Mental Capacity Law Newsletter June 2014: Issue 47

Court of Protection: Health, Welfare and Deprivation of Liberty

Introduction

Welcome to the June issue of the Mental Capacity Law Newsletter family. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Newsletter: the Court of Appeal revisits capacity (and the role of precedent); prohibiting contact; and advance decisions to refuse treatment;

(2) In the Property and Affairs Newsletter: the sequel to the infamous *Rolex* case;

(3) In the Practice and Procedure Newsletter: a rare award of costs in welfare proceedings; the proper place of the press in CoP proceedings; revisiting decisions on appeal; judicial contact with the subject of proceedings; joint instruction of experts in publicly funded cases, and a plea for assistance with streamlining directions hearings;

(4) In the Capacity outside the COP newsletter: two important cases involving capacity and children and two book reviews;

(5) In the Scotland Newsletter: a vitally important decision of Sheriff John Baird which casts significant doubt upon the validity of very many powers of attorney entered into in Scotland and upon the standard template available on the Scots OPG website.

We are also delighted to include with this newsletter a discussion paper on the Convention on Persons with Disabilities and an analysis of both the MCA 2005 and the AWIA 2000 by reference to its requirements. This discussion paper, written by Lucy Series, Anna Arstein-Kerslake, Piers Gooding and Eilionóir Flynn, is vital reading for all practitioners (of whatever hue) seeking to understand the implications of this Convention for domestic law and practice in both England and Scotland.

ThirtyNine ESSEX STREET

Editors

Alex Ruck Keene
Victoria Butler-Cole
Neil Allen
Anna Bicarregui

Scottish contributors

Adrian Ward
Jill Stavert

Table of Contents

Hyperlinks are included to judgments; if inactive, the judgment is likely to appear soon at www.mentalhealthlaw.co.uk.

Deprivation of liberty – questions answered?

We anticipate that most readers with an interest in the CoP's welfare jurisdiction will know that on 5 and 6 June 2014, Sir James Munby P will be holding a massed directions hearing in open court, following which the President will attempt to devise some guidance for the management and resolution of Article 5 cases following the Supreme Court's decision in *Cheshire West*, or *P, P and Q*.

We look forward to sharing the results of the President's deliberations with you in due course!

Capacity in the Court of Appeal (again)

RB v Brighton and Hove Council [2014] EWCA Civ 561 (Arden, Jackson and Fulford LJJ)

Mental capacity – deprivation of liberty

Summary

In June 2007 RB sustained a serious brain injury in an accident. He was treated for eight months in hospital and then transferred to a care home, S House. In 2011 RB ceased participating in rehabilitation programmes and proposed to leave S House. The staff at S House considered that RB was not capable of independent living. Because of his physical and mental disabilities he was likely to (a) resume his former chaotic lifestyle, including using alcohol to excess and (b) to suffer serious or fatal injuries in consequence.

The Council granted a standard authorisation pursuant to Schedule A1 to the MCA 2005. RB brought an application under s.21A MCA 2005 to terminate the standard authorisation. At first instance, District Judge Glentworth accepted that although RB's wish to consume alcohol pre-dated his brain injury, he was unable to weigh up information to make a decision because of his brain injury, and was therefore in a different position to a non-brain injured alcoholic. It was in his best interests to remain in the care home despite his objections. On appeal, HHJ Horowitz refused to interfere with the District Judge's reasoning and conclusion on either capacity or best interests. Before the Court of Appeal, RB argued that two preconditions for deprivation of liberty were not satisfied, namely the mental capacity requirement (set out in paragraph 15 of Schedule A1) and the best interests requirement (set out in paragraph 16 of Schedule A1).

In relation to the first ground, the core submissions were that:

1. RB's inability to control his drinking was the same now as it was before the accident. RB's brain injury is not the cause of his propensity to injure himself through excessive drinking. Furthermore the judge erred in applying s.3(1) MCA 2005: the third of the specified skills, namely using and weighing information, does not and cannot be expected to come into operation when an alcoholic is considering whether to have a drink.

