of future harm, and the steps taken by the clinicians to stress-test their analysis of necessity and proportionality of that restraint. I certainly do not rule out that they would reach the view that the use of such restraint fell within the scope of the defence, albeit that, as noted, the further off and the more 'speculative' the risk, the more the court would wish to probe the reasonableness of the clinicians' judgment.

b. It may be more difficult to make out the criteria for admission to hospital to secure the provision of medical treatment under the provisions of s.2 or (more likely) s.3 MHA 1983.

The person remains subject to the MHA 1983, but is not currently in hospital (whether they are on s.17 leave or discharged under a CTO)

118. The same considerations as set out at paragraph 114 apply, save that it may be more difficult to justify either revoking the s.17 leave or recalling the patient from the CTO (depending on the circumstances). However, ultimately, this is a question of clinical judgment.

The patient is to be discharged from hospital and the MHA 1983

119. The same considerations as set out at paragraphs 115 to 116 apply, save that the decision to discharge from the provisions of the MHA 1983 may be easier to justify if the risk of harm to self or others from non-compliance is a future, rather than an imminent one, so long as there are appropriate mechanisms in place to reevaluate that risk appropriately if non-compliance continues.

c. A schizophrenic patient in the community, with capacity as regards medical treatment, that declines to (i) engage with mental health services; or (ii) take depot medication, and who poses a risk of imminent harm to the public or themselves if they do not take the medication.

Person not previously detained under the MHA 1983

120. Self-evidently, the MCA 2005 would be irrelevant here. Rather, the primary consideration would

[141] *Leicestershire County Council v P & Anor (Capacity: Anticipatory declaration)* [2024] EWCOP 53 (T3) at paragraphs 137(6) and 138 (6). I should say that I do not consider this to be a surprising conclusion – in other words, had the same question been asked in 2023, I anticipate that the same answer would have been given. The surprising element of the case, to the extent that there is one, is that the suggestion was advanced that ss.5 and 6 are limited only to emergencies.

be as to whether the person requires admission to hospital for the treatment of their mental disorder, as discussed at paragraph 112 above.

The person remains subject to the MHA 1983, but is not currently in hospital (whether they are on s.17 leave or discharged under a CTO)

121. The same considerations as set out at paragraph 114 above, with the exception that s.64D (treatment of CTO patients lacking capacity) would be irrelevant.

The patient is to be discharged from hospital and the MHA 1983

122. The same considerations as set out at paragraphs 115 to 116 apply, save the clinicians would also need to be aware that by discharging the patient at a point when they consider that they had capacity to make decisions about medical treatment, they would be discharging them into a situation where they would not be able to have recourse to any of the tools available under the MCA 2005.

d. A schizophrenic patient in the community, with capacity as regards medical treatment, that declines to (i) engage with mental health services; or (ii) take depot medication, and who poses a risk of future but not imminent harm (ie: a number of weeks or months away) to the public or themselves if they do not take their medication now or consistently.

Person not previously detained under the MHA 1983

123. Self-evidently, the MCA 2005 would be irrelevant here. Rather, the primary consideration would be as to whether the person requires admission to hospital for the treatment of their mental disorder, as discussed at paragraph 112 above.

The person remains subject to the MHA 1983, but is not currently in hospital (whether they are on s.17 leave or discharged under a CTO)

124. The same considerations as set out at paragraph 114 apply, save that it may be more difficult to justify either revoking the s.17 leave or recalling the patient from the CTO (depending on the circumstances). However, ultimately, this is a question of clinical judgment.

The patient is to be discharged from hospital and the MHA 1983

125. The same considerations as set out at paragraphs 115 to 116 apply, save the clinicians would also need to be aware that by discharging the patient at a point when they consider that they had capacity to make decisions about medical treatment, they would be discharging them into a situation where

they would not be able to have recourse to any of the tools available under the MCA 2005.

e. A schizophrenic patient in the community, with capacity as regards medical treatment whilst taking oral medication but who has a history of not taking oral medication and losing capacity, who declines to take depot medication.

126. The wording of this scenario is a little ambiguous, but I am proceeding on the basis it is addressing the situation where, if the person does not take their oral medication, they will lose the capacity to make decisions about medical treatment (as opposed to capacity to make other decisions).

Person not previously detained under the MHA 1983

127. If the person, at present, has capacity to make the decision whether or not to take either oral medication or depot medication, then the MCA 2005 is essentially irrelevant. However:

a. It is important to note that, as capacity is time-specific, there may well come a point when the person lacks capacity to make decisions about medical treatment. At that point, they would be treated as if they fell under scenario (a) above – the critical issue, self-evidently, being monitoring whether they have lost such capacity. One further nuance to this is that, in the making of the best interests decisions about the administration of medication required at that point, account will have to be taken of the person's known views about taking it.

b. the Court of Protection has, on occasion, made so called 'anticipatory declarations' to cover the situation where there is a known set of circumstances where a currently capacitous person will lack capacity to make relevant decisions, and there is a clearly defined intervention which might be required at that point.[142] However, there would in reality be little point in approaching the Court of Protection to make anticipatory declarations in this situation, as the court would be very likely to take the view that nothing would be achieved by doing so – the making of such a declaration would not alleviate the requirement to monitor the situation, and, in turn, the provisions of ss.5 and 6 MCA 2005 would be likely to be provide the framework required to ensure that treatment is administered.[143]

128. In this situation, it will be a matter of professional judgment as to whether declining to take depot medication given the known history is enough to warrant admission to hospital under s.3 MHA 1983. It is, on its face, unlikely, but that is not a matter for me as a lawyer to express a definitive

[142] See, for instance, *Wakefield MDC and Wakefield CCG v DN and MN* [2019] EWHC 2306 (Fam).
[143] This is the approach taken, for instance, in *Darlington Borough Council v AW & Ors* [2025] EWCOP 33 (T3).

view.

The person remains subject to the MHA 1983, but is not currently in hospital (whether they are on s.17 leave or discharged under a CTO)

129. For the reasons set out immediately above, the patient needs to be approached as if they are currently capacitous in relation to medical treatment decisions. It will be a matter for clinical judgment as to whether their circumstances, including their decision not to take the depot medication, warrant either revocation of the s.17 leave or recall under s.17E.

The patient is to be discharged from hospital and the MHA 1983

130. The same considerations as set out at paragraphs 115 to 116 apply, save the clinicians would also need to be aware that by discharging the patient at a point when they consider that they had currently capacity to make decisions about medical treatment, but is likely to lose it if they do not continue to take the medication orally, they would be discharging them into a situation where (a) they could not currently have recourse to any of the tools available under the MCA 2005; but (b) would do if and when the patient lost such capacity.

Changes proposed by the Mental Health Bill 2025

131. The basic structure of the MHA 1983 would not be changed by the proposals contained in the Mental Health Bill 2025. However, there are three changes proposed by the Mental Health Bill 2025 which might impact upon the answers given to the scenarios:

a. The threshold for admission under both s.2 and s.3 MHA 1983 will be raised to include the need for identification that "serious harm may be caused to the health or safety of the patient or of another person" unless the person is detained (under s.2) or receives medical treatment (under s.3) (and of the nature, degree and likelihood of harm). I discuss this further in answer to question 11, but I note at this point that this is most likely to have an impact in situations where the risk posed by the person (to themselves or others) is not imminent. It is therefore most likely to have an impact in relation to scenarios (b) and (d).

b. In relation to placing a patient on a CTO, there will be: (1) a requirement for the community responsible clinician (if they are different to the inpatient one) to agree in writing;[144] and (2)

[144] New section 17A(4)(c).

the patient's nominated person must, in principle, be consulted, and may object, but can be overruled if the clinician considers that (a) the patient should be discharged from hospital, but (b) if they were discharged without a CTO, would be likely to act in a manner dangerous to themselves or others.[145] The impact of (1) would be to consolidate what is already good practice in terms of ensuring that a patient is not placed on a CTO without proper liaison between the inpatient and community teams. Its impact will therefore depend on the extent to which such good practice is being followed in the relevant area. The impact of (2) is more difficult to speculate about, and it is not altogether easy to think of a situation in which a nominated person is objecting to a CTO, but not objecting to discharge. If they do, however, the bar for making the CTO will be raised to include a 'dangerousness' criterion.

c. A patient cannot be discharged from the provisions MHA by the responsible clinician, the hospital managers or their nominated person without a more detailed consultation exercise than at present. The most common scenario will be discharge by the responsible clinician who must:

   i. where the person is liable to detention (i.e. actually in hospital, or on leave under s.17) consult with a person: (a) who has been professionally concerned with the patient's medical treatment, and (b) who belongs to a profession other than that to which the responsible clinician belongs;[146]

   ii. where the patient is a community patient, consult with the community clinician if they are different. The hospital mangers must also consult with the community clinician.[147]

d. In reality, but no doubt the Inquiry Chair will wish to consider this with relevant professionals, the consultation set out immediately above already takes place as a matter of good practice. The impact will therefore depend upon the extent to which that practice is followed in relation to any particular organisation.

