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Shared Insights

Mental capacity, care and consent: Applying the legal framework in practice

Speakers

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Marilyn Whittle – Legal Services Director at Sheffield Children's NHS Foundation Trust
Richard Colley – Hospital Liaison Committee (HLC) Chairman, HLC for Jehovah's Witnesses
Emma Sutton KC – Serjeants' Inn Chambers

NHS Sheffield Children's NHS Foundation Trust



Browne Jacobson

Introduction

This Shared Insights session, chaired by Rebecca Fitzpatrick, Partner and Head of the Advisory and Inquest team at Browne Jacobson, brought together a panel of experts to explore the legal framework governing mental capacity, care and consent.

The session covered a broad range of topics at the intersection of law, clinical practice, and ethics. The panel spoke about a young Jehovah's Witness patient with cancer, exploring how clinical teams, the Hospital Liaison Committee, and the courts worked together to support the patient and their family and secure a successful outcome. The session also examined the legal framework governing neglect, drawing on relevant legislation and case law, and considered how capacity and best interests interact in complex real-world scenarios. Further discussion addressed recent and significant case law developments, including the AGNI judgment on deprivation of liberty and the Epsom and St Helier Supreme Court appeal, with practical top tips offered to practitioners on documentation, multidisciplinary working, and when to seek early legal advice.

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How we can help

Browne Jacobson is proud to offer a team of specialist healthcare lawyers providing legal services to NHS bodies, local authorities, commissioners and independent healthcare providers. Our team has a wealth of experience in consent to treatment cases involving both adults and children, mental health law, mental capacity law and safeguarding making us well-equipped to provide expert advice on a broad range of legal issues. This includes:

- Consent to treatment for both adults and children, including when a patient refuses to consent.
- Assessing an individual's capacity to make treatment decisions and a child's Gillick competence to make decisions relating to their healthcare.
- The interaction between the Mental Health and Mental Capacity Acts.
- Advice and representation in health and welfare cases before the Court of Protection, including serious medical treatment and end-of-life cases.
- Advice on deprivation of liberty – whether a deprivation exists and how to authorise it.
- Safeguarding.
- Training for health and social care staff on the Mental Capacity Act and deprivation of liberty. We offer specialist on-demand, consent training, developed to help Trusts embed legally robust consent practices organisation wide. The programme includes on-demand video modules, consent FAQs and a practical legal toolkit.

Jehovah's Witnesses, blood transfusions and the role of the Hospital Liaison Committee (HLC)

Marilyn Whittle – Legal Services Director at Sheffield Children's NHS Foundation Trust
Richard Colley – HLC Chairman

Marilyn opened by setting out the key questions she works through whenever a clinician contacts her with concerns about a Jehovah's Witness patient and the potential need to go to court. These include:

- The patient's age.
- Their capacity or Gillick competence.
- What discussions have already taken place with the patient and their family, and whether they have been given time to process this.
- The urgency of the situation.
- Treatment options available, including whether "usual" options can be altered to minimise the use of blood products, and what blood products are available.
- The risks and benefits of each option.
- Whether the HLC is involved.

Marilyn emphasised the importance of retaining a relationship with the family throughout, noting that it is key for everyone to work from the same page and appreciate differing point of view, even if there is disagreement.

Richard then explained the role of the HLC. The HLC is a free resource and global support network for Jehovah's Witness patients and the clinicians and legal teams looking after them. There are 36 HLCs in the UK and Ireland with 500 members, and over 2,000 HLCs globally. The HLC is available 24 hours a day and offers both on-site and remote support.

Richard explained that the best outcomes are achieved not just by being there in emergencies, but by building relationships with the medical teams beforehand. He spends a lot of time at the hospital, meeting consultants and discussing the core beliefs of what Jehovah's Witnesses can and cannot consent to.

On September 18 2026, Jehovah's Witnesses announced that each Witness patient will personally decide whether to accept transfusions of allogeneic (donor) red blood cells, white blood cells, plasma, or platelets. Their religious position against the transfusion of whole blood, based on the Biblical command to "abstain from blood," remains unchanged. Individual Witnesses or their parents will also make their own informed decision about plasma derivatives. There is no religious connection to using the patient's own blood and so an individual or their family will decide whether to consent to this.