2. Reliance was placed upon the fact that RB preferred S House to alternative accommodation which was offered at a place called V, and RB had capacity to make that decision.

3. As a separate strand of argument it was pointed out that by 2013 RB had ceased participating in rehabilitation at S House. Therefore the "care and treatment"

> referred to in the mental capacity requirement could only be day to day personal care. RB was aware that he needed that. He had capacity to decide that he wished to receive that in a flat, rather than at S House.

In relation to the second ground of appeal, the core submission was that the personal care which RB currently received could equally well be provided in a flat. The sole purpose of RB's detention at S House was to stop him drinking. It was therefore submitted that it was a misuse of the "best interests" provision to incarcerate an alcoholic so as to stop him drinking. On the evidence, it was submitted, there was no basis for concluding that detention in S House accords with RB's best interests.

These arguments were described by Jackson LJ (giving the sole reasoned judgment on behalf of the Court of Appeal) as "formidable." In the course of his judgment, Jackson LJ observed that:

> *"40. The cases which arise for decision under Part 1 of the MCA (including the present case) tend to be acutely difficult, not admitting of any obviously right answer. The task of the court is to apply the statutory provisions, paying close heed to the language of the statute. Nevertheless, as judges tread their way through this treacherous terrain, it is helpful to look sideways and see how the courts have applied those statutory provisions to other factual scenarios. This has nothing to do with either the doctrine of precedent or the principles of statutory interpretation. The purpose is simply to see how other judicial decisions have exposed the issues or attempted to reconcile the irreconcilable."*

The judge went on to dismiss the submission made on behalf of RB that, as in the sphere of sexual relations, a decision (by an alcoholic) whether to have a drink is not one that generally involves a complex process of reasoning, and so the ability to use or weigh information should have little or no significance in assessing capacity in this context, noting that:

> *"64 […] What the court must do in the present case is apply the clear statutory provisions to the facts as found by the first instance judge, District Judge Glentworth. It is inappropriate for the court to start comparing the decision which RB wishes to make in this case with the decisions which other disabled persons sought to make in other cases.*
>
> *65. That approach sucks the court into convoluted reasoning. It also drives up costs. There appear to be innumerable 'capacity' cases out there in the law reports and on the websites... If lawyers are going to trawl through previous cases looking for factual similarities or analogies and then debate these in their skeleton arguments, that will involve a substantial waste of costs and time."*

The Court of Appeal rejected RB's case, holding that:

> *"70. The decisions which RB wishes to make require a process of using and weighing up relevant information. On the basis of the expert evidence and of the district judge's findings of fact, RB is not capable of carrying out that mental process. The difficulties which RB has in using or weighing information and making consequent decisions accord closely with the situation described in paragraphs 4.21 and 4.22 of the Code of Practice. RB is unable to appreciate and weigh up the risks which he will run if he resumes his former way of life and goes out on drinking bouts. Therefore, applying MCA section 3(1)(c), RB does not have capacity to make this decision.*

The Court of Appeal went on to hold that all appropriate steps had been taken to assist RB to

make a capacitous decision, and that it was clearly in his best interests to remain deprived of his liberty in the care home despite his objections.

> *81. Both the Council and the court are aware of RB's wishes, namely to live independently in the community. The MCA section 4(6)(a) requires both the Council and the court to take those wishes into account. I do so. Unfortunately it is not possible for the time being to comply with those wishes.*
>
> *82. RB is not thereby condemned to a lifetime of incarceration without hope of release, as Mr Gordon submits. If only RB would continue to co-operate in rehabilitative programmes (as he did up until 2011) he may well become capable of independent living in the future. In order to comply with the MCA section 4(4), the staff at S House must continue to offer rehabilitation to RB and must encourage him to participate.*
>
> *83. Without proper safeguards a regime of compulsory detention for medical purposes would be unacceptable, indeed Orwellian. However, the carefully drawn provisions of the MCA together with the reviewing function of the court ensure that the power to detain is not misused. In the present case deprivation of liberty is necessary in order to protect RB from seriously injuring himself. That must be in his best interests."*

Comment

This judgment is very significant in terms of the approach that is to be adopted by judges to the MCA 2005 and to the use of case-law to amplify the provisions of the statute. It is, clearly, correct that the starting point must be the plain words of the Act. However, almost every word in Sections 1-4 (in particular) is loaded with significance going far beyond the plain terms; especially given the seriousness of the consequences of a conclusion that a person lacks capacity in one or more domains, it is hardly surprising that both lawyers and in turn judges have sought to look sideways for assistance.

