MENTAL CAPACITY REPORT: THE WIDER CONTEXT

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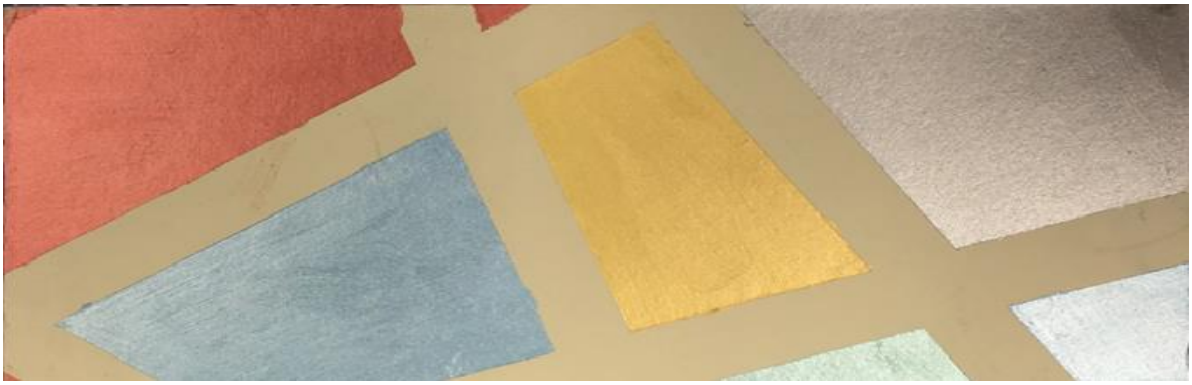

Welcome to the June 2018 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: a rare appellate level decision considering best interests (and confirming that they should be rare);

(2) In the Property and Affairs Report: (partially) endorsing an attorney's actions after the event;

(3) In the Practice and Procedure Report: choosing litigation friends;

(4) In the Wider Context Report: the National Mental Capacity Forum reports, and an important Strasbourg re-cap of the principles applying to capacity;

(5) In the Scotland Report: a new Public Guardian and the MWC is cautious about attorneys consenting to restrictions on liberty;

You can find all our past issues, our case summaries, and more on our dedicated sub-site here.

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

Contents

ENGLAND AND WALES

National Mental Capacity Forum Report

The report of Baroness Finlay, Chair of the NMCF, for 2017 has now been published. Aside from giving mentions in dispatches for our guides, the report outlines the work done by the Forum against the four priorities set by the Chair:

- Hearing the voice of the person
- Improving understanding
- Supporting carers
- Reducing/preventing exploitation

The report does not just address work done by the Forum, but also contains very useful examples of good practice from across a wide range of sectors and geographical areas. It concludes with identifying the following priorities for the next year's work:

1. The Deprivation of Liberty Safeguards proposed by the Law Commission, the Joint Committee on Human Rights inquiry and the Government's responses, as well as the next steps over implementation of improved regulations.
2. The current Mental Capacity Act Code of Practice is a strong candidate for interim revision, as some parts are now out of date; this is particularly true of the DoLS additional code.
3. The difficulties around transition from children to adult services as a person reaches 18 may need clear guidance to create a more seamless transition to independence and greater protection of

those who will probably never reach independence.

4. The cessation of life sustaining nutrition and hydration must be monitored to ensure appropriate protection of the patient, to audit the 'best interests' decision-making processes, and examine the long-term outcomes of such processes. This requires the establishment of a confidential register of such deaths.

5. Those who provide advocacy services of any type hold an enormous amount of responsibility for the safeguarding and wellbeing of vulnerable people. It is important that those providing advocacy services are nationally registered and regulated. There is a need for an independent uniform complaints and disciplinary procedure in the event of concerns being raised.

6. For decision-making support to be effective, those providing support must listen attentively and non-judgementally to the person with impaired capacity, and identify ways to maximise the person's decisions making ability. This requires people across all walks of life to recognise their responsibility to others they encounter in any sector.

Ordinary residence disputes in relation to those with impaired capacity

The Department of Health and Social Care has published the latest round of anonymised determinations of ordinary residence disputes from 2017. These disputes quite commonly involve people who lack capacity to make their own decisions about their residence and care. Insofar as they relate to such issues, the latest determinations are summarised below:

- OR11 – P had a moderate learning disability and autism. From 1998, P lived in Council A, first at home with his mother and then from 2004 in a care home. On 10 December 2012, the Court of Protection decided that it was in P's best interests to reside in independent supported living accommodation. On 17 January 2013, P moved to supported living accommodation in Council B. His accommodation was paid for by way of housing benefit. The Secretary of State concluded that P had been ordinary resident in the area of Council B since 17 January 2013.

