This judgment was delivered in open court but a transparency order is in force. The judge has given leave for this version of the judgment to be published on condition that (irrespective of what is contained in the judgment) in any published version of the judgment the anonymity of the applicant and members of her family must be strictly preserved. All persons, including representatives of the media, must ensure that this condition is strictly complied with. Failure to do so may be a contempt of court.

Neutral Citation Number: [2026] EWCOP 29 (T3)

Case No: 14028041

IN THE COURT OF PROTECTION (TIER 3)
IN THE MATTER OF THE MENTAL CAPACITY ACT 2005
IN THE MATTER OF THE MENTAL HEALTH ACT 1983

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 23/07/2026

Before :

MR JUSTICE PEEL

- -

Between :

Patricia (by her Accredited Legal Representative) **Applicant**

- and -

(1) Cygnet Healthcare Ltd
(2) Patricia's father
(3) Patricia's mother
(4) Patricia's aunt

Respondents

- -
- -

Parashil Patel KC (instructed by **Irwin Mitchell LLP**) for the **Applicant**
Katie Gollop KC (instructed by **Cygnet Healthcare Ltd**) for the **First Respondent**

Hearing date: 8 July 2026

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Approved Judgment

This judgment was handed down remotely at 10.30am on 23 July 2026 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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MR JUSTICE PEEL

Peel J:

1. The hearing before me is listed to determine whether the Court of Protection, pursuant to its jurisdiction under the Mental Capacity Act 2005, has jurisdiction to make the orders sought by the Applicant, to whom I shall refer (following the practice in previous judgments) as Patricia. The specific application, made on 30 June 2026, is for the following:

   "a. An order that Patricia has capacity to decide whether to accept calories by way of forcible feeding or orally.

   b. It is not in her best interests, and is contrary to Article 3 ECHR for her to be subject to further forcible feeding.

   c. It is a breach of her Article 3 and Article 8 rights for Cygnet Hospital….to have refused to obtain an independent second opinion in respect of the use of forced feeding"

2. The application came before Theis J on 3 July 2026, who listed today's hearing to "determine whether the Court of Protection has jurisdiction to make the orders sought by the Applicant".

3. Present and represented before me are:

   i) The applicant, Patricia.

   ii) Cygnet Healthcare Ltd. ("Cygnet"), the Respondent hospital operator.

4. An application was made in advance of the hearing by Patricia's mother, father and maternal aunt to be joined to the proceedings. Pro bono counsel has helpfully prepared a skeleton argument. None of these family members, or their counsel, were able to attend the hearing. At the outset of the hearing, I directed that they should be joined.

5. The position of the parties is as follows:

   i) Patricia asserts that the Court of Protection has jurisdiction to make best interests decisions under the Mental Capacity Act 2005 ("MCA 2005"), notwithstanding

that she is presently detained under s3 of the Mental Health Act 1983 ("MHA 1983).

ii) Cygnet and the family dispute that assertion.

6. Patricia is a 26 year old woman with diagnoses of anorexia nervosa (confirmed in 2010), autism with impaired sensory integration and a profile of Pathological Demand Avoidance. In proceedings in 2023, Moor J said "There is no doubt that Patricia suffers from anorexia nervosa. It has made her extremely ill indeed. I take the view that she is and has been perilously close to death. There is also no doubt whatsoever that over ten years of treatment has simply not worked, including compulsory treatment, treatment in a number of different settings and at a number of different times over a prolonged period".