While it is certainly correct that judges in the CoP should not seek to strive to shoe-horn the very sensitive facts of one case into the ratio of another; we hope that this decision is not taken as a licence to abandon attempts to achieve consistency between decisions where such can properly be achieved. This would, apart from anything else, have a disastrous impact upon the already difficult task of bringing about understanding of the MCA 2005 outside the courtroom. The issue of capacity, in particular, is one in which, in the editors' view, there both can and should be consistency of approach. It is far from obvious why a higher level of sophistication as regards the using or weighing of information should be required in relation to decisions about care, residence or contact, as compared to decision about whether to have a sexual relationship, or whether to marry. (See also the *RC* case covered in this newsletter, in which the ability to weigh information was held to be of little relevance where an individual had strongly held religious beliefs on an issue). Without a clear and consistent approach being taken to the often critically significant requirement of using or weighing information, there is a serious risk that the capacity bar will be set too high in spheres of decision-making in which the state has fewer qualms about intervening.

What does 'prohibiting contact' mean?

PB v RB and Ors [2013] EWCOP B41 (HHJ Altman)

Summary

RB was a 71 year old woman with Alzheimer's disease who lacked capacity to make decisions about contact, including with her son, PB. Proceedings in the CoP took a sadly familiar path, with PB objecting to the care being provided to his mother and voicing those objections to professionals in a way which the court found placed her care at risk. Restrictions were placed on PB's contact with RB, and in due course, DJ Eldergill determined that a member of the local authority should be appointed as welfare deputy for RB, with the power to make decisions about contact between RB and PB. In particular, the deputy was to be permitted to prevent contact beween RB and PB taking place for up to a maximum of 7 days in the event that PB became embroiled in conflict once again which threatened to put RB's care at home at risk. PB appealed on the basis that it was ultra vires s.20 MCA 2005 for the court to provide the Local Authority deputy for welfare with the power to suspend contact for up to one week, because the Act provides that a welfare deputy cannot '*prohibit'* contact.

The appeal was dismissed. The court noted that s.17 MCA 2005 distinguished 'deciding what contact, if any P, is to have with any specified person' and 'making an order prohibiting a named person from having contact with P'. The latter was not within the power of a deputy by virtue of s.20(2)(a) MCA 2005. But 'prohibiting contact' did not mean a permanent ban on contact, as the judge had found at first instance. That being the case, how could the 7 day ban which the deputy was permitted to impose be distinguished from the prohibition of contact?

The difference between the two provisions was determined by asking if the period without contact could be part and parcel and an incident of an on-going management and monitoring of contact in a flexible way for a proportionate period of time and as a proportionate adjustment to the arrangements that would otherwise have taken effect in the particular family, or would it be more of a specific response, standing alone, to a situation with the consequence of a set pattern of no contact probably for a more substantial period of time commensurate with an application to court (paragraph 24)?

In the instant case, it was within the scope of the deputy's powers to prevent contact between RB and PB for up to seven days at a time as part of the day to day management of contact without having to refer back to the court, the court having determined itself the limit to the cessation of contact but allowing the deputy to exercise his discretion in deciding whether to cease contact for short periods within that framework. The deputy had not been given a power to prohibit contact within the meaning of the statute.

