



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

- (1) In the Health, Welfare and Deprivation of Liberty Report: an appreciation of Alastair Pitblado, the Mental Capacity (Amendment) Bill, the Joint Committee on Human Rights considers DoLS reform and fluctuating capacity;
- (2) In the Property and Affairs Report: the OPG mediation pilot
- (3) In the Practice and Procedure Report: court fees reductions and when to join;
- (4) In the Wider Context Report: Lady Hale on *Cheshire West* and the CRPD, Parliamentary debates and developments and a major Council of Europe report on attorneys and advance directives;
- (5) In the Scotland Report: AWI consultation responses and Sandra McDonald reflects on her time as Public Guardian;

You can find all our past issues, our case summaries, and more on our dedicated sub-site [here](#).

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

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HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

Alastair Pitblado

[We are very sad to report the death of Alastair Pitblado, the Official Solicitor and Public Trustee. We will publish in the next issue an appreciation of him by Jim Beck, from the office that he oversaw for over a decade, but in the meantime, we reproduce here Alex's reflections that were published in [Legal Action Magazine](#).]

I last saw Alastair in the Supreme Court at the hearing of his appeal (on behalf of the patient) in the Y case. He was very sick with the illness that ultimately took him, but the fact that he had come almost directly from his hospital bed to attend the hearing was absolutely characteristic of him. He was absolutely tenacious in pursuit of the protection of the rights upon whose behalf he acted as Official Solicitor, and in defending the systems established for their protection. I hope that he would have appreciated the irony that two days after his death the Strasbourg court delivered a judgment making clear just how right he had been in *Re X* to insist on the importance of the participation in proceedings of those being deprived of their liberty.

I did not always agree with Alastair, and indeed vividly recall giving a talk at a conference about why he was wrong on a point, with him in the front row giving me the characteristically quizzical look he gave that meant that there was a lot he could say but was holding back (for now). But there was no doubting the care that he took – and instilled in all those under him to take – to ensure all the complexities had been considered before deciding what call to make on behalf of

any individual “P.” No-one could ask for more of someone bearing such responsibilities, and we owe him a huge debt of thanks.

Mental Capacity Amendment Bill

Acting considerably more quickly than many had expected to give effect to its [commitment](#) to legislate to act upon Law Commission's [Mental Capacity and Deprivation of Liberty](#) report, the Government has [introduced](#) the Mental Capacity Amendment Bill.

This is a rather different Bill to that attached in draft to the Law Commission's report. In particular, all the wider elements of that Bill (e.g. securing greater weight in best interests decision-making for the person's wishes and feelings and greater safeguards in relation to steps constituting a serious interference with a person's Article 8 ECHR rights) have been stripped out, along with such elements as the codification of the concept of 'advance consent.' Instead, the Bill is narrowly focused on a variant of the Law Commission's Liberty Protection Safeguards ('LPS'). The [Explanatory Notes](#), from which some of what follows is drawn, do not give an explanation for why this course been taken; the [Impact Assessment](#) says that "*the Law Commission also proposed making some wider amendments to the Mental Capacity Act which we have decide not to legislate for at this point, as we think there are other effective levers to deliver improvement in these areas.*" We have no doubt that exactly what these levers may be and how effective they are will be probed further at second reading in the House of Lords on 16 July.

We set out the key features of the Bill below, along with some points where it differs from the Law Commission proposals. Not least because

Alex is incapable of providing a detached view, we will leave consideration of its broad merits (or demerits) for others at this stage; we would, though, welcome any thoughts that people may wish to contribute in advance of our next report in September; and many may wish to see Lucy Series' initial observations [here](#) and [here](#). We are also working on further opportunities both to update people and to feed into the Parliamentary process; we will update by way of email in the interim.

The commentary here is presented on the basis that the Bill would be made law exactly as it stands.

Definition of deprivation of liberty

There is no statutory definition of deprivation of liberty, so the definition remains that contained in Article 5 ECHR, as interpreted, in this context, by the Supreme Court in *Cheshire West*.

Interim/emergency deprivation of liberty

Section 4B MCA will be amended so as to provide express authority for a person to take steps to deprive another person of their liberty if four conditions are met. Broadly speaking, section 4B gives authority to take steps to deprive a person of their liberty in three circumstances:

1. where a decision relevant to whether there is authority to deprive the person of liberty is being sought from the Court of Protection;
2. where steps are being taken (either by a responsible body or a care home manager) to obtain authorisation under Schedule AA1 (replacing the concept of urgent authorisations under DOLS); or

3. in an emergency (i.e. solving the problem discussed at paragraphs 45-50 of our [guidance note](#) on deprivation of liberty in the hospital setting).