- OR 12 – P had a diagnosis of Down's Syndrome and learning disability. Prior to March 2015, P lived in supported housing in Council A. P's needs changed and she was assessed as needing a supported living placement. Capacity assessments in February and March 2015 concluded that P had capacity to decide where to live and to sign a tenancy agreement. P was offered a choice of two placements and chose a supported living placement in the area of Council B. Council B disputed that P had capacity to move to the supported living placement in the area of Council B. That conclusion was inconsistent with other assessments undertaken by an independent psychiatrist on 26 June 2012 and 24 September 2016, and a different social worker on 22 August 2013. The Secretary of State noted that capacity was time and issue specific and concluded that, on the balance of probabilities, P did have capacity

to decide to move voluntarily in March 2015 and became ordinary resident in Council B when she moved.

- OR13 – P resided in Council B until June 1992 when she suffered an acquired brain injury after being assaulted. She was treated in hospital in the area of Council A between 1992 and 1997. It was agreed that she lacked capacity to make decisions about her residence and care. In 1997, P was discharged to accommodation in the area of Council B. Council A argued that the accommodation was hospital accommodation and that P was ordinarily resident in Council B by virtue of the deeming provision. Council B argued that the accommodation was non-hospital accommodation, that the deeming provision did not apply, and that P was therefore ordinarily resident in Council A. The Secretary of State had no hesitation in finding that the accommodation fell within the definition of a "hospital" as the evidence showed that P was admitted for treatment for her acquired brain injury for both convalescence and/or medical rehabilitation. P was therefore ordinarily resident in Council B from 1997.

- OR14 – P lived in her own tenancy in the area of Council B for approximately 50 years. In June 2015, P's GP reported that P was "*moderately demented*" and recommended a move to 24 hour residential care. Council B assessed P in July 2015 and concluded that she did not meet the eligibility criteria for residential care. P's daughter challenged this conclusion. Another assessment by Council B in September 2015 concluded that P had capacity and did not require additional services as P was due to move in with her daughter. On 22 September 2015, P moved to live with her daughter in the area of Council A. In December 2015 P was admitted to hospital in the area of Council A. Council A undertook an assessment of P's needs and concluded that she required residential care to meet her needs. In January 2016, Council A assessed P as lacking capacity to make decisions about her care and residence. P was then discharged to a residential care home in the area of Council A which was funded by Council A. Council A contended that Council B had failed in their duty to meet P's needs and that her move to Council A was not for voluntary or settled purposes. The Secretary of State rejected this argument and proceeded on the basis that P had capacity to make her own decisions as to accommodation and care. The evidence indicated that P wished to move to the area of Council A to live with or nearer her daughter. She was therefore ordinarily resident in the area of Council A.

- OR15 – P attended a residential special school in the area of Council B from 2000. In 2009, she was subsequently placed in the area of Council A and the placement involved accommodation funded by the NHS. There was a starting but rebuttable presumption that a person would not acquire an ordinary residence while in NHS funded accommodation but that had to be considered in light of all of the relevant facts. In this regard, there was a dispute as to P's capacity to make decisions about her

residence and care at that time. Although there was no assessment of P's capacity, there was evidence available as to P's cognitive abilities in 2008. The Secretary of State determined that it was more likely than not that P did not have capacity to decide where to live. There was no indication that P's placement in Council A was intended to be temporary or that the area of Council B would remain the focus of her life and activities following her move. The Secretary of State determined that P was ordinarily resident in the area of Council A.

- OR16 – P had been diagnosed with a learning disability, schizophrenia and epilepsy along with a number of physical health needs. She had been admitted to various institutions including hospitals from 1964 to 2004 and a care home from 2004 in the area of Council B. There was no dispute that P lacked capacity to decide where to live. It appeared that Council A granted a standard authorisation depriving P of her liberty in the care home. In 2014, Council B was informed that P no longer qualified for "mental health funding" and that responsibility for P's care passed to Council B's social services authority. Council B disputed the decision that P was no longer entitled to health services. The Secretary of State determined that P was ordinarily resident in the area of Council B placing weight on (amongst other factors) the fact that P indicated a wish to remain in Council B, that she had lived in Council B since 1971, and that in all the circumstances it would be contrary to common sense to suggest that B was ordinarily resident in Council A.

