CHILDREN'S CAPACITY
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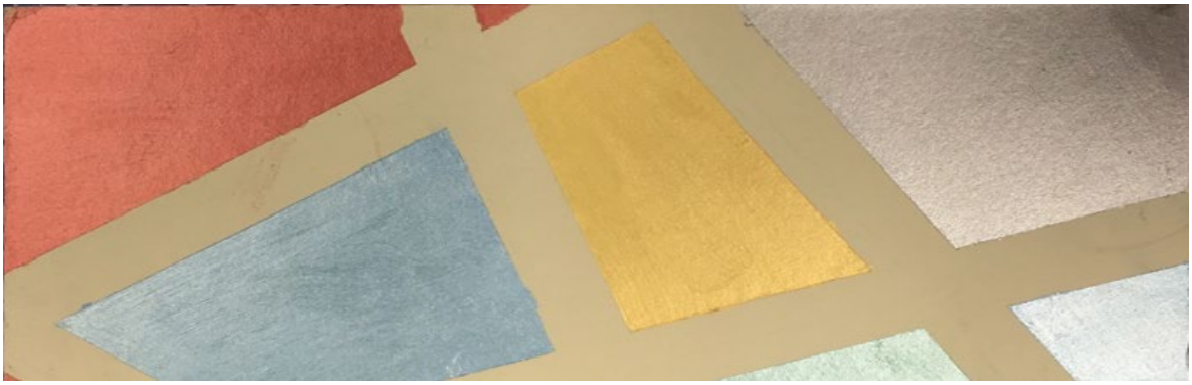

Welcome to the February 2025 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: myth-busting about DoLS and strong words about assessment of capacity of D/deaf people;

(2) In the Property and Affairs Report: revoking Deputyship for a person no longer present in England & Wales;

(3) In the Practice and Procedure Report: litigation capacity and a very clear statement of the ordering of the capacity test, delays in obstetric cases and guidance on neurodiversity before the courts;

(4) In the Mental Health Matters Report: the Mental Health Bill progresses and two important Upper Tribunal cases;

(5) In the (new) Children's Capacity Report: deprivation of liberty before the courts and Parliament, when capacitous consent is not enough, and best interests and the clinical circling of the wagons;

(6) In the Wider Context Report: The Terminally Ill Adults (End of Life) Bill and capacity, CCTV and care homes, and using the arts to be more creative in capacity assessment.

(7) In the Scotland Report: Scottish Government's law reform proposals – the consultation responses, and the OPG digitalises.

There is one plug this month, for a free digital trial of the newly relaunched Court of Protection Law Reports (now published by Butterworths. For a walkthrough of one of the reports, see here.

You can find our past issues, our case summaries, and more on our dedicated sub-site here, where you can also sign up to the Mental Capacity Report.

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

Contents

Introduction

In light of the ever-increasing (and rightful!) focus on legal capacity issues concerning those under 18, we have decided to introduce a stand-alone section to cover such matters.

Deprivation of liberty and children – the courts

Several developments before the courts merit note here:

1. The Court of Appeal are to hear / have heard (depending upon when you read this) the appeal against the decision of Lieven in *Re J*, in which she held that local authorities could consent to the confinement of children subject to care orders.

2. The Supreme Court held in *The Father v Worcestershire City Council* [2025] UKSC 1 that *habeas corpus* is (save in wholly exceptional cases) to challenge any deprivation of liberty to which a local authority's actions under a care order might give rise. The Supreme Court made clear in its judgment (unusually involving a litigant in person, the appellant father) that it was not seeking to prejudge the outcome of the appeal in *Re J* (see paragraph 35).

