Mental Capacity Law Newsletter July 2014: Issue 48

Capacity outside the Court of Protection

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Introduction

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

(1) In the Health, Welfare and Deprivation of Liberty Newsletter: a difficult case on the line between the MHA/the MCA, safeguarding gone wrong, and updates on post-*Cheshire West* developments;

(2) In the Property and Affairs Newsletter: cases on deputies, undue influence and the COP and the duty of attorneys in continuing healthcare disputes;

(3) In the Practice and Procedure Newsletter: a focus on different aspects of access by the media to the court;

(4) In the Capacity outside the COP newsletter: an update on DNACPR notices, a case on charging in relation to monies managed by a Deputy, and updates on the Government's response to the House of Lords Select Committee's post-legislative scrutiny of the MCA 2005;

(5) In the Scotland Newsletter: an update on the legal consequences of delaying reporting by MHOs in welfare guardianship applications, a case on the proper duration of guardianship and an update on the Mental Health Bill.

In this issue, we also introduce two changes. The first is that we are delighted to introduce Simon Edwards as our Property and Affairs editor. The second is that, to reflect that many more decisions are now being reported pursuant to the President's Transparency Practice Guidance, we are introducing 'Short Notes' on cases which do not merit reporting in full here but where one or more short points of wider interest appear. As ever, we welcome feedback to the editors.

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

DNACPR Notices – when is consultation necessary?

R (Tracey) v Cambridge University Hospitals NHS Foundation Trust & Ors [2014] EWCA Civ 822 (Court of Appeal (Lord Dyson MR, Longmore and Ryder LJJ)

Summary

This decision did not concern an incapacitated patient, but is likely to be of relevance to readers insofar as it relates to serious medical treatment decisions at the end of life.

Mrs Tracey had been made the subject of a DNACPR notice shortly after admission to hospital following a car accident. She was suffering from terminal cancer and had a life expectancy of around nine months, leaving aside the effects of the accident. The first DNACPR notice was lifted after Mrs Tracey's family objected to it. Subsequently, at a point when Mrs Tracey lacked capacity to make her own decisions, a second DNACPR notice was imposed. Mrs Tracey died after a further deterioration in her condition. The claim brought by her family against the Trust was that it breached Mrs Tracey's rights under Article 8 of the European Convention on Human Rights ('the Convention') because in imposing the first notice, it failed (i) adequately to consult Mrs Tracey or members of her family; (ii) to notify her of the decision to impose the notice; (iii) to offer her a second opinion; (iv) to make its DNACPR policy available to her; and (v) to have a policy which was clear and unambiguous. The claim against the Secretary of State was that he breached Mrs Tracey's Article 8 rights by failing to publish national guidance to ensure (i) that the process of making DNACPR decisions is sufficiently clear, accessible and foreseeable and (ii) that persons in the position of Mrs Tracey have the right (a) to be involved in discussions and decisions about DNACPR and (b) to be given information to enable them so to be involved, including the right to seek a second opinion.

The claim against the Secretary of State was dismissed, the court stating that 'to hold that Article 8 requires the formulation of a unified policy at national level, rather than having individual policies at local level, is unwarranted and would represent an unjustified intrusion into government healthcare policy.'

The claim against the Trust succeeded but to a relatively limited extent. The Court of Appeal held that there had been an unlawful failure to involve Mrs Tracey in the decision to impose the first DNACPR notice, in breach of Article 8 ECHR for the following reasons:

1. Since a DNACPR decision is one which will potentially deprive the patient of life-saving treatment, there should be a presumption in favour of patient involvement. There needs to be convincing reasons not to involve the patient.

2. It is inappropriate (and therefore not a requirement of Article 8) to involve the patient in the process if the clinician considers that to do so is likely to cause her to suffer physical or psychological harm. Merely causing distress, however, would not be sufficient to obviate the need to involve the patient.

3. Where the clinician's decision is that attempting CPR is futile, there is an obligation to tell the patient that this is the decision. The patient may then be able to seek a second opinion (although if the patient's multi-disciplinary team all agree that attempting CPR would be futile, the team is not obliged to arrange for a further opinion).

In view of the above, and where the court found that the Trust's doctor had not in fact consulted Mrs Tracey about the first DNACPR notice, there was a breach of Article 8.

