



Welcome to the September 2017 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: alcohol and best interests, the price for failing to support, patient choice from the other side of capacity, and Bournemouth brought to life;

(2) In the Property and Affairs Report: Denzil Lush and LPAs, the Law Commission consultation on wills, professional deputies run amok and OPG updates;

(2) In the Practice and Procedure Report: s.21A, medical treatment and the role of the courts, the extension of the pilots, and guidance on CoP visitors;

(3) In the Wider Context Report: mental capacity in (in)action in SARs, litigation friends in tribunals, legal services and vulnerability, and the Committee on the Rights of Persons scrutinises the UK;

(4) In the Scotland Report: a Scottish perspective on powers of attorney problems and attorney registration updates.

You can find all our past issues, our case summaries, and more on our dedicated sub-site [here](#), and our one-pagers of key cases on the SCIE [website](#).

We also take this opportunity to say goodbye to our fellow editor Anna Bicarregui and thank for all her dedication in producing contributions against the odds – we will miss you.

Editors

Alex Ruck Keene
Victoria Butler-Cole
Neil Allen
Annabel Lee
Nicola Kohn
Simon Edwards (P&A)

Scottish Contributors

Adrian Ward
Jill Stavert

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.

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When is one drink too many?

DM v Y City Council [2017] EWCOP 13 (Bodey J)

Article 5 ECHR – deprivation of liberty

Summary

Mr DM was a 69 year old man who had a long history of alcoholism and a longstanding diagnosis of Korsakoff's syndrome. He neglected himself to a significant degree necessitating admission to hospital and was discharged to a 'dry' care home, apparently with his agreement. By the time of the proceedings he had been residing in a care home for 5 years without access to alcohol. For the previous 2 years he had been subject to 24 hour one-to-one supervision and was not allowed to access the community when he chose, after an incident when he purchased alcohol. DM had no relatives and was reported to have only one friend, another resident of the care home. DM wished to leave the care home and to consume alcohol and brought proceedings challenging his deprivation of liberty under s.21A MCA 2005.

Bodey J decided that it was not in DM's best interests to move to another care home where the consumption of alcohol was permitted, despite this being DM's expressed wish and his acceptance of the risk that it would shorten his life, noting that '*everybody has to die sometime*'. There was medical evidence that if DM resumed drinking he would become very unwell, as he had advanced liver disease, and had a life expectancy of about 7 years if not drinking and 3 years if drinking even a relatively modest amount. DM had no recollection of the events that had led to his admission to the care home.

The court's decision was described as 'finely balanced' and the judge admitted that on first reading the papers his view was that DM should be allowed to move to a care home where he could consume alcohol. In the end, the judge concluded that DM should remain in the care home for a number of reasons:

- a. It was not clear that DM would be happy in a new care home as his alcohol consumption would not be unlimited, and he would suffer a faster decline in his mental and physical health.

- b. Even though DM had a compulsive wish to drink, when he had been taken to visit the alternative care home, he said that he didn't know if he wanted to move there and would need to live there for a month or so before deciding. This suggested his wish for drink was not as strong as might have been thought.
- c. DM would lose his only friendship if he moved and it was far from certain that if DM changed his mind, he could return to the same placement.

The judge also concluded there was therefore no benefit in a trial period in an alternative home as this would just give DM a renewed taste for alcohol and it would be cruel to expect him to revert to a dry environment if the trial failed.

Bodey J concluded his judgment by noting that DM would not welcome the decision and saying that the transcript of his decision should be made available so that it could be considered in the event that DM brought a further s21A challenge because his continued residence at the care home was causing him real ongoing frustration and unhappiness.

Comment

This decision is an example of a relatively common scenario that arises in the Court of Protection in respect of people with long histories of alcohol misuse. It is perhaps unsurprising that the judge did not consider DM's wishes determinative given the evidence of serious harm to his mental health, as well as his physical health, if he resumed drinking, meaning that the assertion that acceding to DM's wishes would make him happy was too simplistic.