3. Another in the Lieven J-inspired line of challenges to *Cheshire West* can be found in *Re V (Profound Disabilities)* [2025] EWHC 200 (Fam), in which HHJ Middleton-Roy identified that:

> *13. People with disabilities have the same human rights as those without disabilities. 'V's profound disabilities place a duty on the State to make reasonable accommodation and cater for his particular needs. The measures put in place by the Local Authority to support 'V', on a proper fact-specific analysis, form part of 'V's care provision. 'V' is undoubtedly under close and constant supervision. However, in this Court's judgement, the measures implemented by the Local Authority are not actions of the State which deprive 'V' of his liberty. They are designed to meet his care needs. There are many aspects of 'V's care which may intrude on his privacy, with specific justification, but they are not, in this Court's judgement, interferences with his important right to liberty and security of person under Article 5 of the European Convention on Human Rights.*
>
> *14. Respectfully, this Court disagrees with the submission that there is any material distinction of the principle*

> *in SM[1] this current case. The young person, 'V' who is at the centre of this case, requires support because of his profound disabilities. In practical terms, 'V' cannot leave his care placement of his own volition, due to his enduring disabilities. For 'V', the reason he can't leave his care placement and requires intimate support is because of those disabilities, not by reason of any action of the State. For the same reasons articulated by Lieven J in SM, the facts of this case show that the State is not depriving 'V' of his right to liberty and security of person within the meaning of Article 5 ECHR. 'V's Article 2, 3 and 5 rights are not infringed by the restrictions necessarily implemented by the Local Authority to supervise him, monitor him and provide for his personal care.*

We make the observation that precisely the same arguments as set out here were roundly rejected by the majority of the Supreme Court in *Cheshire West*, and endorsed again in *Re D* (which was not referred to by Lieven J in *SM*, nor by HHJ Middleton-Roy in the instant case). It is not obvious, one might think, why the fact that the person in question is 14, as opposed to 44, should make any difference – not least because there is also no reason to think that the care arrangements for them will change as they turn 16.

4. The President of the Family Division has set out public-facing Practice Guidance (January 2025) for cases transitioning from the National DOL List ("NDL") to the Court of Protection. The Practice Guidance is based on the internal guidance used by judiciary and court staff with respect to such cases, which was referred to in the October 2023 NDL national listing protocol guidance. Importantly, the Practice Guidance now published makes clear that in cases involving 16/17 year olds where a decision is taken that further consideration should be undertaken by the Court of Protection, what should happen is not a transfer, but rather fresh proceedings in the Court of Protection, with the original papers in the NDL proceedings being released into those new proceedings.

Deprivation of liberty and children - Parliament

Children's Wellbeing and Schools Bill, which passed its second reading in the House of Commons on 8 January, would amend s.25 Children Act 1989 significantly to expand its scope. The amendment (in clause 10) is not entirely easy to read in isolation, so Alex has prepared an unofficial version of s.25 Children Act 1989 as it would look with the amendments contained in clause 10. The Explanatory Notes to the Bill provide in material part that:

> *6. The Bill seeks to amend section 25 of the Children Act 1989 to provide a statutory framework for the authorisation the deprivation of liberty of children in a different type of accommodation – one that is not a secure children's home ("SCH"), but which is primarily to be used to provide care and treatment for a vulnerable, complex cohort who may need restrictions which deprive them of their liberty (i.e. that the totality of the restrictions means that the person is under continuous supervision and control and not free to leave of their own accord).*

[1] Ie. the decision of Lieven J in *Re SM* [2024] EWHC 493 (Fam).

> *7. Currently, the only statutory framework for depriving a child of their liberty on welfare grounds (outside other relevant legal frameworks such as in relation to mental health) is via section 25 of the Children Act 1989. This power enables a child to be placed or kept in accommodation provided for the purpose of restricting liberty (a SCH). A core feature of a SCH is that it should be designed for, or has as its primary purpose, prevention of a child from absconding or causing harm to his/herself or others. Other, highly therapeutic accommodation designed for a child would have as its primary purpose the care and/or treatment of the child, as opposed to prevention of absconding or harm, and so cannot currently be used to deprive a child of their liberty via section 25 of the Children Act 1989.*
>
> *18. The effect of this legislative change would be to provide an alternative statutory route to authorise the deprivation of liberty of a child in a more flexible form of accommodation, bringing more deprivation of liberty cases under a statutory framework via s.25 Children Act 1989, with clear criteria for access, mandatory review points and parity with SCH in terms of access to legal aid.*

These amendments have to be read against the current situation, captured most starkly by the Children's Commissioner for England in her recent report. Focusing purely on the wording of the Bill, amongst the matters that the House of Lords will no doubt be considering at Committee stage are:

1. How far the change plugs the current gap that is being met by the High Court under the inherent jurisdiction, given that the test for children in "relevant accommodation" is whether they are likely either to abscond (and suffer significant) harm, or whether, if they are kept in any other description of accommodation they are likely to injure themselves or other persons. Put another way, is "injury" wide enough to capture all the types of harm that are currently being addressed by the High Court's inherent jurisdiction in non-absconding cases?

