

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

(1) In the Health, Welfare and Deprivation of Liberty Report: important decisions grappling with the meaning of best interests in the contexts of religious practices and delusional beliefs, and (finally) detailed statistics about s.21A/*Re X* cases;

(2) In the Property and Affairs Report: a new approach to severance and gifts;

(2) In the Practice and Procedure Report: changes to – and extension of the scope of – the Transparency Pilot and comments sought on a mediation pilot project;

(3) In the Wider Context Report: post-*PJ* problems, problems with care homes and capacity assessments and are moves really under way to change mental health laws?;

(4) In the Scotland Report: draft rules from Strathclyde Sheriff's Court concerning AWI applications.

We are taking a break over summer, but will be back in early September. In the interim, 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](#). Alex will also provide updates on truly critical matters on his own [website](#) (where you can also find the [talk](#) that he gave about the big issues facing the MCA 2005 at our recent 10th birthday party for the Act – thank you to all those who attended and made it such a success).

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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.

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The post-*PJ* problems persist

Djaba v West London MH Trust and others [2017] EWCA Civ 436 (Court of Appeal (Arden, Sales, and McCombe LJ))

Article 5 – Deprivation of liberty – Article 8 – contact – Mental Health Act 1983 – Interface with MCA

Summary

Since 2014, Mr Djaba had been accommodated in a “super seclusion suite” at Broadmoor under a restricted hospital order (Mental Health Act 1983 ss37/41). Built entirely for his confinement, it was a small room divided into two parts with a secure partition between them. Except to review his health, no one was permitted to enter the room without the partition being in place. Diagnosed with paranoid schizophrenia, he was highly resistant to receiving depot medication which had to be given forcibly by treating staff wearing protective equipment, including shields, helmets, and visors. The central issue was

whether the First-Tier Tribunal (Mental Health) (‘FTT’) was required to conduct a proportionality assessment pursuant to articles 5 and/or 8 ECHR taking into account the conditions of his detention. In short, it was not.

The Court of Appeal decided that the decision in *Secretary of State for Justice and Welsh Ministers v MM and PJ* [2017] EWCA Civ 194 was “properly to be carried over directly into that part of the legislation applicable in this case.” Giving the leading judgment, Lord Justice McCombe held:

42. If, as the court said in PJ at [55], the tribunal’s power is a “distinct and separate” one, namely that of discharge, and does not provide for intervention to regulate the conditions under a CTO made by the responsible clinician, then the same must, I think, apply under ss.72 and 73 which also confer a power of discharge. It seems to me that, applying this court’s decision, that power cannot also include power to regulate the conditions of detention. In the material

part of the PJ judgment the court was considering directly the extent of the power under s.72.

43. It is perhaps unfortunate that the court did not address the passages from the speech of Baroness Hale in H and I confess that I had some difficulty in understanding why it had not done so. I can see force in Ms Bretherton's point that it might be thought that specialist tribunals, rather than courts, were better suited to assessing conditions of a patient's detention in a human rights context for the reasons expressed by Baroness Hale in her speech. It seems to me, however, that in the light of the court's decision on the jurisdiction issue in PJ, it did not need to do so... (emphasis added)

Thus, McCombe LJ concluded, the tribunal lacked the jurisdiction to conduct an assessment beyond that dictated by the detention criteria in MHA ss72-73. Any challenge to the conditions of detention would have to be brought in the civil courts. Agreeing with McCombe LJ, Lord Justice Sales added:

49. The matters identified in section 72(1)(b)(i), (ii) and (ia) and requiring to be considered by the Tribunal pursuant to section 73(1) do not include the conditions of detention of a restricted patient or things such as the availability of visiting rights for members of a patient's family. These are aspects of the care of a restricted patient which are within the control of the hospital authorities, who will have to take account of a range of matters in organising his detention in their facility, including the resources available, the Convention rights of the patient and others and the safety of staff and visitors. The governing

NHS Trust for Broadmoor Hospital is a public authority and is amenable to judicial review in the High Court in relation to any legal challenge which a restricted patient might wish to bring in relation to these matters. If a restricted patient needs access to a litigation friend in order to mount such a legal challenge, arrangements can be made to facilitate that. That is an appropriate and effective avenue for legal protection for a restricted patient who wishes to challenge what the hospital authorities have done in relation to his conditions of detention.