7. Patricia is detained under s3 of the MHA 1983 in a hospital operated by Cygnet. Until 1 July 2026, she was receiving nutrition via a mix of oral intake and nasogastric feeding. Since 1 July 2026, at the direction of her Responsible Clinician, and against Patricia's wishes, oral intake has ceased, and the provision of nutrition has been entirely by nasogastric tube ("NGT"), accompanied by restraint and sedative medication. Exclusive Enteral Nutrition ("EEN") takes place twice a day. This regime has been implemented because the previous treatment plan was not working and Patricia was not putting on sufficient weight. I understand that this is the first time in 17 years of treatment that she has received nutrition entirely via tube feeding. It is not disputed that Patricia strongly objects to the change to full NGT feeding, which she says causes her severe physical and psychological distress. She continues to be willing to take food and drink orally. She says that she is not opposed to treatment in principle; she objects to what she describes as a false choice between forced feeding and no feeding. She sets out in her witness statement a number of suggestions as to how her treatment plan should be modified, as part of what she describes as a "completely different framework from anything that has previously been tried". Cygnet say that if the forcible feeding is brought to an end by court determination, they will simply not be able to treat Patricia, and life threatening consequences for her will ensue. Anything short of EEN would not be workable or clinically appropriate.

8. There have been two previous sets of proceedings in the Court of Protection.

i) The first set of proceedings was brought by the relevant NHS Trusts in 2023. Patricia was in a general hospital; she was not detained under s3 of the MHA 1983. The Trusts sought a declaration, which Patricia supported, that she should not be fed by NGT under compulsion. In May 2023, Moor J agreed to make that declaration. In October 2023, Moor J confirmed that the declaration was intended to be a general one, not limited to her hospital admission in May 2023. During the proceedings, Patricia was deemed to have capacity to conduct the proceedings but not to make decisions about treatment. After the decisions, Patricia was discharged home, but subsequently re-admitted to an acute hospital and specialist care was commissioned for her. Eating Disorder Units were sought, but I understand there was some reluctance to admit Patricia given the prohibition under Moor J's order against feeding by compulsion.

ii) In 2025, Patricia's parents and aunt applied to set aside the declaration made by Moor J, believing that Patricia was about to be discharged to a palliative care

setting to die. They wanted to restore the medical option of forced NGT feeding. She was perilously unwell, with a BMI of 7. However, her will to live remained strong and she made it clear that she did not wish to die. The application was heard by Arbuthnot J who decided to discharge Moor J's order so that there was no barrier to compulsory feeding. There was no medical consensus as to whether forcible feeding would be successful. Nor was there, at the time, an available eating disorder placement, nor a choate care plan. Patricia was not detained under s3 of the MHA 1983. Arbuthnot J was satisfied that there had been a change of circumstances since the 2023 proceedings, in that the treatment plan (without any forced feeding) had been shown to have failed. She also considered that discharging the previous order would give better prospects of an appropriate placement being secured. Arbuthnot J said the following in her judgment dated 31 July 2025 (reported as **Patricia's Father & Ors v Patricia & Ors [2025] EWCOP 30 (T3)**):

"161. I am conscious that a decision to revisit the orders made in 2023, will cause Patricia a very great deal of distress but it is right in principle and in Patricia's best interests that I look at her situation and circumstances again, when the autonomy given to her by Moor J has laid an impossible burden on her.
171. I am not being asked to consider what specific treatment she will receive in any SEDU and I agree that that question should be left to the clinicians treating her. My view is that Patricia should have access to the treatment or lack of treatment that any other anorexic patient does. The court should not impose an order which would prevent her from having the treatment which may save her life when she wants to live. I hope that once she gets to a SEDU she will work to increase her BMI within a collaborative treatment plan which will take into account her autism. This will allow her to achieve the aims she has spoken about.
172. All sorts of treatments have been attempted before and there is not much optimism that Patricia can be saved. Any SEDU which can care for her, needs the flexibility which will be given by the removal of the orders.
179. The best that the court could hope for is that she gains weight a little, increases her BMI, so she does not spend her life in hospital or a SEDU, although the evidence from the past was that if she were treated and increased her weight, it might well reduce again when she leaves the facility.
181. I have had to balance the factors set out above and consider Patricia's Article 3 right not to be treated inhumanely when she believes strongly that force feeding will breach her rights. I remind myself I am not being asked to make an order that she be force fed, but to lift the orders which would then allow SEDUs to decide what is the appropriate treatment for this young woman who wishes to live.
182. Having considered the balance of the imminent risk of death versus the harm which will be caused psychologically and emotionally by the lifting of the orders, the balance is in favour of trying to save her life. The removal of the orders will allow the clinicians to work out what is best for Patricia, without the restrictions that currently prevent this."