2. Article 5 ECHR compliance. This is addressed in the human rights memorandum, but two specific, additional, issues that fall for consideration are:

   (a) The need for specificity as to the basis upon which deprivation of liberty is justified in any given case. The European Court of Human Rights is clear that deprivation of liberty can only be justified on one of the exhaustive list of grounds contained in Article 5(1). In the case of a child, this could be Article 5(1)(d) (educational supervision) or Article 5(1)(e) ('unsoundness of mind'). The nature of the evidence required to justified the different limbs is different (in particular, medical evidence being required for the latter, but not the former). It may well be that these are matters which fall to be left to the Family Procedure Rules in due course, but they are a matter which need to be considered by Parliament.

   (b) That Strasbourg has made clear that detention on the basis of Article 5(1)(d) "*must take place in an appropriate facility with the resources to meet the necessary educational objectives and security requirements" (Blokhin v Russia* [2016] ECHR 300). In similar vein, Strasbourg has also made clear that detention on the basis of Article

5(1)(e) must be in an appropriate place, and to be accompanied by appropriate treatment. In *Rooman*, the court also emphasised that the appropriateness of the placement had to be judged by reference to the needs of the individual in question, rather than by the category of accommodation generally. These requirements would apply equally to the High Court considering an application under an amended s.25 CA 1989 as it does in the context of detention under the Mental Health Act 1983.

3. How this regime would interact with the jurisdiction of the Court of Protection to authorise deprivation of liberty for those aged 16 and 17 lacking the relevant decision-making capacity.

The courts, consent and the capacitous young person

O v P [2024] EWCA Civ 1577 (Court of Appeal (Sir Geoffrey Vos, MR, Sir Andrew McFarlane and King LJ)

Other proceedings – Family (public law)

This case concerned a 16 year old who was born female but had started to identify as male at the age of about 12 (we therefore use the male pronoun here). His parents disagreed about the processes that should be followed to address his gender dysphoria – his mother applied to the court for a prohibited steps order and a best interests declaration. At first instance, the mother sought an adjournment for her application for 6 months pending an assessment by a private clinic. The father opposed the adjournment on the basis that the proceedings were causing the young person distress. The court dismissed the proceedings. The mother appealed successfully to the Court of Appeal.

Sir Geoffrey Vos, MR, giving the lead judgment, crisply identified at paragraph 2 that:

> *It is useful at the outset to distinguish between three possible issues with which the courts have to deal. First, there is the issue of whether a child under 16 is **competent** to consent to or to refuse medical treatment (see Gillick v. West Norfolk and Wisbech AHA [1986] AC 122 (Gillick), and more recently, R (Bell) v. Tavistock and Portman NHS Foundation Trust [2021] EWCA Civ 1363, [2022] 1 All ER 416 (Bell v. Tavistock)). Secondly, there is the issue of whether a child (but also an adult) has mental **capacity** to consent to or to refuse medical treatment (see sections 1-6 of the Mental Capacity Act 2005). Thirdly, there is the issue of what is in a child's **best interests**. This issue arises once the presumption as to the **competence** of a child over 16 to consent or refuse medical treatment is engaged (see section 8 of the Family Law Reform Act 1969 (FLRA 1969), which provides that a child over 16 can give consent in the same way as an adult, and no further consent is required from parents or guardians). Despite section 8, the court still retains the right to override consent given or withheld by a child over 16 on welfare or **best interests** grounds in very limited and well-defined circumstances (see Re W (A Minor) (Medical Treatment: Court's Jurisdiction) [1993] Fam 64 (Re W)).*

He went on to hold that:

1. The issue in the proceedings, given that the child was 16 and had capacity to make his own medical treatment decisions, was whether now or in the future the court should override any consent the young person gave to cross-sex hormone treatment.

2. Earlier decisions by the courts in this area, including *Bell v Tavistock*, were made in a different regulatory landscape, before puberty blockers were banned by the government. The judge at first instance did not place enough weight on the rapidly changing regulatory environment or the fact that the assessment by the private clinic was not capable of satisfying the good practice recommendation of the Cass Review as to the need for cases to be discussed by a national multi-disciplinary team.