New Schedule AA1

This will replace DOLS with a new scheme which will be called LPS (although this name is not on the face of the Bill).

Schedule AA1 provides for the new administrative scheme for the authorisation of arrangements enabling care or treatment of a person who lacks capacity to consent to the arrangements, which give rise to a deprivation of that person's liberty. In a change to the Law Commission's proposals, the LPS will only apply to those aged 18 and above.

Under Schedule AA1, a responsible body will be able to authorise arrangements giving rise to a deprivation of a person's liberty in any setting (or in more than one setting). The responsible body will be:

1. The "hospital manager" where the arrangements are carried out mainly in a hospital;
2. A CCG or Local Health Board in the case of arrangements carried out through NHS continuing health care (but not mainly in a hospital);
3. A local authority in all other cases, including where care is arranged by the local authority, and where care is provided to people paying for their own care (self-funders).

Before a responsible body can authorise the arrangements, it must be satisfied that three authorisation conditions are met:

1. the person who is the subject of the arrangements lacks the capacity to consent to the arrangements;
2. the person is of unsound mind; and
3. the arrangements are necessary and proportionate. Note here that, in a difference to the Law Commission proposals, there is no reference to the necessity and proportionality being judged either by reference to the risk of harm to the person themselves or by the risk of harm to others.

A further difference to the Law Commission proposals is that the Bill does not on its face provide that at least two people have to carry out the assessments, so it would appear that all three could be carried out by a person with the suitable experience and knowledge. It may well be that this a matter addressed in the Code of Practice.

The responsible body (or, as below the care home) must also carry out consultation with the person and a range of others, in particular to try to ascertain the cared-for person's wishes or feelings in relation to the arrangements.

A person who is not involved in the day-to-day care of, or in providing any treatment to, the person must also carry out a pre-authorisation review¹ to determine whether it is reasonable for the responsible body to conclude that the authorisation conditions are met. In cases where the person is objecting to the proposed arrangements, an Approved Mental Capacity Professional must carry out the pre-

authorisation review. In that case, the Approved Mental Capacity Professional must determine whether the authorisation conditions are met.

One major difference to the Law Commission proposals is what happens where arrangements are wholly or partly carried out in a care home. The general effect of the relevant paragraph (13) of Schedule AA1 is that the care home manager must arrange the relevant assessments and take the other necessary steps before an authorisation can be given by the responsible body.

Once an authorisation has been given, there are a number of safeguards put in place for the person. These include regular reviews of the authorisation by the responsible body or care home, and the right to challenge the authorisation before the Court of Protection (under a new s.21ZA). Although the Bill is silent on this, we would anticipate that such challenges would attract non-means-tested legal aid as s.21A challenges do at present.

From the outset of the process of authorisation under the Schedule to the point when the authorisation comes to an end, the person is to be represented and supported either by an "appropriate person" or an IMCA.² If the person has capacity to consent to being represented by an IMCA, the person must make a request, or where they lack the capacity to consent, the responsible body must be satisfied that being represented and supported by an IMCA would be in the person's best interests. An IMCA must be appointed unless there is an appropriate person

¹ The concept of 'pre-authorisation review' is essentially the same as that of 'independent review' proposed by the Law Commission.

² Section 39A-D MCA 2005 will be repealed, as these advocacy provisions are tied to DOLS.

who would be suitable to represent and support the person, consents to being appointed and is not engaged in providing care or treatment to the person in a professional role. There are also circumstances in which the appropriate person must themselves be provided with an IMCA.

Authorisations can be varied where (for instance) the responsible body changes because the location of the arrangements change. They can also be renewed, in the first instance for 1 year, and thereafter for periods of up to 3 years.