Comment

The explanation of the difference between prohibiting contact and a 7-day ban on contact in this decision is somewhat tortuously worded, and yet captures a readily understandable distinction on the facts of the case. The deputy is attempting to manage a dynamic situation on the ground by exercising a power, approved by the court, to stop visits where it is clear that problems are otherwise going to arise for P, without having to apply to the court first. If the deputy (or any decision maker) had to apply to the court for a declaration each time a contact visit needed to end early, or to be postponed or cancelled due to X's conduct, the *Cheshire West* flood would rapidly start to look like a small puddle. No doubt it would be simpler if 'prohibition' meant 'permanent ban', but the formulation adopted in this case gives more protection to P (and P's visitors), as the crucial

aspect of the deputyship order which ensured the validity of its time-limited suspension of visits was the court's preliminary authorization of a framework for contact which followed a full investigation of RB's best interests.

Advance decisions to refuse treatment

Nottinghamshire Healthcare NHS Trust v RC [2014] EWHC 1317 (COP)

Summary

This is the sequel to the case of *Nottinghamshire Healthcare NHS Trust v J* [2014] EWHC 1136 (COP) that we reported in our May newsletter.

The case concerned RC (known as J in the first judgment), a young man aged 23 who was in prison but detained under the Mental Health Act 1983. He suffered from what was described as a serious personality disorder, a symptom of which was that he had engaged in significant self-harm on a number of occasions which resulted in profuse bleeding (he was on anticoagulant drugs because of a history of thrombosis). He was a Jehovah's Witness and had made what purported to be an advance decision to refuse specified medical treatment, namely blood transfusions.

The matter came on by way of an urgent ex parte application before Holman J on 9 April 2014.

The first limb of the Trust's application asked for a declaration that a written advance decision was valid and was applicable to the treatment described in the advance decision. The judge considered sections 24 – 26 of the MCA 2005 and declared on an interim basis that the written advance decision was valid and applicable to that treatment notwithstanding that (a) the young man's life may be at risk from the refusal of treatment and (b) that he was a patient detained under the Mental Health Act.

The second limb of the application brought by the NHS Trust related to the interrelation of the provisions of the MCA 2005 in relation to advance decisions to refuse treatment and the applicability in this case of section 63 of the Mental Health Act 1983 which provides: "*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…if the treatment is given by or under the direction of the approved clinician in charge of the treatment.*" The second limb of the application asked the judge to make an interim declaration that "*it is lawful for those responsible for the medical care of the respondent to act in accordance with his written advance decision and withhold treatment by blood transfusion or with blood products in accordance with his expressed wishes notwithstanding the existence of powers under section 63 of the Mental Health Act 1983.*"

Holman J held that he did not feel equipped or willing to make the declaration as he had only heard representations from one side without notice to the patient or any other person. The substantive hearing was ultimately heard before Mostyn J on 24 April; he gave his decision at the hearing, with his reasons following in a judgment dated 1 May 2014.

Mostyn J noted that if a self-destructive course is being pursued by an incapacitated person (who has not made a valid advance decision) then pursuant to Court of Protection Practice Direction 9E life saving measures will likely amount to "serious medical treatment" requiring the issue to be determined by the Court of Protection (paragraph 16). A decision imposing equivalent measures on a vulnerable adult would require a

hearing in, and an order of, the High Court (paragraph 17).

A positive decision to impose non-consensual medical treatment pursuant to section 63 of the MHA is a public law decision susceptible to judicial review – which takes the form of a full merits review. As Mostyn J noted, however,

> *"19.* […] *a decision made by the approved clinician in charge of the treatment in respect of a patient detained under the MHA not to impose any treatment on him or her is not accompanied by any procedure for judicial scrutiny of it. This is surprising, especially as Article 2 of the European Convention on Human Rights is (as here) likely to be engaged…*
>
> *21. In my judgment where the approved clinician makes a decision not to impose treatment under section 63, and where the consequences of that decision may prove to be life-threatening, then the NHS trust in question would be well advised, as it has here, to apply to the High Court for declaratory relief. The hearing will necessarily involve a "full merits review" of the initial decision. It would be truly bizarre if such a full merits review were held where a positive decision was made under section 63, but not where there was a negative one, especially where one considers that the negative decision may have far more momentous consequences (i.e. death) than the positive one."*