Parallels were drawn with the imprisonment of convicted criminals whereby legal remedies in respect of some detention issues are determined by the Parole Board while remedies in respect of other detention issues are determined by the High Court in judicial review proceedings: see, e.g., *R (Hassett and Price) v Secretary of State for Justice* [2017] EWCA Civ 331. His Lordship specifically rejected the submission that the reference to 'appropriate' in the detention criteria included conditions of detention and other ECHR issues (para 51). For good measure, Lady Justice Arden agreed with both judgments and reinforced that the Administrative Court "is able to carry out a sufficient review on the merits to meet the requirements of the Convention."

Comment

Both *PJ* and *Djaba* concentrate on the jurisdiction of the Mental Health Tribunal/MHRT for Wales and are therefore hugely significant. As we have noted previously, it is concerning that the Court of Appeal in *PJ* started from a false premise, holding at para 55 that: "[t]he power exercisable by the tribunal is to discharge the

patient from detention not to 'discharge the CTO.'" This is wrong because MHA s72(1)(c) contains no reference to detention. A patient on a CTO is not liable to be detained in hospital; they are merely liable to be recalled to hospital which is very different. Accordingly, the tribunal has no power to review the legality of detention of community patients.

There is an interesting contrast between tribunals and the Court of Protection. Following *Djaba*, a tribunal has no jurisdiction to review the conditions of detention or, for example, access to family members. And it has long been established that the tribunal lacks jurisdiction to review the legality of psychiatric treatment. These are all matters for judicial review. Whereas the Court of Protection can, albeit within certain parameters, conduct a proportionality assessment pursuant to articles 5 and 8 ECHR which take the detention conditions (eg see *North Yorkshire County Council v MAG*). Indeed, that the court has the jurisdiction to determine HRA claims was not disapproved of by the Supreme Court in *N v ACCG*.

Mr Djaba now finds himself in a similar position to *Colonel Munjaz*. Challenging his seclusion – which could conceptually be a deprivation of his residual liberty – will be a matter for the Administrative Court, not the Tribunal.

Short note: ordinary residence and capacity

The Department of Health has now published anonymised determinations of ordinary residence disputes from 2016. Readers may be interested in two examples which concerned adults lacking the capacity to decide upon residence:

1. OR3/2016: P was a 41 year old woman with a learning disability. In March 2012, she moved to a supported living placement in the area of Council B. Prior to that date, she lived with her mother in a family home in the area of Council A. Although a Supported Self-Assessment Questionnaire completed in October 2011 indicated that a formal capacity assessment was required, no capacity assessment was in fact carried out at the time. The main issue between the parties was whether the deeming provision under section 24(5) of the National Assistance Act 1948 applied, which provides that a person who is provided with residential accommodation is deemed to continue to be ordinarily resident in the area in which he was residing immediately before the residential accommodation was provided. Having regard to the nature of the placement that was provided to P, the Secretary of State decided that the deeming provision did not apply. P had her own tenancy agreement and her rent was met through housing benefit. Council A had no responsibility to pay or make up any shortfall in rent. Therefore, P's accommodation was not provided by Council A under Part 3 and Council A was not under a duty to provide accommodation to P. P was therefore ordinarily resident in the area of Council B. Although P lacked capacity to make decisions about her residence, the Secretary of State made clear that he reached this conclusion irrespective of whether or not P had capacity to decide where to live and/or enter a tenancy agreement.

2. OR 5/2016: P was a 55 year old woman with Down's Syndrome and early-onset dementia. She previously resided with her mother in the area of Council B. After her mother died in April 1994, an assessment was undertaken by Council A which recorded that P wished to move to suitable accommodation in the area of Council B. P moved to an address in Council B to live with her brother in September 1994. Council A continued to fund P's package of care. In May 2015, Council A wrote to Council B setting out its position that, applying the test in *Shah v London Borough of Barnet* (1983) 1 All ER 226, X was ordinarily resident in Council B's area. Council B responded to the effect that it considered that P had fluctuating capacity and P's ordinary residence should remain with Council A in light of the Supreme Court's decision in *R (Cornwall Council) v Secretary of State for Health* [2015] UKSC 46. The Secretary of State concluded that P had been ordinarily resident in Council B since she moved there in September 1994. There was no evidence that P lacked capacity to make decisions as to where she should live at the time that the decision to move to Council B was made. Whilst there was some more recent evidence of fluctuating capacity, it related to a point in time at which P had already been residing in the area of Council B for some 20 years. The appropriate test was the one set down in *Shah*.