9. The consequence of the order was to permit the hospital to feed Patricia by NGT with restraint to the extent thought clinically appropriate. The judge was aware of Patricia's

opposition to forced feeding, the engagement of Articles 2, 3 and 8 of the ECHR, and the likelihood that Patricia would be subject to detention under s3 of the MHA 1983.

10. In September 2025, Patricia was admitted to the Specialist Eating Disorder Unit at the Cygnet Hospital under s.3 of the MHA 1983, and she remains a patient there on the same basis. The basis of the detention is that her anorexia nervosa is of a nature and degree that makes it appropriate for her to receive medical treatment in hospital, it is necessary for her health and safety that she should receive that treatment, and it cannot be provided unless she is detained. She sought discharge from detention under the MHA 1983 through the First Tier Tribunal but this was refused on 18 March 2026. Until recently, her treatment included a meal plan mainly consisting of nutrition supplement drinks four to five times a day, and in the event she could not comply with the full required calorie intake, forced NGT feeds were administered. She has round the clock supervision and under s17of the MHA 1983, leave is only permitted within the hospital grounds. The frequency of forcible feeding has increased over time, culminating in the decision to move from 1 July 2026 to feeding entirely by NGT, with no oral intake.

11. The core dispute therefore is between Cygnet, which seeks to continue forcible feeding, and Patricia, who wishes not to be subject to forced feeding. That is the context for what was, before me, a technical argument about whether this court has any powers to make orders on Patricia's application. Although technical, it is important, and I am acutely aware of the intensely personal nature of the experiences of Patricia.

12. For completeness, I should add that Cygnet has given the commissioning body 28 days notice that that it cannot continue to treat Patricia, for reasons which have nothing to do with her conduct, condition or treatment. The relevant bodies or groups with responsibility for finding an alternative placement have been notified of the proposed discharge, and are tasked with finding an alternative placement.

13. When this application was issued, Patricia's solicitor considered that Patricia had capacity to provide instructions. She was represented directly on 3 July 2026 before Theis J. Since then, on 7 July 2026, a capacity assessment was undertaken by the Responsible Clinician at Cygnet Hospital, and concluded that she lacks litigation capacity. Patricia's solicitor informed the Official Solicitor who did not have the time to make arrangements for this hearing. I was invited to appoint Patricia's solicitor as an accredited legal representative under rule 1.2(4)(b) of the Court of Protection Rules 2017. I approved the application. Counsel and solicitors for Patricia are familiar with the case, and were in a position to proceed with the hearing. Counsel for Cygnet had no objection. It was clearly appropriate, and in accordance with the overriding objective, to exercise my powers to make the appointment. The alternative was to adjourn the hearing so that the Official Solicitor could take up the reins which the parties and I did not consider to be desirable.

14. I am very grateful to Mr Patel KC and Miss Gollop KC for their helpful and high quality submissions in this sensitive and difficult case.

15. It seems to me that the issues which go to the question of jurisdiction are as follows:

    i) Does Patricia have capacity to make feeding treatment decisions? If so, the Court of Protection proceedings fall away.

ii) If not, does the Court of Protection have jurisdiction to make best interests decisions about the medical treatment currently being provided, given the combined provisions of (i) s28 of the MCA 2005 and (ii) s63 and s145(4) of the MHA 1983. I think in fact this is perhaps better framed as whether the Court of Protection has power to make such decisions rather than jurisdiction, although it comes to the same thing in practice. Counsel tell me that, as far as they are aware, this point has not been fully considered in a reported authority and is therefore a novel one.