3. It was entirely possible that there would be a disagreement as to best interests when the assessment was completed, and the judge at first instance had been wrong to suggest that there was no realistic basis on which the court, in the future, might override the young person's consent. Authorities such *as Re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam 64 make clear that the court may override such consent, if that is necessary to protect the young person from grave and irreversible mental or physical harm. That was a question of fact for the court to determine in each case.

Sir Andrew McFarlane, giving a concurring judgment, emphasised at paragraph 46 that:

> *It is important to stress that the court's best interests jurisdiction with respect to consent to medical treatment given by a competent person who is over 16, but under 18, is not a general welfare jurisdiction. As was made plain in Re W (A Minor) (Medical Treatment: Court's Jurisdiction) [1993] Fam 64, the court will only override the consent of a competent young person, who is over 16, where it is necessary for the court to intervene to protect them from 'grave and irreversible mental or physical harm' (Nolan LJ p 94). Each case may turn on its own facts and, whilst the issue of law was not in direct focus in this appeal, I agree with My Lord that the administration of cross-hormone treatment is not in a special legal category in this regard.*

Comment

The issues that arise where a child does not identify with the gender assigned to them at birth continue to exercise the courts, as they do wider society. This case was decided the day after the Court of Appeal allowed the appeal in *C (A Child) (Change of Given Name*) [2024] EWCA Civ 1582, where, amongst the factors leading to the appeal being successful was the fact that the judge at first instance had fallen into the trap of considering it as a 'gender' appeal, as opposed to "*a case involving a change of name in respect of a capacitous young person who is shortly to reach the age of 16 years*."[2]

O v P was, by comparison, squarely, a 'gender' appeal.The exercise of the court's inherent jurisdiction to override the capacitous decision of a young person aged 16 or 17 has largely been confined to cases involving the refusal of life-sustaining treatment,[3] rather than consent to medication prescribed by a clinician. The Court of Appeal confirms in this judgment that the court's jurisdiction is not limited to particular types of treatment decision, and that if there is a substantive best interests dispute against an evolving background of medical and policy guidance in a contested area, the court should not shy away from determining the issue.

The decision is also of use for confirming clearly that, post-16, questions of *Gillick* competence fall

[2] Paragraph 64. It is perhaps a little odd, given the constitution of the Court of Appeal (including King and Baker LJJ) that it described the child in question as 'capacitous,' rather than 'competent,' given that they were 15.

[3] An example being the C case we cover below.

away (see paragraph 3). The issue in terms of whether the child is cognitively able to make their own decision is therefore governed by the MCA 2005; but that is not the end of the story given that children's legal capacity is limited – as here – by their age.

Short note: treatment refusal and the older child

Re C [2024] EWHC 3331 (Fam) (decided in the autumn, but making its way onto Bailii more recently) was a judgment arising from an urgent application made to provide life-saving insulin to a 17 year old girl (C), who was considered to have the capacity to make decisions about her medical treatment. She had type 1 diabetes and a history of poor compliance with her diabetes care. By the time the matter came before the court, there was thought to be a risk to C's life if she was not provided with insulin. Indeed, she went into diabetes keto acidosis during the hearing.

Following *NHS Trust v X* [2021] EWHC 65 (Fam), Arbuthnot J held that there is a "*duty on the court to ensure so far as it can that children survive until adulthood*." While she acknowledged that there were risks to C of having the treatment because of the level of restraint, she had "*no doubt*" that it was in C's best interests for her to have the treatment against her wishes. The application was therefore granted.

Of note, perhaps, is the fact that this was a situation where C's parents were supportive. There was clearly no doubt in the Trust's mind, however, that it was necessary for an application to be brought, rather than seeking to rely upon their consent. This was undoubtedly right, because C's parents could not consent to the confinement required to bring about the treatment, involving extensive physical restraint of C. We would also suggest that, even had such restraint not been in contemplation, the Trust would have been on very thin ice indeed seeking to rely upon parental consent to override the refusal of a capacitous 17 year old. Lady Hale described that proposition in *Cheshire West* as "controversial;" we suggest that it is not merely controversial, but actively improper.