Richard noted the importance of discussing all the options and the patient's views before an emergency arises. The HLC can be present at the consultation in a supportive capacity if the patient or their family so wishes. The HLC can also supply the latest peer-reviewed medical papers on alternatives and facilitate consultant-to-consultant discussions globally if required.

Case study

Marilyn and Richard then walked through a case study, involving a young Jehovah's Witness patient who had lymphatic cancer when he was younger and who was later diagnosed with Stage 4 Hodgkin's lymphoma. Two Trusts were involved for chemotherapy and a stem cell transplant, and the treatment could not safely be delivered without the option of a blood transfusion. The young patient was considered by clinicians to be competent – he understood what was being proposed and why it was extremely serious – but neither he nor his family could consent to blood and blood products, only to the chemotherapy and other treatment. The clinical team felt a court order was needed.

The case was complex because there was no medical literature about a young person having both types of cancer. The HLC helped the oncologists access global research through their network, spent time with the patient, and supported him at the consultation to articulate his views. The HLC discussed with the haematologist what alternatives were available, including TPO-Mimetics and erythropoiesis-stimulating agent support. Because the treatment involved a stem cell transplant, and stem cells are usually stored in plasma, the HLC asked whether they could be stored in albumin instead, and the team did everything they could to accommodate this. Plans were made to minimise the need for blood product support, including giving drugs to stimulate red blood cell production and tranexamic acid to reduce bleeding, and setting lower thresholds for transfusion.

A court application was made, and the patient wrote to the Judge setting out his views and reasons for refusal. His mother also provided evidence, explaining that she wanted her son to have cancer treatment but could not consent to the blood transfusion. She paid tribute to the treatment and care provided by the entire team. The Judge ultimately made a declaration that it was in the patient's best interests to receive blood if required, trusting the medical professionals to keep the amounts as low as possible. A blood transfusion was eventually needed, but the HLC was present throughout that process, supporting the mother. When the patient was transferred back to the other hospital, the HLC there took over and supported him through his recovery. It was a great team effort to try get the best outcome for the patient.

In response to a question about how to support an individual with that deeply held beliefs, Richard said that the HLC offers non-judgemental support, standing alongside patients and families as trusted friends through an exceptionally difficult time.

On the question of resource implications and cost, Marilyn noted that HLC involvement means that calls to her from medics are now far less frequent because alternatives to blood products have already been explored. HLC involvement has also meant that there have been no difficult courtroom disputes, which has likely saved a significant amount of cost and time.

Resources

- Bloodless Medicine | Blood Transfusion Alternatives | JW.ORG Medical Library
- Jehovah’s Witnesses | Hospital Liaison Committee Contact: United Kingdom
- Medical Information for Clinicians of Jehovah’s Witnesses
- Caring for Patients who Refuse Blood — Royal College of Surgeons
- Anaesthesia and peri-operative care for Jehovah’s Witnesses and patients who refuse blood | Association of Anaesthetists
- Jehovah’s Witnesses and Family Life | Global Information Brochures

Neglect in health and social care settings

Victoria Colclough – Partner
Emma Sutton KC – Serjeants' Inn Chambers

Victoria explained that the law on neglect is spread over the Mental Capacity Act 2005, the Care Act 2014 (section 42: safeguarding enquiry, section 44: criminal offence, wilful neglect), human rights law, safeguarding law and a relatively small but important body of Court of Protection (COP) decisions. Part 7 of the Social Services and Well-being (Wales) Act 2014 deals with safeguarding in Wales.

There is no line of authority called "neglect cases" – many cases involve neglect as part of a wider dispute about residence, care, an attorney's suitability to act, safeguarding or deprivation of liberty issues. Where neglect is alleged, the critical questions is not simply "is P being neglected?" but rather "what decision does P lack capacity to make, who has authority to make it, what does P's best interests require and what lawful mechanism exists to secure that outcome?"