Comment

This decision is of significance in the context of mental capacity because the duties of consultation and 'involvement' that apply in respect of a capacitated patient such as Mrs Tracey must surely also apply to an incapacitated patient, albeit that such consultation will take place within the framework of s.4 MCA 2005. It also seems likely that the Court of Appeal's decision will lead to a renewed focus on consulting patients about their future wishes for end of life care, which may gradually result in better evidence about P's likely wishes when decisions come to be made on his or her behalf. If consulting a patient about a DNACPR notice, why not also explain other possible treatments at the end of life, and that it is possible to make an advance decision to refuse treatment, or at least to set out in writing one's views, values, beliefs and wishes?

When is the Court of Protection not the Court of Protection?

R (ZYN) v Walsall Metropolitan Borough Council [2014] EWHC 1918 (Admin) (Leggatt J)

COP jurisdiction and powers - Interface with personal injury proceedings

Summary

In this judicial review application, Leggatt J was asked to decide whether the coming into force of the Mental Capacity Act 2005 had altered the way in which funds received from personal injury awards and held by deputies should be treated for the assessment of capital resources when local authorities consider charging for domiciliary services.

The argument centred around the fact that in the labyrinth of regulations and guidance, it was a requirement for capital to be disregarded that the capital must be administered on behalf of P by the Court of Protection.

The local authority argued that the relevant regulations (the Income Support (General) Regulations 1987 (as amended)) referred to the Court of Protection as it existed before the Mental Capacity Act and, therefore, did not refer to the Court of Protection as it now exists. Further, the local authority argued that a deputy administers the capital on behalf of P and it is not administered by the Court of Protection whereas under the previous law the receiver acted as agent of the Court of Protection.

Both these arguments were rejected. In the result, Leggatt J found that the coming into force of the Mental Capacity Act 2005 had made no change to the way in which capital deriving from a personal injury award and administered by the Court of Protection is to be treated (that is to say, disregarded). He noted, in particular that the suggestion that Parliament may when bringing into force the 2005 Act simply have overlooked the reference to the Court of Protection in the relevant paragraph (44) of the Regulations. Leggatt J noted that:

> *"65. That suggestion might have force if ascertaining the intention of Parliament involved a sociological inquiry into what was actually in the minds of individual legislators. However, that would be to mistake the nature of the interpreter's task. When courts identify the intention of Parliament, they do so assuming Parliament to be a rational and*

informed body pursuing the identifiable purposes of the legislation it enacts in a coherent and principled manner. That assumption shows appropriate respect for Parliament, enables Parliament most effectively to achieve its purposes and promotes the integrity of the law. In essence, the courts interpret the language of a statute or statutory instrument as having the meaning which best explains why a rational and informed legislature would have acted as Parliament has. Attributing to Parliament an error or oversight is therefore an interpretation to be adopted only as a last resort.

66. In the absence of any compelling indication to the contrary, it must therefore be assumed that when the 2005 Act was brought into force Parliament left paragraph 44 unchanged advisedly. That could only be because Parliament was proceeding on the basis that the term "Court of Protection" in paragraph 44 remained apposite when the office of the Supreme Court with that name ceased to exist and was replaced by the new Court of Protection. In these circumstances, any ambiguity in paragraph 44 should be resolved by construing it in a way which accords with Parliament's presumed understanding of its meaning and which treats it as having current effect rather than as an empty legacy of an earlier regime which has been left uselessly on the statute book."

Comment

The result is unsurprising. Parliament is very unlikely to have intended, by a side wind, to alter the basis upon which such capital is treated by the reforms to the law introduced by the Mental Capacity Act 2005. The judgment is useful, however, for a resumé of the labyrinth of the guidance and the regulations.

The HoL Select Committee – the Government responds

The response to the Select Committee's post-legislative scrutiny report was published on 10 June and is available here.

We reproduce here the Executive Summary, and will comment further in due course:

2. Executive summary

2.1 On the 13th March 2014, the House of Lords Select Committee on the Mental Capacity Act 2005 published the report of its ten-month investigation. The Government is grateful to the Committee for its invaluable work. We agree with the Committee's overall finding: that while the Mental Capacity Act (MCA) was a 'visionary piece of legislation', the Act has 'suffered from a lack of awareness and a lack of understanding'.

2.2 The Government, together with our partners, have closely considered the 39 recommendations of the House of Lords together with inputs and insights received from our discussions with a wide range of stakeholders. This document presents our response and sets out a system-wide programme of work over the coming year and beyond that we believe will realise a real improvement in implementation of the MCA.