132. I note that the Mental Health Bill would also make it more difficult for patients to remain on long-term CTOs. New s.17B(10) would impose a maximum duration of 12 months. However, that 12 month period can be extended by the responsible clinician after: (1) consulting the patient, the patient's nominated persons, and any relevant mental health care professional involved in the

[145] New section 17AA. The consultation requirement does not arise if it appears to the responsible clinician that consultation is not reasonably practicable, or would involve undue delay.
[146] New section 23(2A).
[147] New section 23(2C).

patient's treatment or care planning; (2) undertaking a review process to evaluate the ongoing necessity and therapeutic benefit of the community treatment order; (3) consulting a General Medical Council registered psychiatrist regarding the conditions of the community treatment order and obtaining their written agreement that an extension is necessary and in accordance with the principles set out in section 118(2B).[148] Where a CTO is extended beyond 12 months, it must be reviewed at least at 6 monthly intervals in accordance with the same procedure.[149] The Tribunal can also recommend that the responsible clinician consider whether to extend, vary, or terminate the duration and conditions of a community treatment order.[150]

133. The changes set out immediately above in relation to the duration and operation of CTOs are undoubtedly designed to make it more difficult for patients to remain on long-term CTOs without regular consideration of whether they are actually achieving their goals. However, and this will no doubt be a matter for the Inquiry Chair to consider, whether they would actually impact on the approaches to the scenarios set out in question 4 will depend upon what is currently considered good clinical practice in relation to their use. Put another way, the Inquiry Chair may well wish to inquire, in particular, as to the extent that the review process would be likely to lead to:

    a. Significant numbers of patients being discharged from the CTO at the end of 12 months; or

    b. Rather, whether it is likely to lead to more detailed explanations as to why such patients need to remain on them.

Question 6. A Community Treatment Order can only be made for a patient who is under detention for the purposes of treatment. Please consider whether there would be any impediments – legal or procedural - if the law was reformed so that the powers of a CTO were extended to (a) patients being discharged from detention for assessment under s.2 MHA 1983 and (b) patients in the community generally, with a power of detention being a relevant next step if the conditions of the CTO are not complied with?

134. This is in reality an impossible question for me to answer, as it is a question of policy. The policy at present is that CTOs are meant to be a framework contingent on admission for treatment under s.3, and used, as such, as a way to ensure there is a continuity of such treatment once the patient leaves hospital, in large part to prevent 'revolving door' admissions where discharge meant non-

[148] In other words, the principles of choice and autonomy; least restriction; therapeutic benefit and the person as an individual.
[149] New section 17B(11).
[150] New section 17B(10)(c).

compliance and relapse.

135. If CTOs were to be made available for patients on s.2, this raises the prospect of a person being placed on a CTO at a point when their treatment framework was not yet identified and established. It is therefore difficult to see how they could work sensibly within the model identified immediately above. There would also be a distinct pragmatic issue that s.2 is a short-term detention mechanism, so the underlying authority for the CTO would vanish after 28 days (and, in many cases, much less because of the time it would take to set the CTO up). It is therefore not obvious what would be gained from allowing CTOs to be used in respect of patients detained under s.2 (absent rather fundamental changes to how s.2 operates more generally).

136. If CTOs were to be made available for patients in the community who have never been admitted to hospital, this would represent a very dramatic change to the framework of the MHA, which – with the exception of guardianship – is predicated entirely upon admission to hospital first. This is very different to the position in, for instance, Scotland under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the 2003 Act'). In Scotland, a Mental Health Officer can apply[151] to the Mental Health Tribunal for a Compulsory Treatment Order.[152] Measures that can be included within an application for a Scottish Compulsory Treatment Order include:

a. the detention of the patient in a specified hospital;

b. the giving to the patient of medical treatment in accordance with the provisions of the 2003 Act;

c. the imposition of a requirement on the patient to attend specific or directed places with a view to receiving medical treatment: (i) on specified or directed dates; or (ii) at specified or directed intervals;

d. the imposition of a requirement on the patient to attend specified or directed places with a view to receiving community care services, relevant services or any treatment, care or services: (i) on specified or directed dates; or (ii) at specified or directed intervals,

e. the imposition of a requirement on the patient to reside at a specified place;

[151] Under s.63 Mental Health (Care and Treatment) (Scotland) Act 2003.
[152] Note the terminology – despite the similar initials, CTOs in Scotland are compulsory, rather than community treatment orders. Experience has taught me that there can be considerable confusion caused in cross-border discussions as people think that they are talking about the same thing, when they are very different.

f. the imposition of a requirement on the patient to allow specified people to visit the patient in the place where the patient resides;

g. the imposition of a requirement on the patient to obtain the approval of the mental health officer to any proposed change of address; and

h. the imposition of a requirement on the patient to inform the mental health officer of any change of address before the change takes effect.

137. In other words, it is possible in Scotland for a person to be subject to an order – made from the outset by a Tribunal – providing for a framework for treatment in the community without ever having been detained in hospital. There may well be benefits to such an approach, but I need to emphasise what a radical shift this would represent in two ways:

a. by de-linking the community treatment framework from hospital admission;

b. by changing from the administrative model under the MHA 1983 where the Tribunal is only involved in challenges (or mandatory reviews where there has been no challenge), to a model in which the Tribunal is involved from the outset in many cases.[153] The challenge of scaling up such a model from Scotland to England & Wales is not one that should be underestimated.

Question 7. If a patient that suffers from psychosis is concerned about taking depot medication because of a general fear of injections and has a history of not taking oral medication, are there any other lawful powers or approaches that could be taken to ensure that the depot medication is given and/or the oral medication is consistently taken in circumstances where clinicians are concerned that the patient, without the medication, poses (i) a risk of imminent harm to the public or themselves if they do not take the medication; or (ii) the patient poses a risk of future but not imminent harm to the public or themselves if they do not take the medication now or consistently.

138. I have addressed the legal frameworks in answer to question 6 above. The reality is that this much more down to:

a. The availability and resourcing of such teams as Assertive Outreach Teams who are able to

[153] Scotland does have a framework for short term detention in hospital which involves the Tribunal as a reviewing body (in Part 6 of the 2003 Act), but that is catering for a different position.

monitor the situation on an ongoing basis, develop (if possible) a working relationship with the person, and be in a position to ensure that suitably robust steps are taken if the nature and level of the risk rises to an unacceptable point;

b. Cross-team and cross-organisation systems and protocols being in place to ensure that 'red flags' are identified and agreed across the teams / organisations, and continency plans are in place to respond.

Question 8: If a patient (i) in detention or (ii) in the community has declined clinically indicated mental health treatment and clinicians are concerned that a patient poses a risk to the public or themselves:

a. Can the clinicians inform third parties, such as the police, probation, family of the patient, or potential victims of violence?

b. Do clinicians have any legal or regulatory duty to do so? Or is the same indicated by any guidance or best practice that you are aware of?

Does the answer to (a) or (b) differ where the patient is in detention; or where the patient is in the community?

Does the answer to (a) or (b) differ where the patient is subject to a CTO; or it is suspected that the patient lacks capacity to take decisions about his healthcare or medication; or the patient has previously been reported to the police for alleged offences arising from acts of aggression, intimidation or violence; or it is known that the patient's capacity has not been assessed for some time.

Do police officers (the CPS or any officers of the Court) have any legal or regulatory obligation to report to clinicians where a patient in the community is reported to the police for alleged offences arising from acts of aggression, intimidation or violence and/or has a warrant issued for their arrest?

139. This question has multiple strands. I will take it in stages, and in a slightly different order to that set out in my instructions. I should also perhaps note that this is an enormous topic, and somewhat difficult to do justice to within reasonable space confines. In the interests of readability, I will

limit myself to a relatively broad overview, but signpost to further resources should the Inquiry Chair consider it appropriate and necessary to investigate any of these matters with specific witnesses. I would also suggest that if the Inquiry Chair requires further detailed legal analysis of these issues that a report is commissioned from a lawyer with specialist expertise in this area: whilst I have a working knowledge of these issues from a mental health / capacity perspective, I do not profess to be a technical specialist in confidentiality / data protection law.