Whatever one's views of this decision, comparison of the reasoning in this case with that of the Court of Appeal in the *RB* case demonstrates just how far we have come since 2014 as regards engagement with the principle that constructing a best interests decision starts with the individual.

Paying the price for a failure to support

CH v A Metropolitan Council [2017] EWCOP 12 (Sir Mark Hedley)

Article 8 ECHR – contact – mental capacity – sexual relations – COP jurisdiction and powers – damages

Summary

CH was born with Downs Syndrome and an associated learning difficulty. In 2010, he married his wife, WH, and they lived together in his parents' home. They sought fertility treatment, during which a consultant psychologist concluded in late 2014 that CH lacked capacity to consent to sexual relations. On 27 March 2015, the couple were informed of the capacity assessment and WH was advised that she must abstain from sexual intercourse with her husband as that would, given his incapacity to consent, comprise a serious sexual offence under sections 30-31 of the Sexual Offences Act 2003. She was also given to understand by the local authority that should she fail to comply, safeguarding measures would be taken which would require the removal of CH (or herself) from their home. His wife moved into a separate bedroom and significantly reduced any expression of affection so as not "to lead him on". CH could not understand why she did that and,

As Sir Mark Hedley noted, “[t]he impact of all this on CH is not difficult to imagine.”

Importantly, the consultant psychologist had made clear that CH needed a course of sex education to assist him to achieve the necessary capacity. As Sir Mark noted “[t]hat advice was of course in line with the principle set out in Section 1(3) of the Mental Capacity Act 2005 (MCA 2005) which provides – “A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.” However, “[f]or reasons that have never been satisfactorily explained, the Local Authority failed to implement that advice despite requests and protracted correspondence.” In the end, it required proceedings initiated by CH’s sister in February 2016 to bring about both that education and, in due course, a determination that CH had the requisite capacity.

A court order implemented the original psychological advice and the education course finally began on 27 June 2016. The therapist reported that CH had made sufficient progress in all areas but did not understand the health risks from a sexually transmitted disease. However, given that CH and WH were in a committed monogamous and exclusive relationship, he questioned whether that was ‘relevant information’. The court-appointed expert psychiatrist advised that further sex education would be necessary and the same therapist delivered this in early 2017, as a result of which CH now had capacity to consent to sexual relations. The court made a declaration to that effect on 2 May 2017, after which the couple were entitled to and did resume a normal conjugal relationship.

A claim was then brought under the Human Rights Act 1998 on the basis that the local authority breached CH’s rights under Article 8 ECHR. And the court was invited to approve the claim on behalf of CH. As Sir Mark Hedley noted:

12. However, Article 8 is a qualified right and it is important to note where it is alleged the breaches occurred. There can be no criticism of the fact that there was an assessment in late 2014. Given the outcome, the letter of the 27th March 2015 was inevitable having regard to the provisions of the criminal law. The sex education was a response wholly consistent with Section 1(3) of the MCA 2005. Whilst there may have been legitimate debate about the necessity for the second course [of sex education, at the suggestion of the jointly instructed expert] in early 2017, it would not be actionable given the advice tendered to the court and the court’s acceptance of it. It follows that some incursions on the conjugal relations of CH and WH would have been justifiable by Article 8(2).

13. The gravamen of the claim is the delay in implementing the advised programme of education: that is to say the period between 27th March 2015, when conjugal relations were required to cease, (although the lack of capacity had been established in January 2015) and the start of the first sexual education programme on 27th June 2016. Given that the Local Authority would have needed some time to set up the programme, the actionable delay over all is one of not less than 12 months. The Local Authority has not sought to contest that conclusion nor that they are apparently in breach of Section 6(1) of the HRA 1998.”

Sir Mark Hedley made the important observation (rather lost in the press coverage) that:

15. Before turning to the proposed settlement itself one further observation may be ventured. This case is unusual; indeed thus far it may be unique in being applied to a settled, monogamous and exclusive married relationship. In those rare cases where the courts have made declarations of incapacity to consent to sexual relations, they have generally been cases of restraining sexual disinhibition to protect from abuse or the serious likelihood of abuse. However, logically the question of capacity must apply also to married relations and the criminal law makes no distinction between settled relations and sexual disinhibition or indeed between sexual relations within or outside marriage. Society's entirely proper concern to protect those who are particularly vulnerable may lead to surprising, perhaps even unforeseen consequences. Such, however, may be the price of protection for all."