Comment

The ordinary residence test must always be applied to the facts following the approach of *R (Cornwall Council) v Secretary of State for Health* [2015] UKSC 46 (see also our guidance here). These recently published determinations do not set out any new legal principles. However, they do provide useful examples of how the test is applied in practice across a variety of factual circumstances, and the transparency shown in public decision making by the publication of these determinations is very welcome.

New advance care planning assistance

Compassion in Dying having published a new booklet: '*Planning Ahead: My treatment and care*.' It is a practical guide designed to assist both professionals who want to promote Advance Care Planning in their care setting, as well as individuals who want to make plans for their future treatment in line with their beliefs, values and wishes. The booklet can be ordered free of charge here.

Getting things changed

A report has been published into research led by Bristol University conducted in the light of the implementation of the Equality Act 2010 to better understand the gap between policy and practice, and to see how changes can be made to practices on the terms of disabled people themselves. The objectives of the project were to:

1. identify the barriers facing disabled people in the UK, and understand better how social practices get 'stuck';

2. discuss and connect micro and macro theories of social practice, by applying them within the field of disability;

3. explore disabled people's own solutions, and understand better the conditions under which 'coproduction' can have an effect on practice;

4. develop detailed understanding of how organisations and practices can be shifted, on the terms of disabled people themselves;

5. recommend what can be done by disabled people, practitioners and policy makers to tackle the injustices experienced by disabled people.

203 practitioners and 245 disabled people (with impairments ranging from physical, sensory, mental health issues, autism, learning disabilities and dementia, and many multiple or complex impairments) took part in the research over a 3 year period.

The key recommendations for policy makers and practitioners include:

- All public institutions must have systems in place, preferably led by disabled people, to monitor and report on how they're adhering to the Equality Act 2010.

- Disability needs to be valued as part of increasing diversity within organisations, and to be seen as a way of promoting better ways of doing things.

- Informal, more relaxed settings are often the key to better practices, for instance in personal support but also at universities, within hospital waiting rooms, or in dementia groups.

HUMAN RIGHTS DEVELOPMENTS

Capacity, consent and Strasbourg

Shakulina & Ors v Russia [2018] ECHR 464 (European Court of Human Rights (Third Section))

Article 5 – deprivation of liberty – mental capacity - assessing capacity

Summary

This case concerned six Russians who had been deprived of their capacity; four complained of serious irregularities in the court proceedings whereby they had been deprived of their legal capacity. One applicant also complained of her involuntary confinement in a psychiatric facility.

Articles 6 and 8 ECHR

The Strasbourg court took the opportunity to undertake a useful recap of the provisions of Articles 8 ECHR in the context of deprivation of legal capacity, emphasising that such constitutes a serious interference with a person's private life, leading (in the applicants' case) to the loss of their "*autonomy in almost all spheres of their life for an indefinite period of time*."

Whilst the ECtHR emphasised that "*in such a complex matter as determining someone's mental capacity, the national authorities should have a wide margin of appreciation because they have the benefit of direct contact with the persons concerned and are therefore particularly well placed to determine such issues*," the court reminded us that the extent of the State's margin of appreciation depends on two major factors:

1. the nature of the issues and the importance of the interests at stake. Thus, very serious

limitations in the sphere of private life or restrictions on the fundamental rights of a particularly vulnerable social group may warrant stricter scrutiny.

2. the quality of the domestic procedure which resulted in the interference. Although Article 8 of the Convention contains no explicit procedural requirements, the decision-making process involved in measures of interference must be fair and such as to ensure due respect for the interests safeguarded by Article 8.

Key aspects of the judicial decision-making process determining a person's legal capacity include:

1. whether or not the person concerned had had a possibility to participate personally and/or had had some form of representation in the incapacitation proceedings;

2. whether the person concerned had been able to appeal against the incapacitation decision;

3. whether, after the lapse of a certain period of time, an automatic review of the legal status or direct access to the court had been available to incapacitated people; and

4. whether the experts assessing the state of health of the incapacitated people had been neutral.

The court noted that it had previously examined whether:

1. the national courts had relied on an up-to-date medical expert report;

2. whether the medical experts and subsequently the national courts had not only found the existence of a mental disorder, but had also assessed the nature or degree of the disorder as warranting legal incapacitation; and

3. whether the national courts had examined evidence other than the medical expert report and analysed other factors in their determination of a person's legal capacity.