Disclosure to third parties: general principles

140. It is perhaps helpful to start with some general principles. The starting point is that information provided by patients to clinicians is provided in confidence. This means, in turn, that the clinician is under a common law duty to maintain that confidence, and not to use or disclose that information further, except as originally understood by the confider, or with their subsequent permission. A clinician who breached that confidence would therefore be in breach of duty of care, and liable to the patient in tort. They may well also be liable for acting in contravention of Article 8 ECHR, and hence unlawfully for purposes of s.6 Human Rights Act 1998 and also in breach of obligations imposed by data protection legislation.

141. However, there will be circumstances under which disclosure is justified. As a broad proposition, if disclosure is justified by reference to the common law relating to confidentiality, it is likely also to be justified by reference to Article 8(2) ECHR and by reference to data protection legislation, although the precise route through will vary in each case.

142. As has been repeatedly emphasised in a number of public inquiries over the years, the law relating to confidentiality in this area is not intended to get in the way of appropriate information sharing. Perhaps the most useful overarching guide to how this tracks out in clinical practice is contained in the General Medical Practice's Guidance: *Confidentiality: good practice in handling patient information.*[154] As the GMC guidance makes clear – and I should make clear this guidance reflects the law, as opposed to simply setting out the review of the regulator as to good practice – clinicians can disclose personal information (which would include, here, the risk that the patient poses to themselves or others) without breaching duties of confidentiality in one of five situations.

a. The patient consents, whether implicitly or explicitly for the sake of their own care or for local

[154] Available at https://www.gmc-uk.org/-/media/documents/gmc-guidance-for-doctors---confidentiality-good-practice-in-handling-patient-information----70080105.pdf. It was originally promulgated in 2017. It was updated in May 2018 to reflect the requirements of the General Data Protection Regulation and Data Protection Act 2018 and in December 2024 when regulation of physician associates and anaesthesia associates by the GMC came into effect.

clinical audit, or explicitly for other purposes

b. The patient has given their explicit consent to disclosure for other purposes.

c. The disclosure is of overall benefit to (in England & Wales is in the best interests of) a patient who lacks the capacity to consent and the disclosure is made in line with the relevant capacity legislation.

d. The disclosure is required by law, or the disclosure is permitted[155] or has been approved under a statutory process that sets aside the common law duty of confidentiality.

e. The disclosure can be justified in the public interest.

143. The easiest way in which to answer the questions asked of me is by way of a table which sets out when disclosure is – on the face of it – justified. I do not in this table differentiate between the position where the patient is in the community or in detention, as this makes no difference to the position. Where I say "best interests," and to save repetition, I mean that there has been a proper consideration of best interests applying all the factors in s.4 MCA 2005 (see further paragraph 46(a) above) and, in particular, the person's known wishes, feelings, beliefs and values regarding disclosure.

To whom will disclosure be made	**Risk**	**Basis of disclosure**
Police / probation services	To self	1. Capacitous consent. 2. Best interests where lacking capacity. 3. In face of refusal of consent, or where consent cannot be obtained: a. where the method by which the patient might cause harm to themselves could cause harm to others[156] (and the police are the body best placed to take steps to secure against the risk of that harm eventuating);

[155] An example where disclosure is permitted, but not required, is s.115 Crime and Disorder Act 1998, which gives a power to disclose information to organisations such as the police, local authorities, or probation services where it is 'necessary or expedient' for purposes of any provision of that Act, but does not create a legal obligation to do so.
[156] See the Information sharing and suicide prevention: consensus statement - GOV.UK under 'public interest.'

		b. (potentially) where the risk is of serious harm to the person from another, and the public are the body best placed to take steps to secure against the risk of that harm eventuating).[157]
Police / probation services	To others	1. Capacitous consent. 2. Best interests where lacking capacity. 3. In the face of refusal of consent or where consent cannot be obtained, where failure to disclose information may expose others to risk of death or serious harm.[158]
Family of the patient[159]	To self	1. Capacitous consent. 2. Best interests where lacking capacity. It is in practice unlikely – but theoretically possible – that disclosure to the family absent either (1) or (2) could be justified on the basis of securing the patient against risk of death or serious harm. See further question 9 below in terms of disclosing medical / other information to families.
Family of the patient	To others	Unlikely to arise, but capacitous consent or best interests where lacking capacity.
Potential victims of violence	To self	Will not arise
Potential victims of violence	To others – i.e. those victims	1. Capacitous consent. 2. Best interests where lacking capacity. 3. In the face of refusal of consent or where

[157] The GMC notes that "[i]*n very exceptional circumstances, disclosure without consent may be justified in the public interest to prevent a serious crime such as murder, manslaughter or serious assault even where no one other than the patient is at risk. This is only likely to be justifiable where there is clear evidence of an imminent risk of serious harm to the individual, and where there are no alternative (and less intrusive) methods of preventing that harm. This is an uncertain area of law and, if practicable, you should seek independent legal advice before making such a disclosure without consent.*"

[158] I note in this regard the case of *W v Egdell* [1990] 1 Ch 359, where the Court of Appeal held that the public interest in protecting others against possible violence outweighed the public interest in maintaining confidentiality so as to justify a psychiatrist instructed by a patient subject to a restricted hospital order disclosing his report to the patient's responsible clinician (who, in turn, disclosed the report to the Secretary of State and the Department of Health and Social Security) although doing so was contrary to the patient's interests.

[159] See also the answer to question 9 below.

		consent cannot be obtained, where failure to disclose information may expose others to risk of death or serious harm.

144. Wherever disclosure is on a basis other than that of the patient's capacitous consent, the bar for doing so is inevitably higher, because it means that – at first blush – their confidentiality is being waived without their agreement. However, the essential point is that the law does not prevent disclosure where such serves the proper interests of the patient or others. What will be much more important is a clear analysis of: (1) why disclosure is justified; (2) what steps short of disclosure could be taken to address the risks; and (3) 'debriefing' after the event. The legal 'ice' under the clinicians will also be significantly thinner in circumstances where taking anticipatory steps would have avoided the need for disclosure in the face of a side-stepping of consent.[160]

145. Specifically by reference to those who are in some way subject to the MHA 1983, I note that the (English) Code of Practice to the MHA 1983 provides the following in chapter 10 (on confidentiality and information sharing):

> *10.15 Although information may be disclosed only in line with the law, professionals and agencies may need to share information to manage any serious risks which certain patients pose to others.*
>
> *10.16 Where the issue is the management of the risk of serious harm, the judgement required is normally a balance between the public interest in disclosure, including the need to prevent harm to others, and both the rights of the individual concerned and the public interest in maintaining trust in a confidential service.*[161]
>
> *10.17 Whether there is an overriding public interest in disclosing confidential patient information may vary according to the type of information. Even in cases where there is no overriding public interest in disclosing detailed clinical information about a patient's state of health there may, nonetheless, be an overriding public interest in sharing more limited information about the patient's current, and past status under the Act, if that will help ensure properly informed risk management*

[160] See, in the context of data protection obligations, the helpful framing by the Information Commissioner in its guidance on data sharing in an urgent situation or in an emergency: https://ico.org.uk/for-organisations/uk-gdpr-guidance-and-resources/data-sharing/data-sharing-a-code-of-practice/data-sharing-in-an-urgent-situation-or-in-an-emergency/.

[161] See the case of *Egdell* noted in the table above.

by the relevant authorities, families and carers.[162]

146. The second limb of the question asked of me is as to whether there are circumstances under which clinicians are required to disclose information, either by a legal duty, or by a framework of good practice.

147. There are a number of situations in which statute has imposed an obligation to disclose information. A good example is in relation to the prevention of terrorism, the relevant duty being imposed by s.19 Terrorism Act 2000. The MHA 1983 also includes express or implied duties to disclose information for purposes connected with the Act;[163] however, the MHA 1983 does not contain broader powers or duties to disclose information about risk to third parties. There is also no general statute which directly imposes a duty on doctors to disclose information about risks (either to self or others). Rather, whether a duty will arise will depend largely upon whether:

a. The disclosure is necessary to discharge a duty owed by the doctor at common law either to the patient (in the case of a risk to themselves) or others. This will be an intensely fact-specific question.

b. The disclosure is necessary to enable the doctor to discharge an obligation imposed by the European Convention on Human Rights, most obviously a duty to take appropriate operational steps to secure life for purposes of Article 2 ECHR. That will require consideration of the matters set out at paragraphs 9 to 14 above, but will, again, be an intensely fact-specific question.