CH's wife had already brought her own claim for a violation of Article 8 ECHR which had been settled on confidential terms. But for CH, the local authority made the following offer to settle the claim:

1. to make a formal apology to CH for the delay from January 2015 to June 2016 in providing him with the sex education to which he was entitled;
2. to pay to CH damages in the sum of £10,000 as a result of that delay;
3. to pay CH's pre-action costs associated with this claim in the sum of £7,395 (inclusive of VAT);
4. to pay CH's costs of the Part 8 application and seeking the approval of the court for this settlement (in respect of which outline agreement has been reached).

The local authority had also agreed to pay CH's costs of the Court of Protection proceedings agreed at £21,600 (inclusive of VAT). This ensured that the damages would not need to be recouped by the Legal Aid Agency under s.25 of the Legal Aid, Sentencing and Punishment of Offenders Act 2012.

The court approved the terms of the settlement as being in CH's best interests and reflecting a fair outcome to the proceedings. Sir Mark Hedley emphasised, however, that "[m]any would think that no couple should have had to undergo this highly intrusive move upon their personal privacy yet such move was in its essentials entirely lawful and properly motivated. As I have said, perhaps it is part of the inevitable price that must be paid to have a regime of effective safeguarding" (para 25).

Comment

This important decision raises a substantive issue relating to the capacity to consent to sexual relations. In particular, whether the risk of sexually transmitted diseases is relevant information where the individuals are in a committed monogamous and exclusive relationship. Compared to those situations where sexual disinhibition puts P at serious risk of abuse, the sexual health risks must be negligible.

The case also provides a useful opportunity to reflect upon whether capacity to consent to sexual relations ought to be "on a general and non-specific basis" (*IM v LM and others* [2014] EWCA Civ 37, at [77]) or whether a more sensitive

person-specific approach ought to be adopted. After all, sex is a form of contact and capacity to consent to contact is person-specific (see '[The opacity of sexual capacity](#)' (2012) 2 Elder Law Journal 352). In our view, it would be entirely logical, for example, for CH to have capacity to consent to sexual relations with his wife whilst lacking capacity to consent to sexual relations to others as the nature and degree of risks are different.

It is interesting that English law seems comfortable making best interests decisions that P has contact with Y but prohibits in MCA s.27 a decision that it is in P's best interests to have sexual relations with Y. The logic appears to be that such a decision would be too personal to make on behalf of P. But why? Is it not just as personal *not* to make such a decision? To have to do what CH's wife did in this case so as not "to lead him on"? Could it be argued that the absolute prohibitive nature of MCA s.27 is in fact contrary to Article 8 (and potentially 12) ECHR? The warning letter from the local authority in this case also vividly illustrates the stark interface between sexual incapacity and the criminal law. Whether the blanket prohibition in the Sexual Offences Act 2003 is necessarily the appropriate response has also been called into question (for example, see Bartlett, '[Sex, Dementia, Capacity and Care Homes](#)' (2010) 21(2) Liverpool Law Review 137).

We note, finally, that something may have gone awry procedurally (at least as it is reported). Sir Mark Hedley noted that, pursuant to the decision in *Luton v SW* [2017] EWHC 450 (Fam), the claim had to be brought under the Civil Procedure Rules as a Part 8 claim. To comply with *H v Northamptonshire CC* [2017] EWHC 282 (Fam) at

[117], a letter before action was sent on CH's behalf. Sir Mark Hedley then noted that the court's approval to the proposed settlement was required under CPR rule 21.10.

The difficulty with the course of action set out above is that it seems to have conflated two things: (1) the fact that a separate claim for HRA damages should have been brought, something which now appears to be the right course of action in almost all cases (not least to avoid problems with the LAA statutory charge); and (2) the location for such a claim. A CoP judge, as CoP judge, has no ability to hear a Part 8 CPR claim. Either the CoP judge should be hearing and determining a claim brought within the CoP under the CoP Rules (and Practice Direction 11A), or they should be sitting as a judge endorsing a settlement within civil proceedings.