The existence of poor care or risk does not automatically determine best interests. Neglect is not the same as making an unwise decision. If P has capacity to make the relevant decision, the COP cannot substitute its own view.

Self-neglect cases can be legally very difficult – the fact that someone's living conditions, hygiene, nutrition or medical care are extremely poor do not in themselves establish incapacity. It is often a case of looking at what is "good enough". The statutory Care Act guidance also distinguishes self-neglect from neglect by another person. Victoria referenced our previous Shared Insights session on self-neglect in health and social care settings, which can be accessed here.

Emma highlighted a number of key cases in this area:

- *Re RG* [2015] EWCOP 66*:* Demonstrates that neglect can come in many shapes and sizes and does not have to involve deliberate, physical abuse. It's certainly more difficult to prove emotional and psychological abuse, as you don't have cuts and bruises as evidence.
- *Re SH* [2016] EWCOP 2*:* Revoking a health and welfare Lasting Power of Attorney (LPA) due to neglect does not necessarily mean a welfare deputy needs to be appointed. The COP will consider whether a deputyship is necessary, remembering that intervention should be no greater than required.
- *The Public Guardian v AM* [2015] EWCOP 86: The neglect question cannot always be separated neatly into "welfare" and "property" cases – the two aspects can overlap. If there is financial abuse, which results in a depletion of P's resources, there may be an inability to fund care and a neglect of P's welfare.
- *The Mental Health Trust & Ors v DD & Anor* [2015] EWCOP 4 (drawing on *Re Z (Local Authority: Duty)* [2004] EWHC 2817 (Fam)): This is a good case for a "cut and paste" summary of public authority duties towards a vulnerable person at risk of neglect – see paragraphs 22 to 28 of the judgment.
- *G v E* [2010] EWHC 621 (Fam): Good intentions do not make unlawful interventions lawful, i.e. a public authority cannot say that it acted to protect a vulnerable person and did not need to comply with the requirements of the MCA and the ECHR. In this case, there had been no authorisation for P's deprivation of liberty – the local authority's reasons for this were irrelevant, it was still unlawful.
- *Kent County Council v P* [2022] EWCOP 3: The factual circumstances in which neglect can generate a COP application can include malnutrition and poor parental care.
- *Re PS* [2024] EWCOP 42: There is a need to differentiate between deliberate neglect and someone trying their best but not being able to meet P's needs – though the dividing line can be difficult to distinguish.
- *AR* [2026] EWCOP 45: Public bodies must think carefully before raising allegations – it's necessary to distinguish between past neglect and what's happening now. Avoid assuming allegations of past neglect automatically dictate future welfare decisions.

- *A Local Authority v A* [2010] EWHC 978 (Fam): A public authority cannot "rescue" P – it must obtain appropriate judicial authority. Safeguarding duties do not simply give a public authority a power to control, restrain or confine an incapacitated adult.

Most of these cases are from the COP. If there is an issue in relation to P's capacity, then it's possible to make an application to the COP, but **not** if P has capacity. The inherent jurisdiction of the High Court can be used as the "great safety net", but a justification is required for using that route and P must be sufficiently vulnerable. Arguing that P is vulnerable due to a learning difficulty or brain injury is not likely to be sufficient – there needs to be an additional element such as abuse, coercion or undue influence. Record keeping is key to demonstrating this.

Deprivation of Liberty post AGNI

Emma was Lead Counsel for the Official Solicitor in the Attorney General for Northern Ireland reference case ([2026] UKSC 16), known as AGNI. This judgment was handed down on 2 June 2026 and has had huge ramifications across the health and social care sector.

The Supreme Court identified a prisoner confined to a cell as the paradigm example of a deprivation of liberty (DoL). It held that a person must be sufficiently close to that paradigm to be regarded as deprived of their liberty. As a result, significantly fewer people are likely to meet the threshold for a DoL following this judgment.