148. There is extensive guidance about information disclosure. Perhaps the most relevant in the context of medical professionals is the GMC Guidance set out above, and the guidance from the Royal College of Psychiatrists: Good Psychiatric Practice: Confidentiality and Information Sharing (3rd edition) (Nov 2017).

149. In light of failures of information sharing in the context of the prevention of suicide,[164] a consensus statement (most recently updated in 2021) has been published, produced by the Department of Health and Social Care, with an extensive range of health and social stakeholders.[165] The Zero

[162] Broadly similar wording is to be found at paragraphs 10.20 to 10.22 of the Welsh Code of Practice.
[163] For instance, providing information to the Tribunal in the context of an application by the patient. These are summarised at paragraphs 10.7 to 10.10 of the (English) Code of Practice to the MHA 1983.
[164] Identified as a recurrent theme in the 2018 NHS Resolution Learning from Suicide Related Claims report, available at: NHS-Resolution_learing_from_suicide_claims_148pp_ONLINE1.pdf.
[165] Available at: Information sharing and suicide prevention: consensus statement - GOV.UK

Suicide Alliance, on behalf of DHSC, has also published guidance for frontline staff on how to use the consensus statement,[166] which aims to support staff regarding when and how to share information about patients where this may help prevent suicide.

150. I am asked whether the answers that I have set out above differ where the patient is subject to a CTO; or it is suspected that the patient lacks capacity to take decisions about his healthcare or medication; or the patient has previously been reported to the police for alleged offences arising from acts of aggression, intimidation or violence; or it is known that the patient's capacity has not been assessed for some time. The short answer is 'no,' as the legal framework is not contingent on any of these matters. The somewhat longer answer is that each of these factors will go into the mix in determining:

a. the level of knowledge that the relevant professionals have (or should be expected to have) as to the nature and level posed by the person;

b. the approach that the relevant professionals should be taking to identify whether and on what basis they are permitted to disclose information about the risk; and

c. the approach that the relevant professionals should be taking to identify whether and on what basis they may be required to disclose information about the risk.

Obligations by police officers, the CPS and /or any officers of the Court to report to clinicians

151. I am asked whether police officers, the CPS and /or any officers of the Court have any legal or regulatory obligation to report to clinicians where a patient in the community is reported to the police for alleged offences arising from acts of aggression, intimidation or violence and/or has a warrant issued for their arrest?

152. I focus here primarily on the police, because they are those who are in immediate receipt of the knowledge. Any knowledge possessed by others in consequence of that will, in essence, be parasitic on that of the police; further, in general, it will be the police who are most directly involved with the person's circumstances.

153. This is a difficult question to answer in the abstract, because there may be specific circumstances in which the nexus between the police and the clinicians involved in caring for a specific person

[166] Available at: SHARE: consent, confidentiality and information sharing in mental healthcare and suicide prevention - GOV.UK

subject to the MHA 1983 is sufficiently close that an obligation might arise on the facts of a specific case.

154. However, as a broad proposition, there is undoubtedly going to be an entitlement to report if: (1) the person consents; (2) they lack capacity and it is considered to be in their best interests; (3) (where consent is refused, or cannot be obtained) where the public interest provides.[167] In this regard, of particular relevance will be the question of why disclosure to a clinician will be in the public interest: in other words, in lay terms, what could a clinician do with the relevant information to secure against the risk of harm posed by the person to others?[168] This will depend very much on the context:

    a. If the person is on s.17 leave or a CTO, it could well be the case that informing the responsible clinician of the circumstances would lead to the clinician deciding to recall the person to hospital;

    b. If the person is not subject to the provisions of the MHA 1983, it is perhaps important to recall that the obligation to assess whether a person meets the criteria for admission under the MHA 1983 lies under s.13 with the local authority for the area, rather than clinicians.

155. The College of Policing has set out detailed guidance for police officers on information sharing.[169] The College of Policing has also published guidance for police officers in relation to mental ill health. This latter guidance does not expressly cover information sharing in the circumstances described in the scenario. It does cover information sharing in the context of diversion for mentally disordered offenders before making a decision on charging.[170] I do not address this in detail, because this guidance applies in a slightly different context to that being considered by the Inquiry, although I note that the guidance is dated 2016, and therefore does not reflect the current CPS guidance on prosecution in the context of mental ill health.[171]

Question 9: What is the law as regards sharing medical or other personal information with the nearest relative and/or family where a patient withdraws consent for this information to be

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[167] See, by way of analogy, *R v Chief Constable of the North Wales Police Ex p. AB* [1999] QB 396 (where the police were held to be entitled to provide information to caravan site landlord concerning convicted paedophiles living on it if there was a "pressing need" and, if possible, after providing opportunity to comment on proposed disclosure). See also *R (L) v Commissioner of Police of the Metropolis* [2009] UKSC 3.

[168] Different issues may well arise where the police (in particular) are concerned that the person is posing a risk to themselves as a result of a mental health condition.

[169] https://www.college.police.uk/app/information-management/information-sharing.

[170] https://www.college.police.uk/app/mental-health/mental-health-and-criminal-justice-system.

[171] https://www.cps.gov.uk/prosecution-guidance/mental-health-suspects-and-defendants (2019, updated most recently in 2024), which has a specific section on 'diversion.'

shared? What is the position if a patient withdraws consent but (i) is deemed to lack capacity as regards that issue at the time of the purported withdrawal; (ii) has capacity at the time of withdrawal but is later assessed to lack capacity to determine their mental health treatment?

156. I have set out the broad framework above. [172] It is perhaps important to note, however, that, depending upon the circumstances, there will be a distinction between the position in relation to the nearest relative, and that of the family more broadly (assuming that the nearest relative is a family member).

157. In some cases, there will be a prima facie obligation to disclose relevant medical information to the nearest relative so that they can discharge their statutory functions. The clearest example of this is in relation to the consultation required before an application for admission is made. The Court of Appeal considered this issue in some detail in the case of *TW v Enfield Borough Council*[173] in circumstances where the patient had made clear that she did not wish her nearest relative to be contacted. The Court of Appeal identified that her right to maintain the confidentiality of her medical history and file and all the circumstances of her medical case must be a part of her Article 8 ECHR right to a private life, but that this was a qualified right. Aikens LJ identified (at paragraph 49) that:

> *The basic reason for justifying an interference with the Article 8(1) rights of a patient to maintain confidentiality in her medical condition and to prevent the possibility of that breach of confidence causing the patient further distress and ill-health, would be to ensure that the patient's other ECHR right under Article 5, not to be unlawfully detained "except in accordance with the law" is also upheld. In my view that objective would , as a matter of law, be capable of being a legitimate public aim for the purposes justifying an interference with the patient's Article 8(1) rights. After all, as I have already pointed out, the consultation with the "nearest relative" is a vital safeguard for the patient who is faced with an application by an ASW to admit the patient for treatment. The patient herself has no statutory right to object to an ASW's application that the patient be admitted to hospital for treatment provided the statutory procedure is correctly followed. As I have noted, the interference would be "in accordance with the law" because section 11(4) permits,*

[172] I do not address here the extensive body of guidance (for instance in the MHA Code of Practice, or NICE Guideline CG 136 Service User Experience in Adult Mental Health (NICE Guideline CG136)) about good practice in seeking to ensure that regular discussions take place to support patients to understand the importance of appropriate information disclosure with family members and friends.
[173] [2014] EWCA Civ 362

indeed requires, consultation unless it is not "reasonably practicable".

158. Perhaps unsurprisingly, Aikens LJ identified that the decision of the (now) AMHP as to whether consultation was, indeed, reasonably practicable, would depend on whether it is justified and proportionate to do so in the particular circumstances of the case (paragraph 50), continuing (at paragraph 51):

> *In some circumstances, of which the present case is an example, this balance will be a difficult exercise. But I think that my analysis demonstrates that one principle is clear: as a matter of construction of section 11(4), a patient's assertion, even if founded on fact and even if reasonable, that consultation would lead to an infringement of her Article 8(1) rights cannot, as a matter of law, lead automatically to the conclusion that it is "not reasonably practicable" to consult the "nearest relative". Nor is an* [AMHP's] *conclusion that such consultation would lead to an infringement of the patient's Article 8(1) rights enough, in law, to lead to the decision that there should be no such consultation under section 114). Equally, as a matter of construction of section 11(4), it must be wrong in law for the* [AMHP] *to conclude that because consultation with TW's "nearest relative" would require disclosure of details of TW's case and that would therefore constitute an interference with TW's Article 8(1) rights, that must necessarily lead to the conclusion that it was "not reasonably practicable" to consult the "nearest relative".*[174]

159. When the reforms proposed by the Mental Health Bill 2025 come into force, the nominated person will have a greater role in other situations, including treatment[175] and placement on CTOs.[176] At that point, similar balancing exercises will be required, although from a starting point that, at least in some cases,[177] the nominated person will have been chosen by the person themselves so there is, potentially, more chance of a willingness for disclosure to take place.