All life is an experiment – patient choice from the other side of capacity

B v D [2017] EWCOP 15 (Baker J)

Best interests – medical treatment

Summary

In this fascinating case, Baker J had to consider whether it was in the best interests of a soldier, D, to travel to Serbia to receive stem cell treatment for a traumatic brain injury he had suffered at the hands of a fellow soldier. This proposal was advanced by his mother – who brought the proceedings herself, and acted in person – and who Baker J noted was "*utterly devoted to ensuring that he receive[d] the best possible care and support.*" As D had resources to pay for the treatment from a compensation payment, the question for the court was whether

it was in his best interests (i.e. this was not a case where the options open to him were constrained by public funding, notwithstanding the fact that the Ministry of Defence remained responsible for his overall care and treatment).

It was clear that D did not have the capacity to make the decision. His mother served with her application evidence from D's treating neuropsychologist to the effect that, as a result of the impairment to his brain, D lacked the capacity to make decisions concerning his medical treatment:

[...] In particular, he lacked the capacity to understand, use and weigh the relevant information. The neuropsychologist expressed the opinion that, due to his cognitive difficulties, D was not able to understand more complex information. He was able to say that the stem cells will make him "normal" but was not able to follow the description or the rationale of how they work. Furthermore, as a result of his difficulties, he was unable to use or weigh up the options as part of the decision-making process. His rigid thinking patterns made it impossible for him to think flexibly about the pros and cons of the treatment. The neuropsychologist added that D was assessed as being vulnerable to being suggestible to others. He said that his mother thinks the treatment will make him "normal" and therefore he will do it."

D very much wanted the treatment. As Baker J relayed his conversation with him:

"D told me that he wished to have the stem cell treatment and that it would work for him. He said the reason why he wanted to have the treatment

was that he wanted to be a normal person and thought the treatment would help. I asked whether he was ok about flying to another country for the treatment and he said yes. I asked whether he understood that there was no guarantee that the treatment would work and he replied that it would work for him. I asked whether he was happy to take the risk that it would not work and he replied "I am". When I asked D how he was getting on at Y Hospital and whether it was better than where he had been before, he replied "no". When I asked whether he was making progress there, he replied "not at all". When I asked what else he would like to say to me about the treatment, he repeated: "I just want to be normal". Mrs B then spoke, thanking him for coming to the phone and telling her his wishes. She said that she would call him later. D replied "I want stem cell mum, I want to leave here and don't want..." It was not possible to discern precisely what D said at that point, but Mrs B summarised what she understood D had said he wanted, namely that he said that he wanted the treatment because he thinks his speech will improve and the tightness on his left side will improve. At that point, we said goodbye to D."

The evidence before the court included, importantly, evidence from the chief doctor of the clinic in Belgrade, Dr Bulboh, and evidence from an Italian expert, Professor Martino, who was opposed to the treatment.

The proposal was opposed by both the Ministry of Defence and the Official Solicitor as his litigation friend, for slightly different reasons. A balance sheet for and against having the treatment was drawn up by Baker J combining the balance sheets produced by their respective

Counsel. As he noted (at paragraph 55) this set out *“an aide memoire of the key factors and how they match up against each other and as a route to judgment rather than a substitution for the judgment itself,”* and is reproduced below.

Having the stem cell treatment

Advantages	Disadvantages
It accords with D’s consistent and strongly-held wishes and feelings	The efficacy of this treatment has not been established through any clinical trials. According to Prof Martino, Swiss Medica does not adhere to the international regulations that should be followed in these matters
It accords with the views of his mother	D will be exposed to known risks (allergic reaction, developing a tumour, risks associated with the procedure e.g. lumbar puncture and use of a catheter) and also to unknown risks which cannot be excluded because of the absence of clinical trials or research.
Any adverse psychological reaction to being prevented from having the treatment is avoided. Regardless of treatment outcome there may be psychological benefit to D arising from	Travelling to Serbia to undergo the treatment risks disrupting his rehabilitation programme and the ongoing physical and psychological work.