Ultimately, the judgment says that assessing whether someone is deprived of their liberty is now a multifactorial approach and assessors must consider all relevant circumstances. Importantly, the Court said there is some overlap between the objective and subjective elements and the individual's attitude towards the arrangement will therefore be relevant. A person who does not have capacity to consent to their care and living arrangements may nevertheless be able to give valid consent to their confinement, if they have sufficient understanding of their arrangements and are able to express that they are happy with them.

Some helpful post-AGNI resources are as follows:

- Department of Health & Social Care guidance (DHSC) on what constitutes a deprivation of liberty – the most important guidance for both England and Wales
- CQC statement on the Supreme Court's judgment on deprivation of liberty
- Note for Re X judges – Senior Judge Hilder, 2 June 2026
- The Association of Directors of Adult Social Services (ADASS) guidance**:** Updated note following DHSC guidance
- ADASS Deprivation of Liberty Safeguards (DoLS) priority tool
- Practical guide to DoLS referrals – West Midlands ADASS, 7 July 2026
- Considering deprivation of liberty after AGNI – West Midlands ADASS, 8 July 2026
- DoLS signatories' newsletters (aimed at those who sign off DoLS authorisations)
- Local-authority guidance from individual local authorities, e.g. Hampshire County Council, Cambridgeshire County Council and London Borough of Havering (these are local operational guidance, not statements of law)
- Supreme Court overrules Cheshire West: Deprivation of liberty law reshaped for health and social care settings – Browne Jacobson article, 3 June 2026

NHS England was due to publish an updated DoLS e-learning module by July 2026, although this has not happened.

COP judgments have now been published post AGNI, which demonstrate how the judges are applying the multifactorial assessment. The key cases (at this time of preparing this document) are:

- *NHS Leicester, Leicestershire and Rutland ICB v AA [2026] EWCOP 56 (T1)* – 15 October 2026 (Tribunal Judge Sharron): The court found a man living in a supported living placement to be deprived of his liberty. The judge focussed particularly on the medication being prescribed and the concept of "relative normality".
- *TW v Worcestershire County Council [2026] EWCOP 54 (T2)* – 9 September 2026 (HHJ Tindal): The court found a woman living in a supported living placement, who was actively objecting and "experiencing coercion", to be deprived of her liberty.

- *Re PK & MK (Article 8 Protections) [2026] EWCOP 52 (T2)* – 8 October 2026 (HHJ Burrows): The court found that twins living in a residential placement were not deprived of their liberty The judge considered what Article 8 protections remain when Article 5 is not engaged.
- *Derby City Council v SM [2026] EWCOP 46 (T2)* – 3 September 2026 (HHJ Sue Williscroft): The court found that a woman living in a supported living placement was not being deprived of her liberty. The judge held that if P is not objectively confined, then lack of valid consent will not turn the situation into a DoL.
- *Essex CC v MH* [2026] EWHC 2328 (Fam) – 10 September 2026 (Theis J): The court found that a 15-year-old girl, ST, living in a residential placement was being deprived of her liberty, particularly because of the level of supervision, locked doors and windows and the way those restrictions were experienced by her, which she objected to.
- *Salford City Council v AR* [2026] EWCOP 45 (T2) – 4 September 2026 (HHJ Burrows): The court concluded that the substantial restrictions placed on a 25-year-old man with a moderate to severe learning disability and autistic spectrum disorder at a supported living placement did not amount to objective confinement such that Article 5 was not engaged and he was not deprived of his liberty.
- *Argyll and Bute Council v RF* [2026] EWCOP 41 (T3) – 19 August 2026 (Theis J)
- *Re Mustafa (A Child)* [2026] EWHC 2159 (Fam) – 12 August 2026 (Mr Recorder Jack)
- *Oxford CC v P* [2026] EWCOP 33 (T2) – 24 July 2026 (HHJ Owens)

The Epsom and St Helier v Townsend appeal

Emma has been instructed as Leading Counsel to act on behalf of the NHS Trust in the Supreme Court case of *Epsom and St Helier University Hospitals NHS Trust v Townsend*. This is an extremely important case, since the previous Court of Appeal decision has caused real issues and confusion on the ground.