As to the principles that the court should apply when conducting a full merits review on an application for declaratory relief in circumstances where a decision has been made not to impose potentially life-saving treatment under s.63 MHA 1983, Mostyn J held that:

> *"26.* […] *Obviously the expressed wishes of the patient will be highly relevant. If there is an advance decision in place under sections 24 and 26 of the MCA then this will weigh most heavily in the scales. The Hippocratic duty to seek to save life, or the benign but paternalistic view that it is in someone's best interests to remain alive must all surely be subservient to the right to sovereignty over your own body. Beyond this, considerations such as whether the treatment would be futile will no doubt be relevant; for example, if the repair of a laceration would inevitably be followed by a new one or if the patient was suffering from another unrelated terminal disease."*

In this case, the treating clinician, Dr S, and the independent forensic psychiatrist Dr Latham made written reports were almost unanimous. They agreed (paragraph 27) that:

1. RC suffered from a mental illness namely antisocial and emotionally unstable personality disorders. This was a disturbance of the functioning of the mind, which was one of the classic definitions of mental disorder.

2. However, he had full capacity to refuse blood products. His refusal derived almost exclusively from his religious faith. Further, he had full capacity to enter into the advance decision on 4 April 2014. Further still, his decision to adopt the religion of the Jehovah's Witnesses was made with full capacity.

3. So far as RC's capacity to harm himself was concerned on occasions he did so with full capacity. However, on other occasions, particularly at times of severe emotional distress, it was likely that he did so without the capacity to choose to self-harm.

4. RC harmed himself with the intention of distracting himself from distressing thoughts and feelings. He did so without really thinking

about the consequences and dangers. However his view was that it is his body and therefore his choice to damage it.

Where they disagreed was whether the administration of a blood transfusion amounted to treatment which prevented the worsening of a symptom or manifestation of RC's mental disorder. Dr S was of the opinion that it plainly was. Dr Latham disagreed.

On that question, Mostyn J concluded that:

> *"31… It cannot be disputed that the act of self harming, the slashing open of the brachial artery, is a symptom or manifestation of the underlying personality disorder. Therefore to treat the wound in any way is to treat the manifestation or symptom of the underlying disorder. So, indisputably, to suture the wound would be squarely within section 63. As would be the administration of a course of antibiotics to prevent infection. A consequence of bleeding from the wound is that haemoglobin levels are lowered. While it is strictly true, as Dr Latham says, that 'low haemoglobin is not wholly a manifestation or symptom of personality disorder', it is my view that to treat the low haemoglobin by a blood transfusion is just as much a treatment of a symptom or manifestation of the disorder as is to stitch up the wound or to administer antibiotics."*

When it came to capacity, having noted the fundamental principle of the presumption of capacity contained in s.1(2) MCA 2005, Mostyn J noted that:

> *33. […] In this case Mr Francis QC correctly argues that the only the possible question relates to whether RC is able to weigh information in the balance. In his report Dr Latham says:*
>
> *'His ability to weigh the risks of refusing blood against his religious beliefs is difficult to describe because his religious beliefs effectively create, in his mind (and others) an absolute prohibition on blood products and so there is relatively little 'weighing' when it comes to this decision.'*

But, as Mostyn J noted:

> *"34. This aspect of the test of capacity must be applied very cautiously and carefully when religious beliefs are in play. In his essay [On Liberty] John Stuart Mill speaks of the prohibition in Islam on the eating of pork. He describes how Muslims regard the practice with 'unaffected disgust'; it is 'an instinctive antipathy'. There can be no circumstances where a Muslim could 'weigh' the merit of eating pork. It is simply beyond the pale. So too, it would appear, when it comes to Jehovah's Witnesses and blood transfusions. But it would be an extreme example of the application of the law of unintended consequences were an iron tenet of an accepted religion to give rise to questions of capacity under the MCA.*
>
> *35. I therefore place little emphasis on the fact that a tenet of RC's religious faith prevents him from weighing the advantages of a blood transfusion should his medical circumstances indicate that one is necessary.*
>
> *36. I am completely satisfied on the evidence and so declare that RC has full capacity to refuse the administration of blood products."*

Mostyn J further held that the advance decision was valid, complying as it did with all the requirements in ss.24-5 MCA 2005.