16. I take these in turn.

Capacity

17. The first issue is whether Patricia lacks capacity to make decisions about feeding treatment.

18. In the 2023 proceedings, it was common ground that she had capacity to conduct litigation, and as a result instructed her own lawyers. The judge concluded, however, that she did not have capacity to take decisions as to her medical treatment. In the 2025 proceedings, the judge said at paragraph 27 of her judgment that "It is not disputed by the parties that there is reason to believe that Patricia does not have capacity to conduct the litigation for herself and to make decisions as to her medical treatment for Anorexia Nervosa".

19. In her witness statement in this application, Patricia explains that she believes she has capacity both to conduct proceedings and to make decisions about feeding. .

20. In November 2025, and again in February 2026, the Responsible Clinician's capacity assessment concluded that Patricia lacked capacity to make feeding treatment decisions.

21. The updated capacity assessment by the Responsible Clinician dated 6 July 2026 concluded that Patricia lacks capacity to conduct proceedings, but did not address capacity in respect of medical treatment (I understand he was not asked to do so).

22. Although I have not been invited to make a final determination on this, I am satisfied that at the very least, under s48 of the MCA 2005 and on an interim analysis, there is reason to believe that Patricia lacks capacity (i) to litigate and (ii) to make decisions about medical treatment referable to feeding. That being so, she comes within the provisions of the Mental Capacity Act 2005, and falls under the auspices of the Court of Protection.

The interplay of s63 of the MHA 1983 and s28 of the Mental Capacity Act 2005

23. The fact that Patricia is incapacitous, and therefore subject to the Court of Protection, does not mean that the powers of the Court of Protection to make decisions are unlimited. In particular, there is a clear demarcation of power and responsibility between the MCA 2005 and the MHA 1983. It is perhaps, by way of context, worth repeating what Lieven J said in in **Re JK [2019] EWHC 67 (Fam)** at para 66:

"The MHA gives the power to decide whether to compulsorily treat a patient to the responsible clinician and not to the Court. This is a fundamentally different scheme to

that in the MCA where many decisions are given by statute to the court. The difference makes sense because the MHA is a statutory scheme for, inter alia, detention and compulsory treatment in the public interest, where the responsible clinician has a specific role in the statutory scheme. There is no statutory process in the MHA to question the decision of the clinician. However, if the clinician decides to impose treatment, then the individual can judicially review that decision."

24. Although the written skeleton argument of Mr Patel KC covered a number of matters, at its core, in my judgment, his submission is that the combination of s63 of the MHA 1983 and s28 of the Mental Capacity Act 2005 enables the Court of Protection to make unfettered best interests decisions in respect of the appropriateness or otherwise of the feeding regime to which she is subject under the MHA 1983. Or, putting it another way s28 of the MCA 2005 does not, properly read, exclude the Court of Protection from making a best interests decision in respect of the medical treatment for a mental disorder given to Patricia under s63 of the MHA 1983.

25. Neither counsel was able to find a case where the interplay between these two sections has been fully considered. It could affect a number of cases where a patient is detained subject to s3 of the MHA 1983, and is receiving treatment under s63 of the MHA 1983 to which the patient objects. If Mr Patel KC is right, where the patient is (or there are reasonable grounds to think that they may be) incapacitous, the Court of Protection (i) can exercise scrutiny over such treatment and (ii) can make a best interests decision in respect of such treatment. He emphasised, rightly, that I am not concerned with the merits of such matters. I am only concerned with whether the court in principle has the power to exercise jurisdiction over the treatment plan of Patricia.

26. The starting point, submits Mr Patel, is that under ss15-17 of the MCA 2005, the Court of Protection is entitled to make declarations and best interests decisions in respect of Patricia, which include, at s17(d) the giving or refusing consent to the carrying out or continuation of a treatment by a person providing health care for P. He emphasises the well established breadth of the jurisdiction in the Court of Protection to make a best interests decision, which I readily accept.

27. S3 of the MHA 1983 provides (so far as relevant)as follows:

"3 Admission for treatment.