Short Note: Care Home Concerns (1)

The Competition and Markets Authority has [published](#) the initial findings of its care homes market study which are concerning. The market

study was launched by the CMA in December 2016 to examine whether the residential care home sectors is working well for elderly people and their families. Having reached the halfway point, on 14 June 2017, the CMA published its initial findings which highlight wider concerns about the sector, including:

- People finding it difficult to get the information; confusion about the social care system and funding options; and a lack of clarity over finding and choosing a care home;
- A lack of information about prices on care home websites; and care homes' contracts giving homes wide-ranging discretion to ask residents to leave at short notice;
- Complaints procedures not functioning well; and residents finding it very challenging to make complaints.

As a result of its initial findings, the CMA has now opened a consumer protection case to investigate its concerns that some care homes may be breaking consumer law.

These concerns come alongside the widely reported concerns of the CQC as to the quality of care being delivered in care homes outlined in its State of Adult Social Care 2014-2017 [Report](#).

Short Note: Care Home Concerns (2)

A recent report from the Local Government Ombudsman [reported](#) on the Local Government Lawyer website (and available in full [here](#)) highlighted a problem that may well be more widespread. Mrs C lacked capacity to make decisions about her finances. She was discharged from hospital to a residential care

home. The local authority, Worcestershire County Council, funded Mrs C's care home placement of £500 per week for about four weeks. Thereafter, the local authority treated Mrs C as self-funding her care. However, Mrs C's son was unable to pay the care provider as he did not have access to her funds. The care provider then increased the price of care from £500 to £1200 per week i.e. an increase of £700 per week. A significant debt accrued to Mrs C before she passed away. Mrs C's son had attempted to become a court-appointed deputy to manage her financial affairs. However, his mother died before this was completed. He then had to gain probate. Before probate was granted, the care provider sent Mrs C's son a letter saying that it would refer the outstanding debt to its solicitors.

The LGO found that there had been a series of failings on the part of the local authority including:

- Failing to obtain relevant information about Mrs C's capacity and failing to consider Mrs C's capacity to make choices about her finances;
- Stopping funding for Mrs C's care even though it seemed unlikely that Mrs C had capacity to manage her own finances and the local authority was aware that she had no attorney or deputy;
- Failing to take adequate steps to ensure that Mrs C's care was paid for and leaving Mrs C unsupported.

The LGO was also critical of the care provider and, in particular, found that there only a weak justification for significantly increasing the charges to Mrs C. In particular, there was no

evidence that the care provider had difficulty caring for Mrs C or that Mrs C required such an exceptional level of care. The LGO recommended that the invoices should be reissued removing the additional £700 charge and for the local authority to apologise and pay £1,000 for distress.

Capacity failings: (1)

In a further report from the Local Government Ombudsman reported on the Local Government Lawyer website (and available in full here), Warwickshire County Council agreed to pay a man over £2,000 for delays in carrying out mental capacity assessments and not considering fully all the options available to him.

Mr X was admitted to hospital following a stroke. He was keen to leave hospital and to live as independently as possible. He agreed to be discharged to a residential care home but the social worker and care home believed this would be a long term placement. Mr X submitted a housing application to Nuneaton and Bedford Borough Council as he wanted to live more independently with carer support. There were delays by the Borough Council progressing Mr X's housing application. Mr X's psychologist asked whether a move to his own property was an option but the social worker said that Mr X lacked mental capacity regarding his care needs and accommodation. However, no formal capacity assessment was carried out.

Mr X was later admitted to hospital and refused to return to the care home when he was ready for discharge, still wanting to live independently. However, his social worker continued to believe that he lacked capacity to make decisions about his care and residence although no formal

capacity assessment had been carried out. A second social worker became involved and assessed Mr X as having capacity to the relevant decisions. This was backed by Mr X's consultant. Mr X agreed to move to a different care home as a temporary measure but continued his bid for accommodation through the borough council. He eventually secured a tenancy in self-contained accommodation in the area of his choice.