2.3 We intend to ensure that implementation is strengthened and co-ordinated and will consider the case for establishing a new independently chaired Mental Capacity Advisory Board. A national Board and its independent chair could also advocate for and raise awareness of the MCA, gather views on priority MCA issues and opportunities and advise the Government on key priorities for action. The Government will hold implementing partners to account, ensuring they deliver

against their commitments and responsibilities.

2.4 We share the House of Lords' concern at the lack of awareness of the MCA. Everyone has responsibility for raising awareness and every professional who works with individuals who may lack capacity should regard the responsibility to familiarise themselves with the provisions of the MCA as a basic professional duty. The Department of Health will commission a review of current guidance and tools to determine what represents the 'gold standard' that can then be widely disseminated. In 2015, the Government will host a national event to both raise awareness of the Act and to hear the views of professionals and the public as to how we can further develop our programme of work.

2.5 We will take a comprehensive approach to promoting implementation. Professional training is a priority and the Government, together with Health Education England and the Royal College of General Practitioners, have identified immediate actions. NHS England and the Association of Adult Directors of Social Care (ADASS) have committed to lead on work examining the important role that commissioning has to play in encouraging a culture in keeping with the principles of the MCA. The Care Quality Commission (CQC) has prioritised the MCA in the fundamental revision of its regulation and inspection model.

2.6 The Government will ask the Law Commission to consult on and potentially draft a new legislative framework that would allow for the authorisation of a best interests deprivation of liberty in supported living arrangements. In light of this, the Law Commission will consider any improvements that might be made to the Deprivation of Liberty Safeguards (DoLS). In the short term, ADASS will lead a task group to consider the implications of the recent Supreme Court judgment on deprivation of liberty and the Government will commission a revision of the current standard forms that support the DoLS process.

2.7 The Office of the Public Guardian (OPG) is undertaking significant work to increase the level of awareness and understanding of Lasting Powers of Attorneys (LPAs) – working with NHS England to provide guidance for front-line staff and with the CQC to make sure questions on LPAs feature in inspections of health and social care providers. HM Courts and Tribunal Service has committed to increasing the staff complement of the Court of Protection and the Government has committed to the revision of the Court of Protection Rules – with a view to having new rules in place by April 2015.

2.8 The Government believes the MCA is an Act of fundamental importance which we are committed to embedding across our work programmes. We describe early progress in respect of the Care Act 2014, the Prime Minister's Challenge on Dementia and our responses to the failings at Winterbourne View and Mid-Staffordshire NHS Foundation Trust.

2.9 We urge that all those with a role to play in implementing the MCA seize the opportunity provided by the House of Lords report and this Government response. If we maintain recent momentum and implement the programme of work we describe in this report we believe that we can create a culture that values every voice and respects every right of those who may lack capacity."

Delay, insufficient scrutiny, and the unlawful deprivation of liberty

LM v Slovenia Application no. 32863/05 (European Court of Human Rights, Fifth Section)

Article 5 ECHR – deprivation of liberty

Summary

Between July 2005 and January 2006, L.M., who suffered from a psychotic disorder, was admitted to closed and open wards in two psychiatric hospitals. The Strasbourg Court found violations of Article 5(1) with regard to her confinement in the open ward of the Ljubljana Psychiatric Hospital and her involuntary confinement in the closed wards of both hospitals. There were also violations of Articles 5(2), 5(4), 5(4) and 8.

Open ward of the Ljubljana Psychiatric Hospital

L.M. spent four months and sixteen days in the open ward. She had been transferred from the closed ward in hospital pyjamas, with her clothes not being returned to her for ten days thereafter. With the legal proceedings concerning the closed ward admission still ongoing, she was given the impression that she was not allowed to leave or that she might be brought back by force. She had to get permission from staff to leave the ward. But she was able to spend a few hours on leave on 20, 23 24, 27 and 28 October, and 9, 11, 13 and 30 November 2005, during which time her psychiatrists noted that she was disciplined in her outings and always returned to hospital at the designated time. Towards the latter half of her stay, she was able to spend some weekends at her father's home, on condition that he would take her and supervise her medication.