(1) A patient may be admitted to a hospital and detained there for the period allowed by the following provisions of this Act in pursuance of an application (in this Act referred to as "an application for admission for treatment") made in accordance with this section.

(2) An application for admission for treatment may be made in respect of a patient on the grounds that—

(a) he is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital; and

(b)

(c) 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

(d) appropriate medical treatment is available for him.

(4) In this Act, references to appropriate medical treatment, in relation to a person suffering from mental disorder, are references to medical treatment which is appropriate in his case, taking into account the nature and degree of the mental disorder and all other circumstances of his case".

28. S63 of the MHA 1983 provides as follows:

"The consent of a patient shall not be required for any medical treatment given to him for the mental disorder from which he is suffering, not being a form of treatment to which section 57, 58 or 58A above applies, if the treatment is given by or under the direction of the approved clinician in charge of the treatment."

29. S145(4) of the MHA 1983 (under the Interpretation heading) is as follows:

"Any reference in this Act to medical treatment, in relation to mental disorder, shall be construed as a reference to medical treatment the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations".

30. There is no dispute that NGT feeding is properly categorised as treatment for a mental disorder within the meaning of s63 and s145(4). The eating disorder is a direct consequence of, or manifestation of, the mental disorder (anorexia nervosa). Case law supports that view. In **Re KB [1995] 2 WLR 294** (a case also about NGT feeding of a mentally ill patient), the Court of Appeal interpreted "medical treatment" to include ancillary acts such as "nursing and care concurrent with the core treatment or as a necessary prerequisite to such treatment or to prevent the patient from causing harm to himself or to alleviate the consequences of the disorder" and said that "any medical treatment" included treatment to alleviate symptoms of the disorder as well as treatment to remedy the underlying cause of the disorder. In **St George's Healthcare NHS Trust v S [1998] 3 WLR 958**, the Court of Appeal stated that "section 63…may apply to the treatment of any condition which is integral to the mental disorder….provided the treatment is given by or under the direction of the responsible medical officer".

31. The consequence of s63 and s145(4) is that medical treatment for a mental disorder can be directed to take place by the Responsible Clinician under the MHA 1983 even if the patient does not consent. Treatment for Patricia's mental disorder, whether or not she consents to it, can be provided under the MHA 1983. That is so whether she is capacitous or not. The Responsible Clinician can override any refusal or objection by Patricia; this is one of the fundamental differences between the MHA 1983 and the MCA 2005.

32. Mr Patel KC drew my attention to safeguards in respect of certain types of medical treatment under the MHA 1983. Setting these out in broad terms:

i) Under s57, brain surgery may only take place where the patient gives consent and a second opinion is obtained.

ii) Under s58 the giving of medicine after three months since it started requires either the consent of the patient or a second opinion.

iii) Under s58A electro-convulsive therapy shall not be given unless the patient consents and the clinician in charge certifies that the patient is capable of understanding the treatment.

By s58A(5):

" A patient falls within this subsection if a registered medical practitioner appointed as aforesaid (not being the responsible clinician (if there is one) or the approved clinician in charge of the treatment in question) has certified in writing—

(a) that the patient is not capable of understanding the nature, purpose and likely effects of the treatment; but

(b) that it is appropriate for the treatment to be given; and

(c) that giving him the treatment would not conflict with—

(i) an advance decision which the registered medical practitioner concerned is satisfied is valid and applicable; or

(ii) a decision made by a donee or deputy or by the Court of Protection.

33. Mr Patel KC in particular relies on the reference to "a decision made by a donee or deputy or by the Court of Protection" under s58(5) in support of his contention that it is envisaged that the Court of Protection may intervene in the giving of treatment.

34. S28 of the MCA 2005 appears under the title of the section "Excluded decisions". It is as follows:

"(1) Nothing in this Act authorises anyone—

(a) to give a patient medical treatment for mental disorder, or

(b) to consent to a patient's being given medical treatment for mental disorder,

if, at the time when it is proposed to treat the patient, his treatment is regulated by Part 4 of the Mental Health Act."