The decision

Having conducted his full merits review, Mostyn J concluded that the decision made by Dr S not to

use the MHA 1983 to override RC's capacitous wishes was entirely completely correct:

> *"In my judgment it would be an abuse of power in such circumstances even to think about imposing a blood transfusion on RC having regard to my findings that he presently has capacity to refuse blood products and, were such capacity to disappear for any reason, the advance decision would be operative. To impose a blood transfusion would be a denial of a most basic freedom. I therefore declare that the decision of Dr S is lawful and that it is lawful for those responsible for the medical care of RC to withhold all and any treatment which is transfusion into him of blood or primary blood components (red cells, white cells, plasma or platelets) notwithstanding the existence of powers under section 63 MHA."*

Comment

This is a very interesting judgment, not least in its clear upholding of the principle that a person with capacity should be able to refuse medical treatment even if – as here – there is a legal framework which could on its face be used to impose it against their will. This is so even where the result of that refusal is either inevitable or likely death. We would also respectfully endorse the proposition that circumstances such as that arose in this case should be brought to the Court.

The case also sits neatly with that of *A County Council v MS and RS* [2014] EWHC B14 (COP) (the tithing case) that we covered in the May newsletter, in which District Judge Eldergill was at pains to distinguish between the aspects of MS's decision-making that reflected his deeply-held religious beliefs and those aspects that might be said to relate to an impairment or disturbance of the mind or brain.

For further discussion of the questions relating to the inherent jurisdiction touched upon by Mostyn J, please see the comment by Alex here.

Treatment and MCS

Sheffield Teaching Hospitals NHS Foundation Trust v TH & Anor [2014] EWCOP 4 (Hayden J)

Summary

TH is a 52 year old man who is in a minimally conscious state. He was admitted to hospital in February 2014 with a pre-existing serious neurological disability called Central Pontin Myelinolysis, Wernicke-Korsakoff syndrome, suffering from epileptic seizures thought to be due to alcohol withdrawal and hyponatremia. This interim judgment sets out the court's reasoning for adjourning a decision as to whether the continued provision of ANH to TH is in his best interests, despite the apparently clear evidence that whatever the precise details of TH's conscious awareness, he would not have wanted to be kept alive in this condition, which was said by his treating clinician to be permanent and irreversible. The judge stated, having heard from a number of TH's friends and his ex-partner of 20 years that he was "*left in no doubt at all that TH would wish to determine what remains of his life in his own way not least because that is the strategy he has always both expressed and adopted. I have no doubt that he would wish to leave the hospital and go to the home of his ex-wife and his mate's Spud and end his days quietly there and with dignity as he sees it. Privacy, personal autonomy and dignity have not only been features of TH's life, they have been the creed by which he has lived it. He may not have prepared a document that complies with the criteria of section 24, giving advance directions to refuse treatment but he has in so many oblique*

and tangential ways over so many years communicated his views so uncompromisingly and indeed bluntly that none of his friends are left in any doubt what he would want in his present situation." However, further medical evidence including a SMART assessment was required in order that the court had the best medical evidence before it in order to determine whether fulfilling TH's likely wishes was in his best interests.