Finding that L.M. had been deprived of her liberty during this period, the Court observed that "that the general setting of control exercised by the hospital staff exceeded considerably the measures required to monitor the applicant's comings and goings". It reiterated that the applicability of Article 5 did not depend solely on whether she was held in a "locked" ward but on whether the healthcare professionals exercised complete and effective control and supervision over her care and movements. Resonating with *HL v United Kingdom*, Article 5(1) was breached for the following reasons:

> "*135. The Court notes that the parties were in agreement as to the absence of any formal procedure for admissions to and medical treatment in open wards of psychiatric hospitals at the material time. There existed no regulatory framework, written or unwritten, which would determine the conditions of the applicant's confinement in the open ward, such as the reasons for which it could be ordered, the medical evidence that should be obtained in this regard, the time-limits of confinement, or which authority was competent to decide thereupon, and nor was there any regulation of the medical treatment administered during confinement. This absence of any legal provision justifying the applicant's confinement was, again, clearly at variance with the requirements of legal certainty and the protection from arbitrariness.*"

Closed wards of both hospitals

Under Slovenian law, hospitals had to inform the local court within forty-eight hours of an involuntary admission. A person was defined as "involuntary" if either they had capacity to express their wishes and were unwilling to consent, or they lacked capacity to express their wishes, or they were a minor or legally incompetent. The local court was then required promptly, but no later than three days after receiving notification, to visit the person and to order their examination by an independent psychiatrist. A decision as to the necessity of the confinement was required without delay, but no later than thirty days after receiving notification.

In essence, moving L.M. from the closed to the open wards had the effect of disrupting the involuntary confinement proceedings. It meant

that the local court did not determine the necessity for confinement and allowed for possible abuses of psychiatric confinement. The lack of adequate safeguards and legal certainty failed to protect her from arbitrariness contrary to Article 5(1).

Article 5(2)

The Court reiterated well-established principles that those deprived of liberty must be told in simple, non-technical language that she can understand, the essential legal and factual grounds in order to be able to make effective use of her right to have the lawfulness of her detention decided speedily. If she is unable to understand her situation, the information about the confinement and its implications should be given to her representative. The Court held that a four-day interval and an eight-day interval between the confinement and the giving of reasons were not sufficiently prompt and in breach of Article 5(2).

Article 5(4)

After helpfully restating the general principles (paragraphs 152-155), the Court held that Article 5(4) had been breached, principally because the local courts had not determined the legality of L.M.'s confinement following her transfer from the closed to open wards:

> "*158 …* [O]*nce the applicant was no longer considered deprived of her liberty under domestic law, she was unable to obtain a decision on the lawfulness of her earlier confinement. In this regard, the Court reiterates that, even assuming that the applicant was no longer involuntarily confined, she would still be entitled to obtain a decision on the lawfulness of her earlier confinement…*"

Article 8

Noting – importantly – that not actively resisting medication cannot alone be considered as indicative of consent, the Court held that L.M. had clearly expressed an objection to receiving treatment which thereby interfered with Article 8. To be compatible with the rule of law, the forced administration of medication (in this case antipsychotics) required proper legal safeguards against arbitrariness which were found wanting. She had been deprived "*of any effective procedural possibility, judicial or otherwise, of influencing the course of her treatment or having it reviewed by an independent authority*" (see *X v. Finland*, § 220).

Finding also a breach of Article 5(5), L.M. was awarded EUR 10,000 for non-pecuniary damage and costs.

Comment

This Slovenian Bournewoodesque case is of interest in four respects. First, it illustrates how a hospital patient on an open ward can be considered deprived of liberty despite being able to spend hours, sometimes weekends, in the community. We note that L.M.'s inadequately detailed claim that she was *de facto* deprived for four days in the open ward of the Idrija hospital was rejected; the difference perhaps being that the hospital was not intent on preventing her from leaving and she did in fact leave at her own request (paragraph 97-98).

Second, there may be a parallel problem between the Slovenian procedure and s.4B of the Mental Capacity Act 2005. The former required the local court to determine the necessity for confinement within thirty days from being first notified of the confinement. The Strasbourg Court held:

> "*125 … even assuming that the rules of domestic law were complied with, the Court*

> *considers that the legislation allowing for such an extensive amount of time to pass before a decision was made on confinement raises serious concerns under Article 5 § 1, as it implies a lack of procedural safeguards.*
>
> *126 … the Court considers that while the applicant's mental condition might have justifiably been considered by the hospital staff to necessitate urgent hospitalisation, the initial decision made by them to confine her should have been replaced by a decision of the competent authority, that is, the local court, in the shortest possible time.*" (emphasis added)

MCA s.4B authorises a deprivation of liberty if, *inter alia*, it is necessary to prevent a serious deterioration in P's condition while a decision is sought from the Court of Protection. This provides an important breathing space between the deprivation occurring and the decision of the competent authority as to its necessity. However, it contains no time limit. Indeed, it can take weeks – sometimes months – before the Court determines the necessity for a deprivation of liberty, even on an interim basis with sufficient evidence of the relevant matters having been filed. *L.M. v Slovenia* demonstrates that a thirty-day breathing space implies a lack of procedural safeguards and that a more speedy judicial process is required to prevent arbitrariness. Hopefully the anticipated decision of the President will overcome this.