35. Mr Patel submitted that the essential question for me is whether this section prevents the court from reaching a best interests decision in respect of the medical treatment being given to Patricia under s63 of the MHA 1983.

36. Mr Patel's submissions can be summarised thus:

i) The Court of Protection has broad powers to make best interests decisions in respect of an incapacitous person. In **Townsend v Epsom and St. Helier University Hospitals NHS Trust [2026] EWCA Civ 195** Baker LJ said at para 69: "Any decision about the care and treatment of a mentally incapacitated adult … must be taken in the patient's best interests. There is no carve out for 'clinical decisions'."

ii) S28 should be read in a limited, or narrow, manner as only applying to the Court of Protection (i) authorising the giving to a patient of medical treatment for mental disorder, or (ii) consenting to a patient's being given medical treatment for mental disorder. It applies to the giving of treatment or consenting to it. It does not extend to a declaration of best interests that forcible feeding is against Patricia's interests.

iii) The purpose of s28 is to ensure that the Court of Protection does not bypass the safeguards in ss56-58A of the MHA 1983 by purporting to give consent on behalf of the patient. It does not prevent the Court of Protection from exercising a general best interests discretion. He submits that the reference to "a decision made by a donee or deputy or by the Court of Protection" under s58(5) of the MHA 1983 supports that construction.

iv) Had s28 been intended to exclude any best interests decision where an incapacitous person is detained under s3 of the MHA 1983, it would have expressly so stated.

v) In the case law, there are examples of cases where a patient has been detained under s3, but the Court of Protection has nevertheless made best interest decisions; **Mental Health Trust v. BG [2022] EWCOP 26** and **Gloucestershire Health & Care NHS Foundation Trust v. FD & Ors [2023] EWHC 2634 (Fam)**, although he acknowledged, that the s28 point was not considered in those cases.

37. Miss Gollop KC submitted that the effect of Patricia's application would be to seek to intervene in the treatment plan being implemented by clinicians and require them to provide a different plan which as a matter of law is impermissible as was re-emphasised recently in **Townsend (supra)** at para 68(5) where Baker LJ said:

" In exercising its powers to make declarations and orders about the patient's best interests, the Court of Protection cannot compel the doctor to give a treatment that he or she considers clinically inappropriate".

38. She submits that s28 is a catch all provision encompassing all forms of treatment. To interpret it as not including a declaration that forcible feeding is against Patricia's interests is in reality seeking to mandate the doctors not to give certain medical treatment. Seeking to substitute her own proposed treatment plan instead of the clinicians' treatment plan is the other side of the same coin of provision of medical treatment.

39. I prefer Miss Gollop KC's submissions and conclude that the Court of Protection does not have the power to make the orders sought for the following reasons:

i) In my judgment, the scope of s28 is not limited in the manner advocated for by Mr Patel KC. In this case, the effect of Patricia's application is to seek to require Cygnet, as a result of a best interests decision, to put together, and implement, a fresh plan. Mr Patel KC submits that Patricia is not seeking declarations as to consent to treatment which is part of the wording at 28(1)(b) of the MCA 2005; rather, she is seeking a declaration that forcible feeding is not in her best interests. Thus, she says, the relief sought relates to non-treatment rather than

treatment. In my judgment, this argument does not succeed. Treatment and non-treatment are two sides of the same coin. They are all part of the process of the giving and receiving of medical treatment. Whether framed in the positive or the negative, the court is still being asked to authorise treatment and that is an excluded decision. It cannot authorise any medical treatment in accordance with s28, including that sought by Patricia. It seems to me that if the Court of Protection is not empowered to authorise the giving of medical treatment which is regulated by Part 4 of the MHA 1983, or to consent to such treatment, then by parity of reasoning it cannot accede to applications to alter, or interfere with, such treatment. Otherwise, the intent behind Part 4 of the MHA 1983 is neutered, and in effect the powers thereunder are transferred to the Court of Protection where the patient is incapacitous.