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[174] The Court of Appeal criticised the wording of the previous Code of Practice to the MHA 1983 in the guidance it gave to AMHPs in this situation. The 2015 iteration (in England) and 2016 iteration (in Wales) expressly addresses this issue at paragraphs 14.61 (in England) and 14.52 – 14.53 (Wales).

[175] New section 56A.

[176] New section 17AA.

[177] Albeit not all. Where the patient has not appointed a nominated person, and currently lacks the capacity to do so, new Schedule A1 provides (in Part 2) for the appointment by an AMHP. Paragraph 9(2) requires the appointment of a competent and willing donee under a lasting power of attorney or deputy; in any other case, paragraph 9(2) requires that the AMHP must, in deciding who to appoint, take into account the relevant patient's past and present wishes and feelings so far as reasonably ascertainable. Again, therefore, even if the person lacks capacity to appoint a nominated person, the framework still seeks to establish a better alignment between their known views and the identity of the person appointed.

160. Otherwise, families have no specific status under the MHA 1983 in terms of information disclosure. As the MHA Code of Practice notes:

> *10.12 Apart from information which must be given to nearest relatives, the Act does not create any exceptions to the general law about disclosing confidential patient information to carers, relatives or friends.*
>
> *10.13 Carers cannot be told a patient's particular diagnosis or be given any other confidential personal information about the patient unless the patient consents or there is another basis on which to disclose it in accordance with the law. Carers, including young carers, should always be offered information which may help them understand the nature of mental disorder generally, the ways it is treated and the operation of the Act.*[178]

161. One important point to make clear is that there is a fundamental difference between: (1) disclosing confidential information about a patient; and (2) asking about the patient – and, in turn, listening to information provided about that patient. As the (English) MHA Code of Practice puts it at paragraph 10.11:

> *Simply asking for information from carers, relatives, friends or other people about a patient without that patient's consent need not involve any breach of confidentiality, provided the person requesting the information does not reveal any personal confidential information about the patient which the carer, relative, friend or other person being asked would not legitimately know.*[179]

162. The consensus statement provides that:

> *It is also clear that the duty of confidentiality is not a justification for not listening to the views of family members and friends, who may offer insight into the individual's state of mind or predisposing conditions which can aid care and treatment. Good practice will also include providing families with non-person specific information in their own right, such as how to access* services in a crisis, and support services for carers.

[178] Similar wording appears in the Welsh Code at paragraphs 10.17 and 10.18.
[179] Materially similar wording appears in the Welsh Code at paragraph 10.16.

Patient lacks capacity to withdraw decision to consent to continued disclosure of information

163. If the person currently lacks capacity to make the decision to withdraw consent, the decision will be whether such disclosure is in their best interests or (which is relatively unlikely) it could be disclosed on a public interest basis. In deciding whether disclosure is in their best interests, one factor will be that they initially agreed to such disclosure. If that initial agreement was understood to be on a capacitous basis,[180] professionals will have to consider whether the current (incapacitous) attempt to withdraw consent reflects, in effect, the patient's true view. In other words, has the patient truly changed their mind (for instance, as a result of a change in family circumstances)? Or does the patient's objection to continued disclosure represent a temporary objection deriving (for instance) from a mental health crisis? Whilst, ultimately, disclosure may be their best interests even if it is in face of an (incapacitous) objection, the bar for disclosure where it is known to be against a permanent change of mind will be higher than it will be where the disclosure is taking place against the backdrop of what appears (to put it very crudely) a 'meaningless' objection.

Patient has capacity to withdraw decision to consent to continued disclosure of information

164. The question at this point will be whether disclosure could be justified on a public interest basis. As set out above, this is a relatively unlikely scenario. In practical terms, the key consideration at that point is for professionals to continue to investigate the reason for the reluctance to share information and – without coercing them, to seek to persuade them to change their mind.

Question 10. Please set out, and compare and contrast, the legal processes, powers and obligations as regards the discharge of patients that are (i) detained under Part II of the Act; and (ii) are detained under Part III of the Act.

165. The main distinction here is not so much between Part 2 and Part 3 patients, but between so-called 'unrestricted' and 'restricted' Part 3 patients.

166. Unrestricted patients – who (most often) are a patients subject to an order made under s.37 MHA 1983[181] – have been entirely diverted from the criminal justice system to the health system for

[180] Otherwise, I note, it could not properly be charactered as 'agreement.'
[181] They may also be what is often called 'notional s.37' patients. As the MHA Code of Practice explains (at paragraph 22.75): "*For transferred determinate sentence offenders, restrictions added by the Secretary of State for Justice will cease on expiry of the custodial part of the sentence (ie the date the offender would have been released had he or she remained in prison). If the patient continues to require further treatment, they can remain detained within the hospital as if subject to an unrestricted section 37 hospital order. Patients detained under a hospital and limitation direction (under sections 45A and 45B of the Act) will fall into this category if they have*

treatment. Treatment is the purpose of their detention in hospital and the Secretary of State for Justice has no say in the patient's disposal. Decisions on granting community leave, movement through the hospital system and discharge will be taken by the responsible clinician and hospital managers (under s.23 MHA 1983). An unrestricted Part 3 patient can be placed on a CTO. By s.72, the Tribunal also has a statutory duty to discharge if not satisfied that the criteria for detention are met.

167. Restricted patients are those who are subject to a hospital order with restrictions (ss.37/41); a hospital and limitation direction (ss.45A and 45B); a transfer direction with a restriction order (s.47 (sentenced prisoners), or a transfer direction under s.48 (remand or civil prisoners and immigration detainees). In respect of transferred prisoners, the restrictions are applied via the order under s.49. A person charged with an offence before the Crown Court but found not guilty by reason of insanity, or found unfit to plead, may also receive a hospital and restriction order under s.37/41. The restriction order carries no time limit so the patient will remain detained in hospital for as long as they require treatment. Where the patient is also subject to a prison sentence and the patient is a restricted patient by virtue of s. 45A (a limitation direction) or s.49, the restriction will fall away on the date that the patient would be released from prison.

168. Restricted patients cannot be placed on CTOs. Final decisions about restricted patients, including about community leave,[182] transfer, remission or discharge are taken by the Secretary of State for Justice. In authorising the discharge of a restricted patient, the Secretary of State will either authorise such discharge with conditions, a 'conditional discharge[183]' or 'absolutely,' in which case the restrictions will cease and there will be no further involvement of the Secretary of State for Justice. In addition the Tribunal has a statutory duty to discharge patients if not satisfied that the criteria for detention are met. The First Tier Tribunal (Mental Health) has a statutory duty to review the detention of a restricted patient and order discharge – either conditionally or absolutely - if it is not satisfied that the criteria for detention under the Act are met. The Tribunal does not have the power to discharge transferred prisoners, but can decide whether the patient would be ready for

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reached the end of their sentence but still require treatment. These patients are all commonly referred to as 'notional section 37' patients."

[182] Section 41(3)(c)(i) MHA 1983 requires a responsible clinician to obtain consent from the Secretary of State for Justice before granting s.17 leave to a restricted patient.

[183] It is perhaps worth that the Supreme Court made clear in *Secretary of State for Justice v MM* [2018] UKSC 60 that neither the Secretary of State nor the Tribunal can impose conditions on a discharge which give rise to a deprivation of liberty. The Mental Health Bill proposes partially reversing this decision by giving the Tribunal (but not the Secretary of State) the power to discharge into circumstances of deprivation of liberty: see new s.71(4B), where: (a) conditions amounting to a deprivation of the patient's liberty are necessary for the protection of another person from serious harm while the patient remains discharged from hospital, and (b) that for the patient to remain discharged subject to those conditions would be no less beneficial to their mental health than for them to be recalled to hospital.

discharge if they were not a prisoner, and can make a recommendation that they should be returned to prison or, if appropriate, that a referral should be made to the Parole Board.

169. After being granted a conditional discharge by either the Secretary of State for Justice or the Tribunal, the Secretary of State may recall a patient under s.42(3) MHA 1983.

170. In essence, therefore, the real difference between Part 2 / unrestricted Part 3 patients and restricted Part 3 patients is that the Secretary of State has a specific, additional, role to play alongside – and indeed 'above' – the responsible clinician / hospital managers as representative of the public interest.