(1) his having his wishes respected and (2) knowing that what he sees as a potential treatment avenue has at least been tried.

There is a potential for improvement, although the evidence for this is only the anecdotal evidence of Dr. Bulboh unsupported by any research or by the opinion of Prof Martino.

He has made substantial progress through rehabilitation and is anticipated, at some point, to move on to a community step-down placement. If he develops a serious illness as a result of the treatment, his future prospects would be considerably worse.

D may have an adverse psychological reaction when he does not see any benefit from the treatment

The treatment is expensive. He will be spending the money he received from his compensation award on an ineffective treatment when he could otherwise spend the money on care/therapies /treatment or on other things he would like to do to enhance his life

Not having the treatment

Advantages	Disadvantages
He does not undergo a treatment which has no scientifically proven benefit	The decision does not accord with D's wishes
D is not exposed to known and unknown risks	There is a risk that D will have an adverse psychological reaction when told that he will not undergo the treatment
The progress he has made through rehabilitation is not put at risk	The decision does not accord with the wishes of his mother
He does not spend a substantial amount of his compensation monies on a treatment which may be ineffective.	He loses the opportunity of a possible improvement which the treatment might achieve.

Having directed himself earlier as to the approach to best interests by reference to the *Aintree* approach, Baker J then analysed precisely how this mapped onto the facts of the case directly before him. As he noted:

56. The key factor amongst the advantages of allowing D to undergo stem cell treatment, and the disadvantages of refusing, is that it accords with D's wishes. I accept that D has a significantly limited understanding of what the treatment entails and of the prospect of success and of the possible risks. But I am satisfied that he wants the treatment and that he wants it very much.

I agree with the observation of Peter Jackson J in the Wye Valley case quoted above that

"once incapacity is established so that a best interests decision must be made, there is no theoretical limit to the weight or lack of weight that should be given to the person's wishes and feelings, beliefs and values. In some cases, the conclusion will be that little weight or no weight can be given in others, very significant weight will be due."

*Wishes and feelings of an incapacitated adult are an important factor in any best interests analysis. As Ms Dolan recognised, the fact that D, although lacking capacity, is in cognitive terms relatively high-functioning does not by itself mean that his wishes and feelings carry greater weight. But it may make it easier to discern and understand what those wishes and feelings are – easier, adopting the words used by Baroness Hale in the *Aintree* case, to "see things from the patient's point of view". In this case, I am very clear that D has a very strong wish to undergo stem cell treatment.*

57. I also find, as Ms Dolan, I think, accepts, that the views D is expressing are his own views. I do think that B has some influence over her son, but from his own statements, in particular his statements to me, I am very confident that the wishes he is expressing are genuinely his own. The Official Solicitor and the MOD have both relied on D's statement that he wants the treatment so that he can be "normal" as evidence of his lack of understanding of the treatment and its prospects of success. But I see this statement more as an expression of the strength of his wish to have the

treatment. He may be over-optimistic as to the extent to which the treatment may improve his condition, but I find he is aware that it may not work at all. As he said to his mother – “Mum, if I don’t try, I’ll never know”

However, as Baker J noted:

58. The key factors on the other side of the argument – the disadvantages of allowing treatment and the advantages of refusing it – are that it is unsupported by any or at least any significant body of research, that it has not been subjected to clinical trials, and that the evidence that it is, or might be, an effective treatment for traumatic brain injury is almost entirely anecdotal. [...]

Having outlined the key medical evidence, Baker J noted that Dr Bulboh accepted that his treatment was experimental – but that:

60. But all life is an experiment. In my thinking about this case, I have repeatedly come back to those words of Munby J in Re MM, and to the rest of the passage, in particular:

“Physical health and safety can sometimes be bought at too high a price in happiness and emotional welfare. The emphasis must be on sensible risk appraisal, not striving to avoid all risk, whatever the price, but instead seeking a proper balance and being willing to tolerate manageable or acceptable risks as the price appropriately to be paid in order to achieve some other good – in particular to achieve the vital good of the elderly or vulnerable person’s happiness. What good is it making

someone safer if it merely makes them miserable?”