Best interests and clinical circling of the wagons

Birmingham Women's and Children's Hospital NHS Foundation Trust v KB & Ors [2024] EWHC 3292 (Fam) (High Court (Family Division)(Morgan J)

Other proceedings – Family (public law)

Summary[4]

This case concerned a 10 year old girl with a rare genetic condition which had affected her since birth and caused profound disability. She had development delay and was unable to speak or sit independently. She had impaired vision but her hearing was intact. She was fed artificially. Her older brother had the same condition and had died shortly after his first birthday. At the time of the hearing, F had been in intensive care for over a year, following an infection and then the displacement of her nasogastric tube which cause her to aspirate. The treating doctors sought declarations that it was no longer in her best interests to receive ventilation, but instead for her to be extubated and allowed to die. She had previously had a number of PICU admissions, sometimes requiring invasive ventilation. Her parents opposed the application, but the Guardian supported the Trust. Unusually in such cases, there was an alternative option to the child simply remaining in intensive care until

[4] Katie having been involved in the case, she has not contributed to this.

she died – her respiratory needs were sufficiently stable for her to have a tracheostomy and to be discharged home on long term ventilation. The court held that it was in F's best interests to receive long term ventilation at home. The burdens to her were from the medical interventions required to keep her alive, such as suctioning, rather than her underlying condition. There were some risks from having a tracheostomy, and F was at the more severe end of patients who were cared for at home on long term ventilation. There would be a period of some months before long term ventilation was established and she could return home. But she was likely to have views about her continued treatment that aligned with her parents, in light of their religious and cultural beliefs, and she had a level of conscious awareness that meant she could feel pain, but she could also benefit from being with her family and enjoying activities such as spending time in the garden with them or on short outings.

Morgan J found that the senior clinicians at the Trust had previously underestimated F's ability to experience pleasure, having regard to the parents' evidence and the notes of other professionals such as play facilitators who had spent time with F and who had reported many examples of her expressing pleasure and excitement earlier in her admission. At the time of the hearing, Morgan J found that F was able to respond to her family and other people, including by smiling, and was more responsive when they or others spoke to her in her first language, and that she was able to experience pleasure, albeit in a limited way – as had been the case throughout her life due to her disabilities.

Morgan J did not accept that there was clear evidence of significant neurological decline over the period of the admission, noting that there were other possible explanations for a change in F's presentation and a lack of evidence to show there had been marked neurological decline.

Morgan also expressed concern about the transparency of decision-making by the Trust and the failure to keep minutes of MDT meetings at which parents are not present, identifying at paragraph 141 a real risk that:

> *Consciously or otherwise, most likely otherwise, if a professional has arrived already at a conclusion in their own mind that a child's best interests are served by palliative care path to death, there is, as I see it, a real risk that that may affect the lens through which things like awareness and responsiveness are viewed. Assessment of those aspects is more subjective and less susceptible to calibrated measurement than other physiological assessments. There is in my judgment a danger that that risk is magnified when a group of people who have arrived at the same view following discussions reinforce each other. As it happens, there has been a want of transparency as to how decisions have been made and the discussion which has led to them. That is not satisfactory but it is a subtly different point to the anxiety I have, surveying the totality of the evidence that is before me, about how awareness, responsiveness, and benefits have been weighed in the balance by those looking at Fatima's life, who have already reached a decision to invite the Court to declare it lawful for that which sustains it to be withdrawn.*

Comment

It is relatively unusual for there to be two treatment options in respect of an application to withdraw invasive ventilation – often the position is that there is no realistic prospect of the patient leaving intensive care or being discharged from hospital. Morgan J found the decision to be

finely balanced, but ultimately decided that the benefits of life to F had been undervalued, not just by the treating doctors but also – notably – by the Guardian.

Morgan J was clear that, although the medical evidence of the burdens of treatment was relevant and important, the wider considerations about the child's quality of life, having regard to emotional and psychological factors, had to be fairly considered, and set in the context of the child's previous life experiences.

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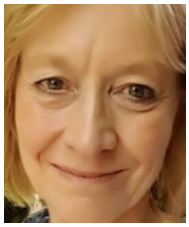

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Conferences

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

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

Advertising conferences and training events

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

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

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