Amongst other things, the LGO found that Warwickshire County Council had failed to consider all the options available to meet Mr X's needs and failed to undertake decision specific mental capacity assessments in relation to where he should live. Warwickshire County council agreed to apologise to Mr X, pay him £2,000 for the frustration and distress caused by the delays in carrying out mental capacity assessments and to review its practice to ensure that mental capacity assessments are carried out at the correct times and documented appropriately.

Capacity failings: (2)

We highlight here a tragic [Serious Case Review](#) in relation to a man, "Tom," who took his own life in 2014, which raises a number of complex questions as to the assessment of capacity in relation to those with an acquired brain injury, in particular where the individual is then "situationally incapacitated" by others – in his case exploitative and drug using peers. As the author, Margaret Flynn, highlights: "Tom's circumstances highlight the fraught boundaries between personal responsibility, public obligation and the assumption of mental capacity." We also highlight the fact that his circumstances, and the wider issues raised, are

also addressed in a powerful article in the *Journal of Adult Protection* (available [here](#)), from a person with a unique perspective, Alyson Norman, who is both a trained psychologist and also Tom's sister.

MENTAL HEALTH ACT REFORM?

The remainder of this section is dedicated to recent developments, both domestically and on the international plane, regarding the potential for reform of mental health laws, which will impact both directly and indirectly upon the field of mental capacity law.

The Government speaks

The Government announced its intention to reform mental health legislation in England and Wales in the Queen's Speech on 21 June. So far, very little detail has been provided about precisely how the Government intends to reform the Mental Health Act 1983, but the broad intention has been [set out](#) as follows:

As we set out in our manifesto, our considerations will include:

- *Looking at why rates of detention are increasing and taking the necessary action to improve service responses;*
- *Examining the disproportionate number of those from certain ethnic backgrounds, in particular black people, who are detained under the Act;*
- *Reviewing the use of Community Treatment Orders, to see if they remain fit for purpose in helping people leaving hospital to receive*

better care and support in the community;

- *Considering how the rights of family members to get information about the mental health and treatment of their loved ones can be improved;*
- *Ensuring that those with mental ill health are treated fairly, protected from discrimination, and employers fulfil their responsibilities effectively.”*
- *The Government also announced that it proposes to consult on the future of social care.*

We will be following these developments very closely and with great interest.

Mental Health Alliance Survey Report: A Mental Health Act Fit for Tomorrow

In a report published at the end of June, the Mental Health Alliance published: *“A Mental Health Act fit for tomorrow: An agenda for reform.”* The Alliance, a coalition of more than 65 organisations that originally came together in 2000 to provide a focus for campaigning on common concerns about reform of the Mental Health Act, carried out the first wide-scale survey of 8,631 individuals (including those with lived experience, families, carers, and loved ones and

¹ The report records that the survey received 8,631 responses from a wide range of groups: 46% were currently receiving treatment for mental illness (4,017 people); 14% had previously been detained under the Mental Health Act (1,218 people); 0.5% were currently detained under the Mental Health Act (44 people); 44% were carers, family or friends of someone with a mental illness (3,803 people); 26% were professionals (2,281 people). The report – fairly – reports limitations in the survey: “[o]verall, the Alliance engaged well with

mental health professionals¹), to examine the underlying principles of the MHA 1983 and how people’s rights are currently protected, where it is working well and what could be changed and improved.

We reproduce here the executive summary, but suggest that the report bears careful reading, not least because it sits at an interesting angle to the report of the UN Special Rapporteur covered elsewhere in this issue, which is very firmly predicated upon the abolition of any form of compulsory treatment. It also sits an interesting angle to fusion debates, highlighting a desire for advance decisions to be treated equally under the MHA 1983 and MCA 2005 but otherwise not addressing wider issues of capacity based mental health legislation

Executive Summary

- *Respondents told us that people are denied opportunities to be involved in their care, along with their family, friends and carers. It is clear that ‘Advance Decisions’ are not promoted and respected.*
- *A majority of respondents agreed that compulsory treatment in hospital is sometimes necessary when people pose harm to themselves or others. ² However,*

some groups who are often underrepresented in mental health research (particularly respondents who are LGBTQ+). However, we did not succeed in engaging all of the groups of respondents we intended to. For example, we struggled to engage with BME respondents and men. Respondents based in Wales were not proportionally represented in the response.”