The court noted that it had previously found violations of Article 8 of the Convention in situations where the national courts, by virtue of the domestic law, had been unable to provide a tailor-made response to a person's particular circumstances and had had the choice only between full capacity or total incapacitation of the person concerned.

Applying those principles to the cases before it, and on facts that are not directly relevant for our purposes, the court had little hesitation in finding that the Article 8 rights of the individuals concerned had been breached. The court further noted that noted that the different nature of the interests protected by Articles 6 and 8 of the Convention may require separate examination of the claims lodged under these provisions, but that in the present cases having regard to the findings under Article about procedural defects in the incapacitation proceedings it was not necessary to consider Article 6 separately.

Article 5

Ms Shakulina also complained of her involuntary psychiatric confinement. An emergency doctor had ordered the her urgent hospitalisation on account of her deteriorating state of health. In particular, she had been living in insanitary

conditions, had not been paying utility charges, had been using an open fire, had been cooking on a radiator, and had delusional ideas about her neighbours. Her brother, who was her legal guardian at the time, consented to her hospitalisation. The psychiatric hospital then became her guardian, and consented to the hospitalisation. She was then subsequently detained on the basis of an order of the District Court, acting on expert opinion to the effect that she had schizophrenia.

In a further addition to the small but important body on the nature of consent to confinement (analysed in Alex's paper here), the court noted that it appeared that the government was claiming the applicant's treatment in the psychiatric hospital had been voluntary because her guardians had consented to it and that, thus, the applicant was not deprived of her liberty within the meaning of Article 5(1) of the Convention. Relying on its analysis in the earlier Shtukaturov case, the court found that: "*even though the applicant was legally incapacitated, it did not preclude her from understanding her situation and expressing her opinion on the matter* [and that] *she was able to understand her situation and did not agree to her psychiatric confinement. Therefore, she was deprived of her liberty for the purposes of Article 5 § 1 of the Convention*."

Whilst the court found that Ms Shakulina was undeniably suffering from a mental disorder and thus could be considered "a person of unsound mind," there had not been any proper analysis of the kind or degree of the applicant's mental disorder and a number of serious procedural defects in the judicial authorisation of her continued involuntary psychiatric confinement. Her deprivation of liberty was therefore unlawful.

Comment

On one view, the observations of the court in relation to incapacitation relate to a far-off legal procedure of which we know little. However, the reality is that appointment of a deputy under the MCA or a guardian under the Adults with Incapacity Act may [1] have the effect of amounting to legal incapacitation of the individual in question, at least in respect of all decisions within the scope of the deputy/guardian's authority.

This judgment should again make us ask whether the changes in the Court of Protection Rules in (now) rule 1, introducing the menu of options for P's participation – which were introduced in large part in response to the earlier case-law of the court – go far enough? And what of the position in Scotland in relation to guardianship applications?

This judgment is also of interest for the fact that no reference is made to the CRPD, despite the fact that the case was brought by the admirable MDAC (now Validity), who have been assiduous

[1] We say "may" because we note that Strasbourg appeared to consider that that the Finnish system, which allows for a "*mentor*" to represent a "*ward*" in relation to matters pertaining to their person only where the latter is "*unable to understand its significance*" did not amount to a deprivation of restriction of legal capacity, because "*the interference with the applicant's freedom to choose where and with whom to live that resulted from the appointment and retention of a mentor for him was therefore solely contingent on the determination that the applicant was unable to understand the significance of that particular issue. This determination in turn depended on the assessment of the applicant's intellectual capacity in conjunction with and in relation to all the aspects of that specific issue.*" (*AM-V v Finland* [2017] ECHR 273).

in other cases in highlighting its provisions. In any event, however, the judgment does not suggest that the Strasbourg court considers that measures to remove or limit legal capacity on the basis of (in CRPD terms) psychosocial disability are per se unlawful. Rather, the court proceeds on the basis that they constitute a serious interference with the rights of the individual, must proceed on the basis of proper evidence and suitable procedural protections, and, crucially, represent a tailor-made solution to the circumstances of the individual. It would be interesting to see how the Strasbourg court reacted to the provisions of s.5 MCA 2005 which, as they stand, represents both a much less draconian – and more tailor-made – way of responding to temporary or permanent impairment of capacity, but, conversely, a measure which is surrounded with very few procedural safeguards.