Third, paragraph 158 may serve to assist those who wish to challenge the legality of a MCA Schedule A1 authorisation after it has been terminated. If they are "*entitled to obtain a decision on the lawfulness of* [their] *earlier confinement*", this clearly raises issues regarding regulation 5(g)(ii)(aa) of the Civil Legal Aid (Financial Resources and Payment for Services) Regulations 2013 (SI 2013/480) which exempts P or their RPR from means tested legal aid but only if "*an authorisation is in force*" under Schedule A1. Whether this should read "*is or was in force*" may need to be reconsidered in due course.

Finally, building on the decision of *X v Finland*, we note that vulnerability to challenge of s.63 of the Mental Health Act 1983. With some minor exceptions, involuntary hospitalisation of a psychiatric patient for more than 72 hours under the MHA contains an automatic authorisation to treat their mental disorder, even against their capacitous will (aside from electro-convulsive therapy). No consent or second opinion is required. No assessment of capacity or, if found wanting, of best interests is required on a literal reading. This would now clearly appear to be at odds with Article 8. To minimise the risk of such a breach, strict adherence to the MHA Code of Practice paragraphs 23.37 and 23.41 and to the MCA Code of Practice paragraph 13.30 is therefore required.

Short Note: Assisted Suicide cases fail in the Supreme Court

R (on the application of Nicklinson and another) v Ministry of Justice; R (on the application of AM) v The Director of Public Prosecutions [2014] UKSC 38 (Supreme Court (Lord Neuberger (President), Lady Hale (Deputy President), Lords Mance, Kerr, Clarke, Wilson, Sumption, Reed and Hughes))

In the appeal brought by the widow of Tony Nicklinson, the Supreme Court has unanimously held that the question whether the current law on assisted suicide is incompatible with Article 8 lies within the United Kingdom's margin of appreciation, and is therefore a question for the

United Kingdom to decide.[1] Five Justices (Lord Neuberger, Lady Hale, Lord Mance, Lord Kerr and Lord Wilson) held that the court has the constitutional authority to make a declaration that the general prohibition on assisted suicide in Section 2 Suicide Act 1961 is incompatible with Article 8. Of those five, Lord Neuberger, Lord Mance and Lord Wilson declined to grant a declaration of incompatibility in these proceedings, but Lady Hale and Lord Kerr would have done so. Four Justices (Lord Clarke, Lord Sumption, Lord Reed and Lord Hughes) concluded that the question whether the current law on assisting suicide is compatible with Article 8 involved a consideration of issues which Parliament was inherently better qualified than the courts to assess, and that under present circumstances the courts should respect Parliament's assessment.

On the second appeal, the Supreme Court unanimously allowed the DPP's appeal against the Court of Appeal's conclusion that his 2010 Policy for Prosecutors in respect of Cases of Encouraging or Assisting Suicide" setting out his policy in relation to prosecutions under Section 2 was not sufficiently clear in relation to healthcare professionals. The Supreme Court held that the exercise of judgment by the DPP, the variety of relevant factors, and the need to vary the weight to be attached to them according to the circumstances of each individual case were all proper and constitutionally necessary features of the system of prosecution in the public interest. In light of the Supreme Court's conclusion on the second appeal, a cross-appeal brought by AM did not arise.

[1] This is adapted from the official summary; an article on this case, in the context of the current very live Scottish debate upon the subject, will appear in the August issue.

The LGO and capacity

In Knowsley MBC (9 June 2014), the Local Government Ombudsman found the Council to be at fault for failing to have a support plan for a man with autism and severe learning disability requiring 24 hour care and for not carrying out annual and other timely reviews. It also failed to formally assess his capacity to make specific decisions and had not followed the correct procedures for determining his best interests. As a result, he was required to live with a co-resident in supported accommodation which led to a deterioration in his challenging behaviour and significant avoidable distress. The recommendations included the payment of £500 to be spent on Mr X and £500 to his mother for the uncertainty caused.