171. I should also note in terms of treatment, the provisions of Part 4 apply identically, irrespective of whether the patient is a Part 2 or a Part 3 patient. Part 4A applies equally where an unrestricted patient has been placed on a CTO.

Question 11. The Mental Health Bill proposes various changes to the MHA 1983. To what extent would the proposed reforms impact, if at all, any of the answers you have provided to the questions above?

172. I have touched on the answer to this question at various stages in my report so far (especially in relation to the answers to questions 4 and 5 and also – in relation to the changes from nearest relative to nominated person – in answer to question 8). As I noted in the answer to those questions, one important change is in relation to the criteria for detention under both s.2 and s.3 MHA 1983. These are being made more restrictive, reflecting both Strasbourg case-law (as set out at paragraph 13 above), and the view of the Mental Health Act Review that, in essence, detention was too readily reached for as an option.[184] Whether and how this makes a difference in practice will depend in very significant part on all the elements which sit between the black letter law and the interaction between individual clinician and individual patient – including how the changes in the Bill are

[184] I have not been asked to give evidence as the operation of the Review, and it would be inappropriate for me to do so. It is, however, perhaps important context to note that proceeded in circumstances where there had – for whatever reason – not been a high-profile attack such as that the subject of this Inquiry for a period of time (although there had undoubtedly been situations in which a person with a mental health condition had carried out an act leading to death or serious harm). The focus of the Review – as can be seen from the subtitle of its final report (*Increasing Choice, Reducing Compulsion*) – was therefore much more on patient autonomy than it was on public protection. That focus, in turn, tracked through into the draft Mental Health Bill. In between publication of that Bill in 2022 and the introduction of the current Mental Health Bill, the attacks by Valdo Calocane took place. It appears to be clear that some of the changes between the draft Bill and the Mental Health Bill 2025 reflected the impact of those attacks – in particular the addition of consultation requirements in s.23 around discharge. The attacks did not, however, lead to a fundamental change of course as regards either detention criteria or the increased focus on patient choice in relation to the making of medical treatment decisions.

implemented, how the Code of Practice is drafted, how professional training changes, how resource pressures are managed, and how cross-team and cross-organisation working is supported. In the latter regard, I should perhaps note that the provisions in the MHA 1983 relating to the Police are not being changed (save – importantly – for the removal of police stations as places of safety for purposes of ss.135-136). It is conceivable, therefore, that currently existing strains between NHS bodies (and local authorities) and the Police in the context of the *Right Care, Right Person* policy will be accentuated if the perception is that those who may be deteriorating, but who are not yet in crisis, cannot be looked at through the prism of hospital admission under the MHA 1983, but still fall within (relatively wide) ambit of ss.135 and 136 MHA 1983. This is, however, a matter that it would be more appropriate for the Inquiry Chair to investigate with the relevant core participants than for me to speculate upon.

173. It is perhaps also important to note that the Mental Health Bill places an increased focus on patient choice in relation to the making of medical treatment decisions. The precise mechanisms by which this goal is achieved are complicated, but in summary they make it more difficult – but in no circumstances – impossible to treat in the face of a patient's contemporaneous refusal, or, where they currently lack capacity to make medical treatment decisions, where it is known that would wish to object. I should, though, make clear that the Bill does not propose any radical changes to practice – what it is, in essence, doing is placing on a statutory footing what is already meant to be good clinical practice. It may be a matter for the Inquiry Chair to consider with relevant core participants the extent to which the changes to be introduced match current practice.

Question 12. What recommendations do you think the Chair of this Inquiry should make to ensure lessons are learned and to prevent attacks similar to that of VC in the future?

174. I am unsure as to whether it is really appropriate for me to propose recommendations in the capacity in which I have been appointed to assist the Chair. However, with that substantial caveat, I might suggest that the following four matters may merit consideration.

<u>Securing legal confidence amongst professionals</u>

175. I use the phrase 'legal confidence' deliberately, rather than the more often used term 'legal literacy.' It is not just a matter of clinicians and other professionals understanding what the law is (not that this is not hugely important), but also a matter of understanding how the law and their professional practice interact. I see in a whole range of contexts that such legal confidence is altogether lacking. This can manifest itself in a range of different ways, including:

a. Seeing the law as in some way alien and / or 'superior' in a hierarchy, as opposed to the framework for the exercise of judgment. This, in turn, can lead to the law being seen as a barrier to sensible clinical decision-making – most obviously in the context of information sharing. As set out above, the law does not prevent appropriate information sharing; to the contrary, it permits it and, indeed, on occasion may even mandate it. In a different context, it can lead to the seeking of advice from lawyers as to what to do to resolve what, or should be, clinical dilemmas. Put another way, I now always train clinicians, social workers and other equivalent professionals on the footing that they should only ever go to their legal department with a clear idea of what they want to do and why, and then get the legal department to find a way to achieve it (unless, of course, it is something which is in fact legally impossible). In that way, they are not deferring judgment to lawyers who simply do not have the tools to be able to answer the relevant questions.

b. Not seeing how the different pieces of the law interact. This can take different forms, including not being confident in understanding the operation of the ECHR,[185] the interaction between primary legislation and Codes of Practice (not helped, of course, when Codes of Practice are not updated, so the Codes, themselves, can be wrong), or the difference between a case-specific judicial determination and a binding judicial holding as to the meaning of a word within legislation. Most perniciously, perhaps, in the context with which this inquiry is concerned, is the failure to understand where legal duties to act to come from, and where the MHA 1983 and, in particular, the MCA 2005 sit in the context of those duties. The MCA 2005 is now regularly, and routinely, seen as the starting point for consideration, as opposed to a framework for acting in discharge of duties arising from elsewhere. It is, frankly, a recipe for disaster if the starting question is as to a person's capacity to make decisions, as opposed to much more fundamental questions such as: (1) what is the nature and level of the risk; (2) what appears to be the clinically appropriate response to that risk; and (3) what powers might be needed to implement that response. It is only when those questions are asked and answered that it is possible that it is then possible to know where the person's capacity to take decisions in relation to the various actions proposed comes in.

Requiring consideration of capacity

176. I have noted at paragraphs 59 to 61 the complexity of the presumption of capacity in the MCA 2005. It can be too easy for overstretched professionals to 'hide' behind the presumption of

[185] In which regard, I should commend to the attention of the Chair the work of the British Institute of Human Rights, which produces resources which are specifically tailored to those working in mental health services which help them 'internalise' the provisions of the ECHR in language which appears relevant.

capacity, especially where a conclusion that a person has capacity feels morally easier by allowing decisions to be characterised as 'lifestyle choices,' or to avoid the need for a difficult conversation about service shortages (in other words, avoiding a conversation about the fact that a resource is not available by relying on the person's decision not to engage with it, rather than probing whether this decision is capacitous). This has been a phenomenon long recognised in the wider social care landscape,[186] and has been the subject of increasing focus in recent years in the psychiatric context.[187]

177. It is likely that the updated Code of Practice to the MCA 2005 will seek in due course to emphasise the importance of considering capacity where there is good reason to do so. The Chair might consider that provisions in a Code do not go far enough, and that there should be a legal duty on professionals to consider capacity where there is reason to do so. In the context of other work that I have done where failures appropriately to consider capacity has led to serious consequences, I have had cause to try to think of how such a duty to consider capacity could look. For the Chair's benefit, and to concretise matters, I set out my sketch of such a duty below. It is focused not on the MCA 2005 per se (such that it would not necessarily need to sit within the MCA 2005, but could be a standalone legislative measure), but rather on the duties, powers and obligations owed to the relevant individuals at both common law, and under legislation such as the MHA 1983, the NHS Act 2006, the Care Act 2014, the Social Services and Well-Being Wales Act 2014 (all informed, as discussed at paragraph 9 above, by the 'meta' duties under the HRA 1998). The duty to consider capacity would arise in specified circumstances, including where concerns are raised by others (for instance family members) about the person's capacity. Such a duty would have particular relevance in the situation where the person is not currently subject to the MHA 1983 such that, as discussed above, the only basis upon which treatment could be delivered would be either the person's capacitous consent, or under the provisions of the MCA 2005 which apply where they lack capacity. It would also, however, also apply in relation to any situation covered by the MHA 1983 which is, or will be, capacity-based (an example being in relation to the appointment of a nominated person under the changes to be introduced by the Mental Health Bill), as well as to situations where capacity-based decisions need to be taken about a person detained under the MHA 1983 (for example in relation to physical health treatment unrelated to their mental disorder).