Finally, it is difficult when reading the discussion of whether Ms Shakulina was consenting to her confinement not to have in mind the recent blog by Mark Neary about the capacity assessment being undertaken for his son for purposes of the 'community DOLS' application being prepared by Hillingdon. If the 'test' that was being set was whether was able to express a view on the matter, one might think that he both could and does – and that, on this test, he should not be considered to be deprived of his liberty.

Involuntary detention – a further go-round in Geneva?

For those who have been following the split in Geneva between the UN bodies as to whether involuntary detention and/or treatment is ever permitted (as to which, see further here), the most recent opinion of the Human Rights Council Working Group on Arbitrary Detention ('WGAD') makes fascinating reading.[2]

The WGAD was considering a complaint relating to Japan regarding the detention, on (broadly) psychiatric grounds of a Mr N. The WGAD, noted that:

> *35. The Working Group notes that article 9 of the Covenant* [i.e. the International Covenant on Civil and Political Rights] *requires that no one shall be deprived of his or her liberty except on such grounds and in accordance with such procedures as are established by national law. In the present case, the Working Group observes that article 29 of the Act on Mental Health and Welfare for the Mentally Disabled (Act No. 123 of 1950) permits hospitalization only when two or more designated mental health doctors have made the same judgment that the person in question has a psychiatric disorder and that he or she could harm himself or herself or others due to his or her psychiatric disorder unless he or she is hospitalized for medical care and protection. In such a case, the Governor of the Prefecture shall inform the person in question, in writing, of the fact that he or she is to be involuntarily admitted.*
>
> *36. Without making any assessment of the compatibility of the above-mentioned provisions of the Act on Mental Health and Welfare for the Mentally Disabled with the international human rights obligations of Japan, it appears obvious to the Working Group that those provisions were not followed during the involuntary hospitalization of Mr. N.*
>
> […]

[2] It is available here http://www.ohchr.org/Documents/Issues/Detention/Opinions/Session81/A_HRC_WGAD_2018_8.pdf, in advanced unedited form.

> *38. The Working Group wishes to underline that any instance of deprivation of liberty, including internment in psychiatric hospitals, must meet the standards set out in article 9 of the Covenant. The Working Group, in the United Nations Basic Principles and Guidelines on Remedies and Procedures on the Right of Anyone Deprived of Their Liberty to Bring Proceedings before a Court, states that, where a person with a disability is deprived of his or her liberty through any process, that person is, on an equal basis with others, entitled to guarantees in accordance with international human rights law, necessarily including the right to liberty and security of person, reasonable accommodation and humane treatment in accordance with the objectives and principles of the highest standards of international law pertaining to the rights of persons with disabilities. A mechanism complete with due process of law guarantees shall be established to review cases of placement in any situation of deprivation of liberty without specific, free and informed consent. Such reviews are to include the possibility of appeal.*
>
> [...]
>
> *45. The Working Group also notes that Japan has been a party to the Convention on the Rights of Persons with Disabilities since 20 January 2014. The Working Group reiterates that it is contrary to the provisions of article 14 of the Convention to deprive a person of his or her liberty on the basis of disability. Moreover, as stated in the Basic Principles and Guidelines, the involuntary committal or internment of persons on the grounds of the existence of an impairment or perceived impairment is prohibited.*
>
> *46. The Working Group once again wishes to emphasize that Mr. N was initially detained for the minor offence of attempted theft of a can of carbonated drink. Neither at the time of his detention nor prior to that there is any evidence of Mr. N being violent or otherwise presenting a danger to himself and/or to others. His subsequent transfer to Tokyo Metropolitan Matsuzawa Hospital had no connection to the initial incident of attempted theft. It is therefore clear to the Working Group that the deprivation of liberty of Mr. N was carried out purely on the basis of his psychiatric disorder, and was thus discriminatory* (emphasis added).

From paragraph 46, it would appear, therefore, that the WGAD takes the view (as does, inter alia, the UN Human Rights Committee) that it is lawful to deprive a person of their liberty where they both have a psychiatric disorder and either pose a risk to themselves or others. Paragraph 45 suggests that the WGAD consider that they are, in so doing, applying Article 14 CRPD. The CRPD Committee by contrast takes the view (in its Guidelines on Article 14) that "*the involuntary detention of persons with disabilities based on risk or dangerousness, alleged need of care or treatment or other reasons tied to impairment or health diagnosis is contrary to the right to liberty, and amounts to arbitrary deprivation of liberty*."