In South Essex Partnership University Trust and Bedford Borough Council (May 2014), Mr X was a 58 year old man with paranoid schizophrenia who was living in a flat in squalor. His family were concerned about his poor self-care and inadequate diet. He was 2.5 stone underweight, his teeth were rotten and bedclothes had not been washed in months. So concerned were his family at one point that his parents took him to live with them. The Local Government Ombudsman and Parliamentary and Health Service Ombudsman found that the Trust's failure to carry out a proper capacity assessment of his ability to make decisions about managing food and looking after himself was a service failure. There was sufficient evidence to challenge the assumption of capacity, with occupational therapy reports noting he was underweight and that there was no food in his flat. Thus, the presumption of mental capacity resulted in him being malnourished. The Trust

failed to ensure that support workers visited him regularly or encouraged him to attend to his oral health and adopt a healthy lifestyle. The Council had failed to carry out a community care assessment of his needs and there was a delay in seeking appropriate accommodation for him. A joint payment of £2000 for the impact of failing to properly assess his capacity and £500 to his sister for distress and inconvenience was recommended.

Short Note: Guardianship and Deprivation of Liberty in Northern Ireland

JMcA v The Belfast Health and Social Care Trust [2014] NICA 37 (Northern Ireland Court of Appeal (Morgan LCJ, Coghlin LJ and Horner J))

At first instance [2013] NIQB 77, Treacy J held that guardianship contained an implicit power to prevent the person leaving their residence. In our comment on this case (which does not appear in the COP Cases Online Database) we expressed surprise at the tenor of that decision which has now been overturned by the Court of Appeal in Northern Ireland. It held that a guardianship order does not provide any mechanism for the imposition of any restriction on the entitlement of the person to leave the home at which they are residing for incidental social or other purposes. The Court identified a lacuna in the law and, with reference to DOLS, stated, "*It is clear that urgent consideration should now be given to the implementation of similar legislation in this jurisdiction*."

In this regard, it should be noted that the draft Mental Capacity Bill that has just been issued for consultation in Northern Ireland includes provisions for the authorisations of deprivation of liberty in care homes and hospitals in a fashion that is modelled upon Schedule A1 to the MCA 2005, albeit with applications being made to a 3 member panel convened by the relevant Health and Social Care Trust.

Updated autism strategy

The Government has published its updated autism strategy and will be publishing statutory guidance to support the strategy in the next six months.

Criminalisation of forced marriage

Section 121 of the Anti-social Behaviour, Crime and Policing Act 2014 came into force on 16 June 2014, making forced marriage a criminal offence. In relation to individuals who lack capacity to marry, the criminal offence is committed by '*any conduct carried out for the purpose of causing the victim to enter into a marriage (whether or not the conduct amounts to violence, threats, or any other form of coercion)'.* See in this regard also the earlier judgment of Parker J in *XCC v AA & Ors* [2012] EWHC 2183 (COP) and the guidance there as to the obligations and health and social care professionals:

> *"[184] … in my view it is the duty of a doctor or other health or social work professional who becomes aware that an incapacitated person may undergo a marriage abroad, to notify the learning disabilities team of Social Services and/or the Forced Marriage Unit if information comes to light that there are plans for an overseas marriage of a patient who has or may lack capacity. The communities where this is likely to happen also need to be told, loud and clear, that if a person, whether male or female, enters into a marriage when they do not have the capacity to understand what marriage is, its nature and duties, or its consequences, or to understand sexual relations, that that marriage may not be recognised, that sexual relations*

will constitute a criminal offence, and that the courts have the power to intervene."

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Conferences at which editors/contributors are speaking

The duty of patient involvement in DNACPR decisions

Tor is speaking at a seminar at 39 Essex Street at the Hall in Gray's Inn at 6pm on 3 July on the implications of the decision in *Tracey*. The seminar is chaired by Fenella Morris QC, and the other speakers are Vikram Sachdeva Professor Penney Lewis of King's College London, and Dr Jerry Nolan, Royal United Hospital, Bath. For more details and to reserve a place, please email beth.williams@39essex.com.

'Taking Stock'

Neil is speaking at the annual 'Taking Stock' Conference on 17 October, jointly promoted by the Approved Mental Health Professionals Association (North West and North Wales) and Cardiff Law School with sponsorship from Irwin Mitchell Solicitors and Thirty Nine Essex Street Barristers Chambers – and with support from Manchester University. Full details are available here.

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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.

Chambers Details

Our next Newsletter will be out in early August. 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.

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THE QUEEN'S AWARDS FOR ENTERPRISE INTERNATIONAL TRADE 2013

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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.

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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.

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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.

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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.

Simon Edwards
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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 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.

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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.