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[186] The House of Lords Select Committee convened to conduct post-legislative scrutiny of the MCA 2005 identified in 2014 that "[t]*he presumption of capacity, in particular, is widely misunderstood by those involved in care. It is sometimes used to support non-intervention or poor care, leaving vulnerable adults exposed to risk of harm. In some cases this is because professionals struggle to understand how to apply the principle in practice. In other cases, the evidence suggests the principle has been deliberately misappropriated to avoid taking responsibility for a vulnerable adult*" (HL Paper 139, paragraph 105).

[187] See, for instance, the article by Dr Chloe Beale: Magical thinking and moral injury: exclusion culture in psychiatry | BJPsych Bulletin | Cambridge Core.

Section 1: Duty to consider capacity

(1) Any person (A) discharging a function which is dependent on the capacity of another person aged 16 or over (B) must consider the capacity of B in the circumstances provided in subsection (5) below.

(2) 'A function which is dependent on the capacity of B' has the meaning provided in section 2.

(3) 'Capacity' means capacity applying the provisions of the Mental Capacity Act 2005.

(4) 'Consideration of capacity' means consideration of whether the person has or lacks the capacity relevant to the discharge of the function, without a presumption that they have such capacity.

(5) The circumstances when the capacity of B must be considered include:

(a) where A reasonably understands B to have any impairment or disturbance in the functioning of their mind or brain;

(b) where the decision B proposes to take appears to be unwise, especially if they are putting either themselves or others at risk;

(c) where the decision B proposes to take is significantly out of character;

(d) where a person properly interested in B's circumstances has raised a concern as to their capacity with A.

Section 2: Functions dependent on capacity

(1) A function which is dependent on the capacity of a person (B) means a relevant function the discharge of which would give rise to liability on the part of a person (A) if –

(a) B has the capacity to make a decision relevant to any act being carried out by A, and

(b) B does not agree to the act being carried out by A.

(2) For purposes of this section, A carries out a relevant function if they act on the basis of –

(a) a statutory duty;

(b) a statutory power; or

(c) an obligation owed to B at common law.

(3) In relation to subsection 2(a) or (b), it does not matter whether the statutory duty or statutory power makes express reference to the Mental Capacity Act 2005.

(4) Regulations may provide for specific functions to be identified as functions dependent on capacity for purposes of this section.

Addressing uncertainty

178. There are always, and are likely always to be, enormous challenges in addressing the position of those with mental ill-health. There will never be enough resources, not least because it is unrealistic to think that wider society and – in consequence – elected politicians – will ever see funding of this area as a sufficient priority to achieve true parity with physical health. This is particularly so in relation to serious mental ill-health, which is all too often ignored as too 'difficult' in the context of stigma-reducing events such as World Mental Health Day.

179. However, I think that it is important to emphasise that some of the challenges that exist would exist even with greater funding. Above all, professionals – and families – are working with uncertainty. Perfect risk prediction is, as the Chair will no doubt hear from core participants, impossible. And, as the European Court of Human Rights has increasingly emphasised, risk aversion carries with it its own risks. There is also often ethical uncertainty as to what the 'right' thing to do in any given situation. This uncertainty can arise from a host of sources, of which I single out two. The first is uncertainty as to whether and under what circumstances coercion is justified, especially in the face of bodies such as the World Health Organisation (in effect) telling psychiatrists that their practices are illegitimate by reference to the UN Convention on the Rights of Persons with Disabilities.[188] The second is, understandable, concern about the use of the provisions of the MHA 1983 in the context of the potential for racial discrimination. This uncertainty can be resolved, or compounded, by multiple perspectives being involved in decision-making.

180. In this context, it may be appropriate to draw to the Chair's attention work that I was involved in as part of the Wellcome-funded Mental Health and Justice project. Driven by a hypothesis that, all too often, the way in which uncertainty is resolved in the context of mental health and capacity issues feels unsatisfactory, we carried out a 'policy lab' to identify some of the ways in which uncertainty could be resolved justly. The findings of the lab can be found here.[189] For present purposes, I would highlight that a very significant contribution to resolving uncertainty justly is where systems enable – and indeed prompt – individual professionals to recognise uncertainty, and provide space and time to professionals to address the factors provoking that uncertainty, rather than requiring them to reach a conclusion immediately.

[188] See, for instance, the WHO's 2023 guidance: Mental health, human rights and legislation Guidance and practice. I refer back to paragraph 14(c) above in relation to the CRPD.
[189] Uncertainty-Policy-Lab-Final.pdf

Further reform of the MHA 1983

181. It would be remiss of me to conclude without noting that one legal reform that would make a substantial difference would be if the Mental Health Act 1983 was made to do what is said on the tin. If the MHA 1983 were truly to be an act to secure the mental health of those in the country, it would look very different – and would contain very much more emphasis on 'positive' rights to services.[190] Whilst it would be unduly idealistic to assume that securing such rights to services would eliminate attacks such as those carried out by Valdo Calocane, a legal framework which did not focus upon crisis management (which is, in reality, what the MHA 1983 does) would perhaps go some way to minimising the chances that they occur again.

Conclusion

182. I apologise for the length of this report. However, given the range and detail of questions asked, it has proven unavoidable. If there are matters which I can expand upon, the Chair should not hesitate to seek such expansion through Counsel and Solicitor to the Inquiry. I would also be happy to speak to it should such be of assistance.

Statement of truth

183. I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true. The opinions I have expressed represent my true and complete professional opinions on the matters to which they refer.

184. I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

Signed: GRO-B

Date: 19 November 2025

ALEX RUCK KEENE KC (HON)
39 Essex Chambers
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[190] Such a model has been thought about in Scotland in the context of the Scottish Mental Health Law Review. It is, perhaps, not altogether surprising that Scottish Government, whilst welcoming the conclusions of the Review, has not moved so far to implement the more far-reaching recommendations of the Review.

NOTTINGHAM INQUIRY
INDEX TO EXPERT REPORT OF ALEX RUCK KEENE KC (HON)

No.	Inquiry URN	Document Description
1	NHSE0000312	Mental Health Act 1983: Code of Practice (England) (2015)
2	WITN0288002	Mental Health Act 1983: Code of Practice (Wales) (2016)
3	NHSE0000343	Mental Capacity Act 2005 Code of Practice (2007)
4	WITN0288003	Mental Capacity Act 2005, Deprivation of Liberty Safeguards (2009) Code of Practice
5	WITN0288004	Reference Guide to the Mental Health Act 1983 (2015)
6	WITN0288005	General Medical Council's Practice Guidance: *Confidentiality: good practice in handling patient information*
7	WITN0288006	Royal College of Psychiatrists: Good Psychiatric Practice: Confidentiality and Information Sharing (3rd edition) (Nov 2017)

APPENDIX:
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"[H]e is the doyen of the Mental Capacity Act and the Mental Health Act."
Chambers and Partners (2025)

Alex Ruck Keene KC (Hon) is an experienced barrister, writer and educator. His practice is focused on mental capacity, mental health and healthcare law. He also writes extensively, editing and contributing to leading textbooks and (amongst many other publications) the 39 Essex Chambers Mental Capacity Law Report, the 'bible' for solicitors (and others) working in the area. He is the creator of the website Mental Capacity Law and Policy, providing resources and expert commentary on some of the most difficult mental capacity issues.

Alex complements his practice with a deep interest in research and education. He is a Professor of Practice at the Dickson Poon School of Law, King's College London, a Visiting Professor at the Geller Institute of Ageing and Memory, University of West London, a Visiting Senior Lecturer at the Institute of Psychiatry, Psychology and Neuroscience, King's College London and a Research Affiliate at the Essex Autonomy Project, University of Essex. In addition to his academic positions, he lectures widely on the Mental Capacity Act 2005 and the Mental Health Act 1983 and trains judges, social workers, doctors, nurses and other professionals who have cause to work with them.

Alex now spends much of his time on policy matters. From 2023 to 2025, he was a consultant on the Law Commission's Disabled Children Social Care project, having previously a consultant to their Mental Capacity and Deprivation of Liberty Project. Throughout 2018, he was the legal adviser to the Independent Review of the Mental Health Act 1983. He was a specialist adviser to the Joint Committee on Human Rights for their 2020 inquiry into the human rights implications of the Government's response to COVID-19 and specialist adviser into their 2021-2022 inquiry into human rights in the care setting. He sits on the Court of Protection Rules Committee, and is also a member of the International Family Law Committee, with a specific brief to raise the profile of cross-border capacity issues. He also sits – uniquely – on both the Mental Health and Disability Committee of the Law Society of England and Wales and on the Mental Health and Disability Sub-Committee of the Law Society of Scotland.