In this case, I think it almost certain that D will be much more than miserable if he is denied the opportunity to have stem cell treatment. I do not accept that his reaction will be confined to mere “disappointment”. It is highly likely that he will demonstrate an adverse reaction in his behaviour which may significantly impede and delay his rehabilitation. In saying that, I do not deny the possibility that D may also be distressed, and suffer an adverse reaction, if the treatment does not go well, or if he suffers side-effects or contracts an illness as a result of the treatment. But, as Peter Jackson J observed in the Wye Valley case, as cited above, “for people with disabilities, the removal of such freedom of action as they have to control their own lives may be experienced as an even greater affront than it would be by others who are more fortunate.” Thus, as identified in the balance sheet above, regardless of treatment outcome there may be psychological benefit to D arising from his having his wishes respected and knowing that what he sees as a potential treatment avenue has at least been tried. As Baroness Hale emphasised in the Aintree case, decision-makers must look at the patient’s welfare in the widest sense, not just medical but social and psychological. If D is denied the opportunity to have stem cell treatment on the grounds that this is the safer option, there is in my judgment a strong argument that his safety may be bought at too high a price in terms of his happiness and emotional welfare.

61. I have not found this an easy decision but, having appraised the risks and considered the advantages and disadvantages of the options in this case,

I have ultimately reached the clear conclusion that this court should give its provisional consent to D travelling to Belgrade to receive stem cell treatment [subject to a stringent series of conditions that would have to be met before he could give final approval.]

Comment

This case shows – again – the *Aintree* effect. D was, of course, ‘lucky’ that he had his own resources so that the decision that Baker J had to construct on his behalf was not one constrained by the willingness of statutory bodies (here the MOD) to fund particular options. But the willingness of Baker J to take a calculated risk on the part of D is striking.

For those who want to think more about this decision sits with the CRPD, see Alex’s post [here](#).

DOLS – where now?

Readers may have seen an article in [Community Care](#) in the summer suggesting that the Government is considering introducing interim measures pending a full-scale replacement of DOLS. These are said to include relaxing the statutory timescales for DoLS applications and the criteria for DoLS assessors, including BIAs and mental health assessors. We understand that Government officials have met with a number of DoLS leads and best interests assessors to discuss a limited number of potential measures. But no final decision has been taken. We also understand that -contrary to the suggestion in the story - there has been no decision to put implementation or consideration of the Law Commission’s proposals on hold until at least 2019 because of Brexit-induced lack of space in the Government’s legislative

programme. We await the new Government’s formal response to the Law Commission’s proposals which should shed more light on the path ahead.

Clinical Trials Regulations

For aficionados of ss.30-34 MCA 2005 and the provisions there relating to mental capacity and research, you will wish to be aware that the European Medicines Agency recently [confirmed](#) that the EU Clinical Trials Regulations (which will affect the governing framework within which many of the research investigations covered by the sections) will not now be coming into force into May 2019 at the earliest. Quite how this will then play out domestically in light of Brexit is another matter...

The legacies of Bournemouth and Mr C

BBC Radio 4’s test case series have recently dramatised [HL’s](#) detention in Bournemouth hospital and re-broadcasted [Mr C’s](#) gangrenous leg case, each providing a drama of the events followed by commentary on the legacy of the rulings. Compulsory listening, they provide the missing human side to even the most humanised of legal judgments. We learn that HL now has the confidence that he is understood but, still 20 years after his experience, retains an inherent distrust of strangers that look official. Now in his 60s and found not to be deprived of his liberty at home, HL is a “*chilled out fellow*” and goes out with Mr and Mrs E when he wants to. For Mr C, after the court decided that he had capacity to weigh up the risks of death from not having the amputation, he told his solicitor he wanted to leave all his money to himself when he died. Er...

With great sadness...