² This includes, the report notes (page 12) 64% of previously-detained respondents. When the question was reframed to ask “[a]re there circumstances in which

they were clear that important principles are currently flouted, that genuine parity between physical and mental health is needed. They gave strong support to the prospect of Advance Decisions being respected under the Mental Health Act.

- *The survey showed that legislation is needed urgently to address unintended consequences of the Act. The outmoded 'nearest relative' allocation system, for example, causes intolerable misery and delay for people at their most vulnerable.*
- *The Government must deliver a fundamental review of the Mental Health Act. The Act is now over 30 years old and not fit for purpose.*
- *The sheer scale and range of responses to our survey shows the demand for reform. The questions not fully answered also underline the urgency for more research to be carried out with the people whose voices are too-often ignored.*
- *The Mental Health Alliance believes reform is urgently needed and is committed to helping the Government to conduct a review of the Act.*

If the Government does undertake the promised review of the MHA 1983 outlined above, then as has already been [highlighted](#), it is crucial it does so on the basis of independent research as to what is actually (a) happening; and (b) needed, in particular from the perspective of service users.

someone should be treated against their wishes if they have the capacity to make decisions about mental health treatment but refuse it?" 50% of respondents agreed

This survey provides a very useful starting point (and we suspect that the raw data may prove even more useful), and also an indication of some of the difficulties that may be encountered in the process.

Report of Special Rapporteur on Right to Mental Health and Human Rights

In an important [report](#) published on 6 June, the United Nations Special Rapporteur on the right to health, Dainius Pūras, has set out a call for a "sea change" in mental health care around the world. His report on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health represents the latest, and by some margin the most detailed, critique of traditional conceptions of mental health and models of psychiatric treatment. Our other commitments mean that we do not have time at present to do more than reproduce the summary, but we do (a) lay down a marker that we will be returning to this report and the debates that it raises in the coming months; and (b) invite readers to follow the progress of the Wellcome Trust funded "Mental Health and Justice" project that is looking, from many different perspectives, at aspects of the debate.

Abstract summary:

This report challenges the dominant biomedical paradigm and the role of unequal power relationships that characterizes and treats mental distress for people around the globe today. Importantly, the report elaborates how the dominant biomedical narrative of

overall; 48% of previously-detained respondents agreed and 54% of professionals agreed.

mental health, closely guarded by biomedical gatekeepers, contributes to a global burden of obstacles that fuels systemic and widespread human rights violations and impedes the paradigmatic change needed to respect, protect, and fulfill the right to mental health of everyone. The report provides guidance to stakeholders on how the right to health is threatened by the existing mental health paradigm and how rights--based change is possible, affordable, and occurring in communities across income settings around the world. Critically, the report characterizes the global state of mental health not as a crisis of chemical imbalances but a crisis of power imbalances, requiring urgent policy responses to address the social determinants of mental health as well as the inward reflection of powerful stakeholders on their role in perpetuating a corrosive status quo. Care and support in the community must replace outdated models of excessive biomedical treatment and institutionalization including the use of coercion and the gratuitous, first line use of psychotropic medicines.

Key messages: There is no health without mental health:

- *Mental health is grossly neglected within health systems around the world. Where mental health systems exist, they do so in isolation, segregated from regular healthcare, despite the intimate relationship between physical and mental health.*
- *To address the grossly unmet need for rights-based mental health care and support, an assessment of the global burden of obstacles that has maintained the status quo is required, these include:*

the dominance of the biomedical paradigm; power asymmetries in policymaking, medical education and research, and care relationships; and, the biased use of evidence in mental health