The Court of Appeal previously held that it is not possible to carve out "clinical decisions" from best interests. For a person who lacks capacity, a clinician cannot say that a treatment option is not available because it is not clinically appropriate – all treatment options are subject to a best interests analysis. Therefore, if there is a dispute over whether a treatment option is in a person's best interests, the matter needs to come before the court – even if that option is not thought to be clinically appropriate and therefore not available. This goes against fundamental medical law and the inability of a court to compel a doctor to provide a certain level of treatment to a patient that they are not willing to. The Supreme Court appeal will be heard in January 2027, after which it is hoped there will be some clarity. Emma shared her "top tips" pending the decision from Supreme Court:

- The best interests process needs to be more explicit – ensure there is rigorous documentation of the conversations that have taken place and the decisions made.
- Ensure greater involvement with families from the outset, with meaningful explanations and discussions that are carefully documented.
- Try hard to seek agreement with the family about treatment options – involving them early in discussions will help with this.
- Lower the threshold for legal advice and seek to mediate. Where disagreements persist, seek legal advice quickly.
- Documentation is now more important than ever. Clinical records should distinguish between clinical appropriateness and best interests.
- Ensure multidisciplinary working and second opinions – sooner rather than later!

Questions

A delegate asked a question about the "communication" aspect of the capacity assessment under the MCA. If P is unable to communicate verbally but can via Discord, is that acceptable? The panel confirmed that, provided there is evidence of P understanding and retaining the information that has been given to them, and the assessor is satisfied that it is P who is communicating via Discord, then that is fine. There have been cases where P has communicated via blinking. Therapists are often coming up with inventive means to enable patients to effectively engage with the assessment process and communicate their decision.

Key takeaways

- When treating Jehovah's Witness patients, early engagement with the patient, their family and the HLC is essential. The HLC is a free, 24-hour global resource that can facilitate access to peer-reviewed research, alternatives to blood products and consultant-to-consultant discussions.
- On 18 September 2026, Jehovah's Witnesses announced that each Witness patient will personally decide whether to accept transfusions of allogeneic red blood cells, white blood cells, plasma or platelets. Their religious position against the transfusion of whole blood remains unchanged.
- There is no line of authority called “neglect cases” – many cases involve neglect as part of a wider dispute about residence, care, an attorney’s suitability to at, safeguarding or deprivation of liberty. The critical questions are: what decision does P lack capacity to make, who has authority to make it, what do P's best interests require, and what lawful mechanism exists to secure the outcome? Poor care or risk does not automatically determine best interests, and self-neglect is legally distinct from neglect by another person.
- The AGNI judgment ([2026] UKSC 16) has fundamentally reshaped deprivation of liberty law. A multifactorial assessment of all relevant circumstances is now required, and significantly fewer individuals are likely to meet the threshold for a deprivation of liberty. A person who lacks capacity to consent to their care arrangements may nevertheless give valid consent to their confinement if they have sufficient understanding and are content with the arrangements.
- The Supreme Court appeal in *Epsom and St Helier University Hospitals NHS Trust v Townsend* is to be heard in January 2027. The Supreme Court will consider whether there is an obligation on an NHS commissioning body to apply to the Court of Protection to resolve disputes about medical treatment (including life-sustaining treatment) where the treatment sought on behalf of an incapacitated patient is not being offered by the patient’s treating clinicians because they have concluded that such treatment is clinically inappropriate.
- Rigorous documentation is more important than ever. Clinical records should distinguish between clinical appropriateness and best interests. Practitioners should ensure meaningful family involvement from the outset, multidisciplinary working and second opinions, and prioritise mediation. Where disputes cannot be resolved between clinicians and patients and/or their families, seek legal advice at an early stage.
- Communication for the purposes of a capacity assessment under the Mental Capacity Act 2005 is not limited to verbal communication. Alternative means – including digital platforms and non-verbal methods – may be acceptable provided the assessor is satisfied that P understands and retains the relevant information and that it is P who is communicating.

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