We report the untimely passing of Paul O'Donnell, Professional Advisor for mental health and capacity law across both health and social care in Cumbria. Over many years, Paul inspired countless trainee best interests assessors and AMHPs with his resolute commitment to a human rights based approach to practice. Born in London, where he worked for the BBC, Paul moved to Cumbria pursuing a career in the Probation Service before qualifying as an approved social worker. He was instrumental in the developing BIA and AMHP courses at the University of Cumbria, with his keen analytical mind dedicated to improving the standards of mental health social work. But he also had a significant interest in philosophy, gift for language and a sharp ear for pomposity. His greatest joy was the imparting of knowledge to others and his greatest forte was to translate the spirit of the legislation into professional practice.

Paul was open, honest, a man of great integrity and true gent. He was not afraid to tell you what you did not want to hear and would not tolerate continued ignorance once told. But that was the measure of the man: an incredible ability to see through the fog of a dispute and lead others in the direction that was right for the person at the heart of it. For example, in one of his reported cases, after receiving the judgment his first reaction was, *"This is the best outcome for George; see I knew we were right!"*. Indeed, his love of the law and all things human rights, and passion he instilled in others, will be deeply missed... Our Cumbrian sounding board has gone... He went far too soon.

For those able to come, Paul's funeral is taking place on 14 September 2017 at 1.40pm at the

crematorium on Dalston Road, Carlisle, followed by the repass from 2.30pm at the Blue Bell Inn, 6 The Square, Dalston, Carlisle CA5 7PJ.

Editors and Contributors



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Alex is recommended as a 'star junior' in Chambers & Partners for his Court of Protection work. He has been in cases involving the MCA 2005 at all levels up to and including the Supreme Court. He also writes extensively, has numerous academic affiliations, including as Wellcome Research Fellow at King's College London, and created the website www.mentalcapacitylawandpolicy.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. 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](#).



Annabel Lee: annabel.lee@39essex.com

Annabel appears frequently in the Court of Protection. Recently, she appeared in a High Court medical treatment case representing the family of a young man in a coma with a rare brain condition. She has also been instructed by local authorities, care homes and individuals in COP proceedings concerning a range of personal welfare and financial matters. Annabel also practices in the related field of human rights. To view full CV click [here](#).



Nicola Kohn: nicola.kohn@39essex.com

Nicola appears regularly in the Court of Protection in health and welfare matters. She is frequently instructed by the Official Solicitor as well as by local authorities, CCGs and care homes. She is a contributor to the 4th edition of the *Assessment of Mental Capacity: A Practical Guide for Doctors and Lawyers* (BMA/Law Society 2015). To view full CV click [here](#).

Editors and Contributors



Simon Edwards: simon.edwards@39essex.com

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](#).



Adrian Ward: adw@tcyoung.co.uk

Adrian is a Scottish solicitor and a consultant at 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](#).



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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

The Legal Profession: Back to Basics

Adrian is speaking at the [Annual Conference](#) of the Law Society of Scotland in Edinburgh on 19 September 2017.

JUSTICE Human Rights Law Conference

Tor is speaking at JUSTICE's [Annual Human Rights Law Conference](#) in London on 13 October.

Mediation Awareness Week

Tor is taking part in a [panel](#) on 16 October on "Mediating Medical cases after Charlie Gard" as part of Mediation Awareness week.

Adults with Incapacity: the Future is Now

Adrian is speaking at this half-day LSA conference on 18 October in Glasgow. For more details, and to book, see [here](#).

National Advocacy Conference

Alex is speaking at the [National Advocacy Conference](#) in Birmingham on 19 October. For more details, and to book tickets see [here](#).

National IMCA Conferences

Alex is speaking at the two Irwin Mitchell/Empowerment Matters National IMCA Conferences in [Sheffield](#) on 20 October and [London](#) on 10 November.

Deprivation of Liberty Safeguards: The Implications of the 2017 Law Commission Report

Alex is chairing this [conference](#) in London on 8 December.

Taking Stock

Neil is speaking at the annual AMHPA [conference](#) in Manchester on 19 October.

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 October. 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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