In March 2022, Alex was made an honorary KC, reflecting his contributions to mental capacity and mental health law outside the court room.

Areas of expertise

- Court of Protection and Medical Treatment
- Community Care and Mental Health
- Healthcare

Court of Protection and Medical Treatment

"knows everything about Court of Protection." Chambers and Partners 2024

Alex has been recognised for several years as one of the leading experts in the Mental Capacity Act 2005. He is instructed in cases by individuals, NHS bodies, local authorities, as well as foreign governments. He is one of the very few practitioners who has experience of appearing/advising upon all aspects of the Court of Protection's jurisdiction. Because Alex's work straddles policy, academia and practice, he tends now to be instructed in cases raising novel points of law or policy, frequently at appellate level.

Cases of Note:

- *Attorney General of Northern Ireland's Reference* – listed for October 2025: revisiting the meaning of deprivation of liberty in the context of those with cognitive impairments
- *Re Sudiksha Thirulamesh (dec'd)* [2024] EWCA Civ 896 – what is to happen where a person appears not to believe their doctor
- *R (Maguire) v His Majesty's Senior Coroner for Blackpool & Fylde & Anor* [2023] UKSC 20 – the application of Article 2 ECHR in the context of those subject to the Deprivation of Liberty Safeguards
- *Re JB* [2021] UKSC 52 - The first case in which the Supreme Court considered the approach to capacity, in the context of sexual relations.
- *Re D* [2019] UKSC 42 - The case in which the Supreme Court determined the meaning of deprivation of liberty for 16 and 17 year olds with impaired capacity.
- *An NHS Trust v Y* [2018] UKSC 46 - The case in which the Supreme Court confirmed that there is no obligation to seek Court of Protection approval before withdrawing life-sustaining treatment where there is agreement as to what is in the person's best interests.
- *N v ACGG* [2017] UKSC 22 - The case in which the Supreme Court definitively determined how best interests decision-making interacts with public law decision-making.
- *R(LF) v HM Senior Coroner for Inner South London* [2017] EWCA Civ 31 - The case determining the meaning of the concept of deprivation of liberty in the intensive care setting,.
- *Aintree University Hospitals NHS Trust v James* [2013] UKSC 67 - The first case in which the Supreme Court considered the MCA 2005, in the context of delivery of treatment at the end of life.
- *The Health Service Executive of Ireland v Moorgate* [2020] EWCOP 12 - An example of the international cases Alex does, in which Mr Justice Hayden 'stress-tested' the relative protections of Schedule 3 to the Mental Capacity Act 2005 and domestic legislation relating to compulsory mental health treatment. Alex also co-wrote on The International Protection of Adults (OUP, 2015), the first book to examine the cross-border protection of the property and persons of adults with impaired capacity.

Community Care and Mental Health

Alex is heavily involved in the development of mental health policy. He spent 2018 as legal adviser to the independent Review of the Mental Health Act 1983, whose report can be found here. Alex's instructions in the mental health field include, in addition to those noted below, (unreported) cases concerning remote assessment during the pandemic. Alex also co-leads the Mental Health, Ethics and Law MSc course at King's College London, and was a senior researcher on the Mental Health and Justice project which ran from 2017-2022.

Cases of Note:

- *R (Worcestershire County Council) v Secretary of State for Health and Social Care* [2023] UKSC 31 – The meaning of 'ordinary residence' in the context of s.117 MHA 1983
- *Sessay v (1) South London & Maudsley NHS (2) Met Police* [2012] 2 WLR 1071 - The case in which the Divisional Court had to consider for the first time the powers under which incapacitated patients can be required to remain upon hospital premises pending their admission under the MHA 1983
- *TTM (By His Litigation Friend TM) (Claimant) v (1) Hackney London Borough Council (3) East London NHS Foundation Trust (Defendants) & Secretary of State for Health (Interested Party)* [2011] 1 WLR 2873 - In this case, the Court of Appeal determined authoritatively the scope of Articles 5(1) and 5(5) European Convention on Human Rights in the context of admission for treatment under the MHA 1983.
- Munjaz v United Kingdom [2012] ECHR 1704 - The European Court of Human Rights gave guidance both as to the operation of Articles 5 and 8 ECHR in the context of detained patients facing seclusion.

Healthcare

Alex has had a long-standing interest in healthcare matters, especially those raising ethical dilemmas. He is on the British Medical Association's Medical Ethics Committee and the Legal and Ethical Policy Unit of the Faculty of Intensive Care Medicine, intervening on the Faculty's behalf in cases up to and including the Supreme Court. He has been a legal member of working groups convened to produce guidance by bodies including the British Medical Association, the Royal College of Physicians and the Association of Anaesthetists of Great Britain and Ireland. He sits on two clinical ethics committees, one run by a major teaching hospital, and one by a large mental health trust.

Cases of Note:

- *Abbasi v Newcastle upon Tyne Hospitals NHS Foundation Trust* [2025] UKSC 15 - When should clinicians be named in serious medical treatment cases?
- *R (JJ) v Spectrum Community Healthcare CIC* [2023] EWCA Civ 885 – Could a capacitous quadriplegic prisoner demand to be fed boiled sweets and crisps in the face of concerns from the healthcare team that such would lead to him choking?
- *AB v CD* [2021] EWHC 741 (Fam) - A case in which the court had to address the question whether parents can consent to the administration of puberty blockers where their minor child seeks to consent.
- *NHS Trust v X* [2021] EWHC 65 (Fam) - The first post-HRA case to consider whether the refusal of treatment by a minor is binding.
- *R (Conway) v Secretary of State for Justice* [2017] EWCA Civ 1431 - The compatibility of the ban on providing assistance with suicide in s.2(1) Suicide Act 1961 with the European Convention on Human Rights.

Recommendations

Alex has been recognised for several years as one of the leading experts on the Mental Capacity Act 2005, ranked as a 'star individual' by Chambers and Partners and a Tier 1 Silk by Legal 500. Prior to his appointment, he was also ranked as a tier 1 junior for Community Care and Court of Protection in The Legal 500.

- *"Alex's brain is the size of the universe, he is the most exceptional source of wisdom."* Chambers and Partners 2023
- *"A true expert full of passion for the rule of law, fairness and equality. Has a very easy manner and ability to clearly explain complicated areas of law with clarity and ease." The* Legal 500 2021
- *"He has excellent attention to detail and he's creative in how he approaches cases, good to work with and very responsive"* Chambers and Partners 2021
- *"An impressive barrister and the font of all knowledge on Court of Protection work."* Chambers and Partners 2019

Memberships

- Court of Protection Bar Association (Committee member)
- Court of Protection Practitioners Association
- Mental Health Lawyers Association
- Administrative Law Bar Association
- European Law Institute

Qualifications

Education

- Modern History BA (Hons) First Class, Oxford University, 1998
- MA International Relations, Johns Hopkins School of International Studies, 2000
- Postgraduate Diploma in Law, Distinction, College of Law, 2001
- Bar Vocational Course, Very Competent, Inns of Court School of Law 2002

Scholarships and Prizes

- Lord Bowen and Lord Mansfield Scholar, Lincoln's Inn.

Additional Information

Alex's expertise in the field of mental capacity law has been recognised by Parliamentary bodies in England and further afield: in November 2013, Alex gave oral evidence to House of Lords Select Committee considering the operation of the MCA 2005 as part of a panel of legal experts addressing the functioning of the MCA 2005 and the Court of Protection. In January 2025, he gave evidence to the Public Bill Committee convened to consider the Terminally Ill Adults (End of Life) Bill.

More broadly, Alex gave evidence to the ad hoc committee of the Northern Ireland Assembly convened to consider the Mental Capacity Bill there introduced in 2015. At the request of Gerard Quinn, UN Special Rapporteur on the Rights of Persons with Disabilities, he also co-wrote a report in 2021 on the compatibility of the 2000 Hague Convention on the International Protection of Adults with the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), available here.

Appointments

- Visiting Fellow at the Institute of Advanced Legal Studies for academic year 2013-4
- Mental Health and Disability Committee, Law Society of England and Wales: 2014 to date
- Mental Health and Disability Sub-Committee, Law Society of Scotland: 2015 to date
- Wellcome Research Fellow, King's College London: 2017-2022
- Visiting Lecturer, King's College London: 2017-2020
- Research Affiliate, Essex Autonomy Project, University of Essex: 2017
- Visiting Senior Lecturer at the Institute of Psychiatry, Psychology and Neuroscience at King's College London: 2019
- Visiting Professor, King's College London: 2020

Languages

- French (conversational)