In his concluding remarks, Hayden J noted that:

> "55. *I must record that the Official Solicitor's lawyers appear not to share my analysis of the cogency and strength of TH's wishes regarding his treatment. I confess that I have found this surprising. If I may say so, they have not absorbed the full force of Baroness Hale's judgment in Aintree and the emphasis placed on a 'holistic' evaluation when assessing both 'wishes and feelings' and 'best interests'. They have, in my view, whilst providing great assistance to this court in ensuring that it has the best available medical evidence before it, focused in a rather concrete manner on individual sentences or remarks. To regard the evidence I have heard as merely indicating that TH does not like hospitals as was submitted, simply does not do justice to the subtlety, ambit and integrity of the evidence which, in my judgment, has clearly illuminated TH's wishes and feelings in the way I have set out.*
>
> *56. I reiterate that whatever the ultimate weight to be given to TH's views it is important to be rigorous and scrupulous in seeking them out. In due course the clarity, cogency and force that they are found to have will have a direct impact on the weight they are to be given. 'Wishes' and 'best interests' should never be conflated, they are entirely separate matters which may ultimately weigh on different sides of the balance sheet."*

Comment

This interim judgment is of particular interest in light of the efforts made by the court to ascertain TH's likely wishes about the continuation of ANH, despite the absence of any written advance decision to refuse treatment in such circumstances. Some readers may wonder why, having ascertained with some clarity what TH would likely have chosen, the further evidence and continued court proceedings are required – could it really be in TH's best interests for the end of his life to be determined by others in a way that he would have rejected, notwithstanding his inability to appreciate what is happening? The case has already received some coverage in the media, and it is to be hoped that when the court's final decision is made, publicity is given to the significance of creating an advance decision to refuse treatment, or a welfare LPA, in order to avoid drawn out court proceedings at the end of one's life.

The case that got away – the MCA/the MHA and the inherent jurisdiction

Finally, we note that the editors' day jobs have prevented us covering the important decision of Hayden J in *Northamptonshire Healthcare NHS Foundation Trust and Anor v ML & Ors* [2014] EWCOP 2. We will cover it in the next issue, because it has a number of important observations about the proper dividing line between the MCA and the MHA, as well as the place of the inherent jurisdiction.

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Conferences at which editors/contributors are speaking

The Deprivation of Liberty Procedures: Safeguards for Whom?

Neil is speaking at the day-long conference arranged on 13 June by Cardiff University Centre for Health and Social Care Law and the Law Society's Mental Health and Disability Committee, to discuss the extent to which the DOL procedures comply with international human rights standards, and whether they offer adequate protection for the rights of service users and their carers. The Conference will focus on the implications of the ruling of the Supreme Court *Cheshire West* as well as the likely impact of the Report of the House of Lords Committee on the Mental Capacity Act. Other speakers include Richard Jones, Phil Fennell, Lucy Series, Professor Peter Bartlett, Sophy Miles and Mark Neary. Full details are available here.

End of Life Care and the Law – Wirral Hospice St John's and Hill Dickinson

Tor and Parishil are speaking at this conference in the North West on 25 June 2014 which covers end of life issues including DNACPR notices, advance decisions to refuse treatment, and the MCA and CoP. Full details are available here.

Other conferences of interest

Mental Health Lawyers Association COP Conference

The MHLA is holding its first COP conference on 6 June in London. The key-note speaker is Mr Justice Charles, Vice-President of the Court of Protection, and other speakers include representatives from the LAA and the Official Solicitor's office. Full details are available here.

BABICM Summer Conference

The British Association of Brain Injury Care Managers is holding its summer conference on 25 and 26 June 2014 at the Hilton Birmingham Metropole. Entitled "Nobody Does It Better! Current Practical Issues in Brain Injury," the conference will examine issues facing brain injury case

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 Mind in return for postings for English and Welsh events. For Scottish events, we are inviting donations to Alzheimer Scotland Action on Dementia.

managers: (1) sex, capacity and the law; (2) what constitutes privileged documentation; and (3) the implications of the judgment in *Loughlin v Singh*. For more details and to register, please click here.