ii) Should the court grant the non-treatment declaration sought, it would have the effect of requiring Cygnet to cease to implement a treatment plan which is considered clinically appropriate and is being provided under s63 of the MHA 1983. In my judgment, that cannot have been the intention of s28; it would enable the Court of Protection to recast the clear framework of the MHA 1983.

iii) The clear purpose of s28 is to separate power between two legislative regimes. It would be surprising if the 2005 Act intended to reserve to the Court of Protection wide-ranging powers, in the case of incapacitous patients, to make best interests decisions which override the decision making under the MHA 1983. The purpose of s28 (which is under the section "Excluded Decisions" of the MCA 2005) is to exclude the Court of Protection from exercising power in respect of Part IV of the MHA 1983. Had the legislation intended to reserve to the |Court of Protection something as significant as a supervisory best interests oversight, it would surely have said so in terms.

iv) I observe that:

a) The notes to s28 in the Court of Protection Practice 2026 read as follows: "the powers under Part 4 of the MHA 1983 take precedence over the decision making powers under MCA 2005 in relation to treatment for mental disorder of detained persons"; and

b) The Government's Explanatory Notes for the MCA 2005 says this about s.28:

"94. This deals with the question of people who are detained for psychiatric treatment pursuant to the Mental Health Act 1983. ***The section ensures that the Mental Capacity Act does not apply to any treatment for mental disorder which is being given in accordance with the rules about compulsory treatment set out in Part 4 of the 1983 Act.*** *The specific statutory safeguards which the 1983 Act gives in relation to compulsory psychiatric treatment must always be afforded to those patients to whom that Act applies."*[emphasis added]

These notes support the proposition that the intention is that the Court of Protection is not able to intervene in <u>any</u> treatment given under the MHA 1983.

v) The fact that the concept of best interests under the MCA 2005 is broad does not assist Patricia's submissions, because the Act expressly limits the exercise of that discretion at s27-28 thereof. Excluded decisions are not susceptible to an analysis of best interests.

vi) The fact that in other cases (see para 36(v) above), where patients were detained under s3 and no issue arose as to the Court of Protection's jurisdiction, does not take the matter much further. In those cases, the point was not considered. And in other cases, the Court of Protection did not exercise such a jurisdiction, or was not asked to. Theis J, the Vice-President of the Court of Protection, recently handed down judgment in **Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust & Anor v QF [2026] EWHC 1621 (Fam)**. In that case, P (who had a diagnosis of Complex Post Traumatic Stress Disorder) was detained under s3 of the MHA 1983. The relevant NHS Trusts sought declarations in respect of blood transfusions which were agreed between all parties. There was no dispute that the treatment fell within the s63 MHA 1983 definition. It also seems to have been common ground that no application could be made to the Court of Protection. Theis J said at para 67: "The effect of s28 MCA 2005 prevents an application in the circumstances of this case being made to the Court of Protection, as it is a medical treatment decision under Part IV MHA." I recognise that the point does not seem to have been fully argued, but the fact that the Vice-President said this in the context of a comprehensive, careful judgment, to my mind is of some significance to this case where the same contextual matters arise: capacity, detention under s3, the patient objecting to a particular treatment, and Articles 2 and 8 rights. Similarly, Deputy High Court Judge Butler-Cole KC in **North Tees and Hartlepool NHS Foundation Trust v KAG (2024) EWCOP 38 (T3)** made an agreed order under the inherent jurisdiction, rather than any orders under the Mental Capacity Act 2005, in respect of an incapacitous woman detained under s3 of the MHA 1983.