- *There is unequivocal evidence that the dominance of and the overreliance upon the biomedical paradigm, including the front-line and excessive use of psychotropic medicines, is a failure. Yet, around the world, biomedical interventions dominate mental health investment and services. This is not only a failure to integrate evidence and the voices of those most affected into policy, it is a failure to respect, protect, and fulfill the right to health. When resources appear to scale up mental health services, particularly in low and middle income countries, investments must not be dominated by medicalized service models.*
- *Power and decision-making in mental health policy, services, and care relationships is concentrated in the hands of biomedical gatekeepers, particularly biological psychiatry. These gatekeepers, backed by the pharmaceutical industry, consolidate this power based on two outdated medical myths: that people experiencing mental distress and diagnosed with "mental disorders" are dangerous and that biomedical interventions in many cases are medically necessary. These concepts and other "conventional wisdoms" perpetuate stigma, discrimination, and the unacceptable practice of coercion and violence that is widespread in mental health systems today.*
- *The biased use of evidence has corrupted our knowledge about mental*

health and is a serious human rights issue. Power and the dominance of the biomedical paradigm distorts how evidence is used in policy making and service delivery, affecting progress towards rights--based mental health services around the world today. A troubling example is the use of evidence to inform people with mild and moderate forms of depression that they should receive psychotropic medications (antidepressants), despite the clear evidence that any positive effect is because of placebo. The excessive use and misuse of psychotropic medications violates the right to health.

- The evolving normative framework ushered in by the Convention on the Rights of Persons with Disabilities around mental health requires a paradigm shift. There are many paths towards this change, but only one direction.

- A shift away from the dominance of the biomedical paradigm and vast power asymmetries requires mental health policymaking to scale across public sectors and integrate mental health throughout public policy. There is a human rights imperative to bring the social, psychosocial, and underlying determinants of mental health to the forefront of mental health promotion.

- The evidence and human rights imperative for a paradigmatic shift in mental health policy and decision-making is a powerful external force for change. However, change also requires courageous action from within the corridors of power, specifically from within the psychiatric profession. The power and proximity the profession has to policymaking establishes a

responsibility to use their influence to support the process of navigating mental health systems from isolated silos of mistrust and paternalism to integrated community models that foster empowerment, resilience, and inclusion.

- Psychosocial distress will always be a part of the human experience, particularly in the face of growing inequality and discrimination. Outdated paternalistic concepts of treatment must be replaced with psychosocial care and support in the community and at the primary care level. Low cost, effective options are possible and being used around the world today.

- Champions of the paradigm shift in mental health are necessary to facilitate the rights-based change required. Key stakeholder champions include Member States, the leadership of organized medical professions, including psychiatry, academic centres working on mental health, and civil society.

Editors and Contributors



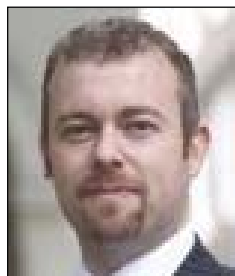
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Alex is recommended as a 'star junior' in Chambers & Partners for his Court of Protection work. He has been in cases involving the MCA 2005 at all levels up to and including the Supreme Court. He also writes extensively, has numerous academic affiliations,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



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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. 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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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](#).



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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](#).

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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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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](#).



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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

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

Alex is chairing and speaking at this conference in London on 14 July which looks both at the present and potential future state of the law in this area. For more details, see [here](#).

The Legal Profession: Back to Basics

Adrian is a speaker and panellist on “The Legal Profession: Back to Basics” at the Annual Conference of the Law Society of Scotland at Edinburgh International Conference Centre on the afternoon of Tuesday 19th September 2017. For more details, and to book, see [here](#).

JUSTICE Human Rights Law Conference

Tor is speaking on the panel providing the Equality and Human Rights Update at JUSTICE’s Annual Human Rights Law Conference in London on 13 October. For more details, and to book, see [here](#).

National IMCA Conferences

Alex is speaking on both litigation friends and a potential Vulnerable Adults Bill at the two National IMCA Conferences (North and South) organised by Empowerment Matters and sponsored by Irwin Mitchell. The [northern conference](#) is in Sheffield on 20 October; the [southern](#) is in London on 10 November.

National Advocacy Conference

Alex is speaking on advocacy as a support for legal capacity and doing a joint workshop with Jess Flanagan on advocacy and available options at the National Advocacy Conference in Birmingham on 19 October. For more details, and to book tickets 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 September. 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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