We also note in this context the admissibility decision (in November 2017, but which has only just come to our attention) of the Strasbourg court in *N v Romania*. In its – now usual – review of relevant international instruments, the court took specific note both of Article 14 CRPD and of the Committee's guidelines on the Article (see both paras 102-3 and 147). However, these did not lead the court to conclude that deprivation of the liberty on the basis of unsoundness of mind was, per se, unlawful, as the Committee contends (see the review of general principles at paras 141-142). Rather, and in similar vein to the WGAD, the court proceeded on the basis that Article 14(1)(b) CRPD was aimed at stopping situations where the sole reason for detention

was the individual's disability: see paragraph 159 and the discussion in the preceding paragraphs about the absent of evidence that Mr N posed any danger to society.

World Health Organisation report on institutional care in Europe

A report published in June by a WHO project on adults with psychosocial and intellectual disabilities living in institutions in the WHO European Region examined a total of 75 institutions across 24 countries in the Region and Kosovo using the WHO QualityRights Toolkit. Out of all the quality ratings made, only 25% showed compliance with international standards, meaning that long-term institutional care in the Region has significant room for improvement. As the report identifies:

> *long-term institutional care for people with psychosocial and intellectual disabilities in many European countries is far below the standard. A significant proportion of the assessed institutions were violating the fundamental rights of people with psychosocial and intellectual disabilities, including their legal capacity, autonomy, dignity, liberty and security of person, physical and mental integrity and freedom from torture and ill treatment and from exploitation, violence and abuse. Some of the most egregious violations reported were: use of mechanical and pharmacological restraints to manage difficult behaviour, a culture of impunity with regard to reported cases of sexual abuse, numerous irregularities concerning informed consent, discrimination and barriers to access to high-quality care for general and reproductive health, lack of alternative or complementary mental health treatment options and a general lack of opportunities for meaningful daily activities within or outside the institutions.*

SEND assistance from abroad

For those seeking to make arguments based upon the CRPD before the SEND Tribunal, in particular for measures to be taken to ensure provision of education on an inclusive basis, we would suggest that reference might usefully be made to the detailed report just issued (so far in advanced unedited form) by the CRPD Committee in response to a complaint against Spain in relation to its provision of special educational needs.

OTHER INTERNATIONAL DEVELOPMENTS OF RELEVANCE

Vulnerable Adults – a Singaporean solution?

On 18 May 2018, the Government of Singapore passed the Vulnerable Adults Act (a link to the Bill is here, which we understand was passed without amendment). The passing of the Act follows extensive consultations and engagements with the public and stakeholders with strong support for the Bill, with many acknowledging the problems associated with Singapore's rapidly ageing population. The Act is intended to provide greater protections for vulnerable adults. Section 4(1) sets out the key principles:

> *(1) In performing any duty or exercising any power under this Act in relation to a vulnerable adult, the Director and every protector, approved welfare officer and enforcement officer must have regard to the following principles:*
>
> *(a) the duty is being performed or the power is being exercised for the purpose of protecting the*

vulnerable adult from abuse, neglect and self-neglect;

(b) a vulnerable adult, where not lacking mental capacity, is generally best placed to decide how he or she wishes to live and whether or not to accept any assistance;

(c) if a vulnerable adult lacks mental capacity, the vulnerable adult's views (whether past or present), wishes, feelings, values and beliefs, where reasonably ascertainable, must be considered;

(d) regard must be had to whether the purpose for which the duty is being performed or the power is being exercised can be achieved in a way that is less restrictive of the vulnerable adult's rights and freedom of action;

(e) in all matters relating to the administration or application of this Act, the welfare and best interests of the vulnerable adult must be the first and paramount consideration.