vii) I am not persuaded that the provisions of s57-58A of the MHA 1983 set out above support the more limited interpretation placed by Mr Patel KC on the construction of s28 of the MCA 2005. Had it been Parliament's intention to exclude the Court of Protection from making best interests decisions only in respect of those sections, it would surely have said so. Instead, s28 of the MCA 2005 specifically refers to Part 4 of the MHA 1983 (which includes s63 thereof). The reference at s58(5)(c)(ii) to a decision made by the Court of Protection must mean a <u>previous</u> such decision, which is logical; in circumstances where the Court of Protection has made a prior decision in respect of EVT, the clinicians giving treatment under the MHA 1983 must abide by that.

viii) Nowhere in the MHA 1983, nor the MCA 2005, is it stated in terms that the Court of Protection retains jurisdiction to make best interests decisions which take precedence over Part 4 of the MHA 1983.

ix) If the Court of Protection does retain the power to make best interest decisions overriding s63 MHA 1983, the pathway to being discharged from detention upon application to the First Tier Tribunal would be largely redundant as the incapacitous patient would instead have the ability to apply to the Court of Protection to challenge clinical treatment. It is not easy to see how the MHA 1983 would work in practice if this is the case. It would give way in many

instances to the Court of Protection, contrary to the clear separation of powers and responsibilities between the two Acts.

Conclusion

40. I have therefore come to the conclusion that s28 of the MCA 2005 applies to this case, and the Court of Protection does not have the power to make any best interest decisions. I am not sure this is strictly an issue of jurisdiction, but in any event I will dismiss the Court of Protection application.

Procedural matters

41. Although not directly relevant to the application before me, this case threw up a number of procedural matters in circumstances where an incapacitous patient is detained under MHA 1983 and where, as I find, by reason of s28 of the MCA 2005, the Court of Protection does not have power to make best interests orders in relation to medical treatment.

42. Where there is an issue, or any doubt about, whether a particular treatment falls within s63/s145(4) of the MHA 1983, the matter should be brought before the court: **A NHS Trust v A [2013] EWHC 2442 (Fam)** per Baker J (as he then was) at para 80. The court will consider the matter on a "full merits based review" (following the applicable judicial review test on challenges to s63): para 13 of **R (on the application of JB) v Haddock (Responsible Medical Officer) [2006] EWCA Civ 961**. In this case, there is no such doubt.

43. Where a patient is receiving treatment under s63 MHA 1983, and agreement is reached as to withdrawing or providing life sustaining treatment, there is no obligation on the parties to come to court: **An NHS Trust and others v Y (Intensive Care Society and others intervening) [2018] UKSC 46**.

44. I acknowledge that in some instances the clinicians/hospital/NHS Trust prefer to seek the approval of the court for any such agreement. In some reported cases (as noted above), that has taken place in the Court of Protection; in others (noted above), it has taken place in the Family Division under the inherent jurisdiction. And in **Leeds and York Partnership NHS Foundation Trust v FF and GG [2025] EWCOP 26 (T3)** McKendrick J made declarations both under s19 of the Senior Courts and under s16 of the MCA 2005. It seems to me that in respect of treatment encompassed by s63 of the MHA 1983 (whether life sustaining or not) agreed applications should not be brought to the Court of Protection. Rather, they should be brought by way of inherent jurisdiction/declaratory relief under s19 of the SCA 1981. Arguably, the inherent jurisdiction based on the "vulnerable adult" jurisprudence is the preferred route in the light of the Vice-President's comprehensive judgment in the **Cumbria case [supra]** explaining its existence and applicability where the incapacitous person is detained under s3 MHA 1983.

45. Where there is disagreement in respect of treatment which falls under s63 of the MHA 1983, Mr Patel KC submitted, and I agree, that relief cannot be sought by the patient under the inherent jurisdiction because the statutory provisions of the MHA 1983 provide the answer, namely that the views of the clinicians prevail. For that reason, the application before me was confined to the Court of Protection.

Other remedies available to Patricia

46. This does not mean that Patricia is without potential remedies. It is common ground that she is entitled to bring judicial review proceedings in respect of the s63 treatment. She is also entitled to bring a Human Rights challenge under s7 of the Human Rights Act 1998. I make no further comment on these matters.