Chambers Details

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

David Barnes
Chief Executive and Director of Clerking
david.barnes@39essex.com

Alastair Davidson
Senior Clerk
alastair.davidson@39essex.com

Sheraton Doyle
Practice Manager
sheraton.doyle@39essex.com

Peter Campbell
Practice Manager
peter.campbell@39essex.com

London 39 Essex Street, London WC2R 3AT
Tel: +44 (0)20 7832 1111
Fax: +44 (0)20 7353 3978

Manchester 82 King Street, Manchester M2 4WQ
Tel: +44 (0)161 870 0333
Fax: +44 (0)20 7353 3978

Singapore Maxwell Chambers, 32 Maxwell Road, #02-16,
Singapore 069115
Tel: +(65) 6634 1336

For all our services: visit www.39essex.com

Editors

Alex Ruck Keene
Victoria Butler-Cole
Neil Allen
Anna Bicarregui

Scottish contributors

Adrian Ward
Jill Stavert

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THE QUEEN'S AWARDS FOR ENTERPRISE INTERNATIONAL TRADE 2013

Alex Ruck Keene
alex.ruckkeene@39essex.com

Alex been recommended as a leading expert in the field of mental capacity law for several years, appearing in cases involving the MCA 2005 at all levels up to and including the Supreme Court. He also writes extensively about mental capacity law and policy, works to which he has contributed including 'The Court of Protection Handbook' (forthcoming, 2014, LAG); 'The International Protection of Adults' (forthcoming, 2014, Oxford University Press), Jordan's 'Court of Protection Practice' and the third edition of 'Assessment of Mental Capacity' (Law Society/BMA 2009). He is an Honorary Research Lecturer at the University of Manchester, and the creator of the website www.mentalcapacitylawandpolicylaw.org.uk. To view full CV click here.

Victoria Butler-Cole
vb@39essex.com

Victoria regularly appears in the Court of Protection, instructed by the Official Solicitor, family members, and statutory bodies, in welfare, financial and medical cases. She previously lectured in Medical Ethics at King's College London and was Assistant Director of the Nuffield Council on Bioethics. Together with Alex, she co-edits the Court of Protection Law Reports for Jordans. She is a contributing editor to Clayton and Tomlinson 'The Law of Human Rights', a contributor to 'Assessment of Mental Capacity' (Law Society/BMA 2009), and a contributor to Heywood and Massey Court of Protection Practice (Sweet and Maxwell). To view full CV click here.

Neil Allen
neil.allen@39essex.com

Neil has particular interests in human rights, mental health and incapacity law and mainly practises in the Court of Protection. Also a lecturer at Manchester University, he teaches students in these fields, trains health, social care and legal professionals, and regularly publishes in academic books and journals. Neil is the Deputy Director of the University's Legal Advice Centre and a Trustee for a mental health charity. To view full CV click here.

Anna Bicarregui
anna.bicarregui@39essex.com

Anna regularly appears in the Court of Protection in cases concerning welfare issues and property and financial affairs. She acts on behalf of local authorities, family members and the Official Solicitor. Anna also provides training in COP related matters. Anna also practices in the fields of education and employment where she has particular expertise in discrimination/human rights issues. To view full CV click here.

Contributors: Scotland

Adrian Ward

adw@tcyoung.co.uk

Adrian is a practising Scottish solicitor, a partner of T C Young LLP, who has specialised in and developed adult incapacity law in Scotland over more than three decades. Described in a court judgment as: "*the acknowledged master of this subject, and the person who has done more than any other practitioner in Scotland to advance this area of law*," he is author of *Adult Incapacity*, *Adults with Incapacity Legislation* and several other books on the subject. To view full CV click here.

Jill Stavert

J.Stavert@napier.ac.uk

Dr Jill Stavert is Reader in Law within the School of Accounting, Financial Services and Law at Edinburgh Napier University and Director of its Centre for Mental Health and Incapacity Law Rights and Policy. Jill is also a member of the Law Society for Scotland's Mental Health and Disability Sub-Committee, Alzheimer Scotland's Human Rights and Public Policy Committee, the South East Scotland Research Ethics Committee 1, and the Scottish Human Rights Commission Research Advisory Group. She has undertaken work for the Mental Welfare Commission for Scotland (including its 2013 updated guidance on Deprivation of Liberty) and is a voluntary legal officer for the Scottish Association for Mental Health. To view full CV click here.