The Vulnerable Adults Act is intended to complement existing laws that protect vulnerable individuals such as the Women's Charter and Mental Capacity Act (the latter modelled very closely upon the English MCA 2005). The powers conferred in the Act enable the State to intervene by way of, for example, entering a vulnerable adult's premises (section 8), assessing his or her condition (section 6), and relocating that individual to a place of safety (section 11) if he or she is at risk. The threshold for exercising these powers is a high one – either the individual must be a "vulnerable adult" (defined as an individual over the age of 18 and is, by reason of mental or physical infirmity, disability or incapacity, incapable of protecting himself or herself from abuse, neglect or self-neglect) and who is experiencing or at risk of abuse, neglect or self-neglect (section 5). According to the Ministry of Social and Family Development ("MSF"), the Act is designed to be used as a matter of last resort where family and community interventions have been exhausted or are ineffective. The Minister for Social and Family Development made a public plea for the community to step forward and break the silence by reporting any suspected cases of abuse, neglect or self-neglect. The Act protects whistleblowers from civil and criminal liability as long as they act with reasonable care and in good faith. The MSF intends to bring the law into force before the end of the year.

It is instructive to consider from our perspective what we might learn from overseas jurisdictions dealing with similar problems and concerns. In our domestic legal system, the regime of last resort which is deployed to protect vulnerable adults is the inherent jurisdiction of the High Court – a device which was called "the great safety net" by Lord Donaldson MR in *Re F* [1990] 2 AC 1 cited with approval by the (soon to be) President of the Court of Protection, Lord Justice McFarlane, in *A Local Authority v DL* [2012] EWCA Civ 253. That "the great safety net" of the inherent jurisdiction has survived the passing of the Mental Capacity Act 2005 in England and Wales is not now in doubt. However, what is far from clear is the precise remit of the inherent jurisdiction and the circumstances in which it can – and should – be exercised. This is often left to be tested on a case by case basis. There

is an argument that a codified statutory framework, along the lines of the Singapore Vulnerable Adults Act, setting out the principles, powers and circumstances in which those powers can be exercised, might provide greater certainty and confidence to act (or refrain from acting) in what are very often extremely difficult, sensitive and delicate circumstances. Scotland already has a statutory framework for the protection of adults at risk of harm in the Adult Support and Protection (Scotland) Act 2007.

The express protection for whistleblowers might also engender a culture of more openness which is particularly critical where acts of abuse take place behind closed doors. It will be interesting to see how the Singapore Vulnerable Adults Act is interpreted and utilised in practice in future years.

Gibraltar Lasting Powers of Attorney and Capacity Act 2018

This new law came into effect in April 2018, including provisions (modelled on the MCA) relating to lasting powers of attorney and advance decisions, and a scheme (modelled on that in the Jersey Capacity and Self-Determination Law 2016) for authorising 'significant restrictions upon liberty.' It will be interesting seeing how these statutory definitions fare before the courts, hooked as they are very much on redefining the objective 'acid test' in ways that, on their face, may appear to water down the universality of the meaning of the right to liberty so strongly emphasised by Lady Hale in *Cheshire West*.

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Simon has wide experience of private client work raising capacity issues, including *Day v Harris & Ors* [2013] 3 WLR 1560, centred on the question whether Sir Malcolm Arnold had given manuscripts of his compositions to his children when in a desperate state or later when he was a patient of the Court of Protection. He has also acted in many cases where deputies or attorneys have misused P's assets. To view full CV click here.

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Adrian is a recognised national and international expert in adult incapacity law. While still practising he acted in or instructed many leading cases in the field. He has been continuously involved in law reform processes. His books include the current standard Scottish texts on the subject. His awards include an MBE for services to the mentally handicapped in Scotland; national awards for legal journalism, legal charitable work and legal scholarship; and the lifetime achievement award at the 2014 Scottish Legal Awards.

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Jill Stavert is Professor of Law, Director of the Centre for Mental Health and Capacity Law and Director of Research, The Business School, Edinburgh Napier University. 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 2015 updated guidance on Deprivation of Liberty). To view full CV click here.

Conferences

Conferences at which editors/contributors are speaking

Court of Protection seminar: The capacity to marry and divorce, and damages in the Court of Protection

Tor is speaking, with Fenella Morris QC, at a seminar organised by Irwin Mitchell on 21 June in London. For more details, and to book, please use this email address.

Other conferences of interest

UK Mental Disability Law Conference

The Second UK Mental Disability Law Conference takes place on 26 and 27 June 2018, hosted jointly by the School of Law at the University of Nottingham and the Institute of Mental Health, with the endorsement of the Human Rights Law Centre at the University of Nottingham. For more details, see here.

Towards Liberty Protection Safeguards

This conference being held on 24 September in London will look at where the law is and where it might go in relation to deprivation of liberty. For more details, and book, see here.

Advertising conferences and training events

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

Our next report 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 Report in the future please contact: marketing@39essex.com.

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