Part 7 of Schedule AA1 sets out the interface between the LPS and the Mental Health Act 1983. This is another major area of difference to the Law Commission Bill, which would (in general) have excluded the use of the LPS in the mental health setting. Part 7, by contrast, broadly speaking maintains the current position (and also maintains much of the drafting of Schedule 1A albeit in – if this possible – even more complicated form). The effect is that patients who are detained under the Mental Health Act 1983 or who are objecting to being in hospital for mental health treatment (or to that treatment), cannot be made subject to an authorisation under Schedule AA1.³ But in the community a person could be subject to an authorisation under Schedule AA1 and subject to Mental Health Act requirements, so long as the authorisation does not conflict with those requirements. Note in this context that s.16A is being repealed: the Court of Protection would not therefore be bound by the same eligibility issues

in the mental health setting which led to the complexities in the *Dr A* case.

One final difference to the Law Commission Bill worth noting at this stage is that this Bill does not introduce a tort of deprivation of liberty actionable against a private care provider. In light of the continued distinction between false imprisonment and deprivation of liberty identified by the Court of Appeal in *Jollah*, discussed in the Wider Context report, it would appear that it will remain the case that a self-funder who does not meet the (tighter) test for false imprisonment would have no direct recourse against the care provider where steps are not taken to ensure that arrangements are authorised.

Next steps

Second reading of the Bill is in the House of Lords on 16 July. We do not anticipate that Royal Assent would be granted before early next year, and, given that a transition period will be required before the DOLS can be replaced by the LPS, it is likely that the amended Act would not be fully in force until 2020 at the earliest, and potentially 2021.

Joint Committee on Human Rights Report: the Right to Liberty and Security

[On 29 June, only a matter of days before the Mental Capacity (Amendment) Bill was introduced, the Joint Committee on Human Rights published the [report](#) into its inquiry into the reform of DOLS. Whilst we recommend reading the whole report to get the Committee's full consideration of the questions of (1) whether DoLS should be reformed

³ Unless the person falls within the 'learning disability' exception, at which point the LPS could be used.

as a matter of urgency; (2) whether the Law Commission's proposals strike the right balance, and (3) whether there should be a statutory, definition of deprivation of liberty, we reproduce here the summary (with footnotes omitted) for those needing / wanting to cut to the chase.]

Article 5 of the European Convention on Human Rights (ECHR) prohibits arbitrary deprivation of liberty. Consequently, it is vital to have mechanisms to ensure that the arrangements made for vulnerable people who lack mental capacity are in their best interests. It is also important that resources are, as far as possible, directed to care rather than to legal and bureaucratic processes. This report seeks to advise the Government on how to address a serious problem that has emerged in these legal and bureaucratic processes.

The current Deprivation of Liberty Safeguards (DoLS) scheme safeguards against arbitrary detention of people who are deemed to lack capacity to consent to their care or treatment, such as older people living with dementia, people with autism and people with learning disabilities. However, the scheme is broken. The Supreme Court's decision that a person is subject to "confinement" when "under continuous supervision and control" and "not free to leave" (the 'acid test'), irrespective of their contentment, has resulted in a tenfold increase in the number of DoLS applications.

This has placed extreme pressure on Local Authority resources. Seventy percent of the almost 220,000 applications for DoLS authorisations in the past year were not authorised within the statutory time frame. Consequently, many incapacitated people continue to be deprived of their liberty unlawfully

and those responsible for their care, or for obtaining authorisations, are having to work out how best to break the law.

At the Government's request, the Law Commission has produced proposals for a new system of safeguards. The Commission proposes replacing DoLS with Liberty Protection Safeguards (LPS). LPS would authorise the specific arrangements that give rise to the deprivation of liberty. They are, therefore, more targeted than DoLS, which authorise the deprivation of liberty in general. LPS would apply to wider categories of people than DoLS, as they would extend to domestic settings, persons aged 16 and over, and persons of "unsound mind". DoLS currently only apply to care homes and hospitals and over 18s with a mental disorder.

We support the principle that Article 5 safeguards should be applied to all those deprived of their liberty regardless of their care arrangements, but the potential expansion of the scheme into domestic settings runs the risk of creating an invasive scheme that is difficult to operate effectively. This highlights the importance of establishing more clearly the definition of "deprivation of liberty" so that such safeguards are applied to those who truly need them.

The Law Commission did not grapple with this difficult issue. We recognise that deprivation of liberty is an evolving Convention concept rooted in Article 5; the difficulty is how this is interpreted and applied in the context of mental incapacity. In our view, Parliament should provide a statutory definition of what constitutes a deprivation of liberty in the case of those who lack mental capacity in order to clarify the

application of the Supreme Court's acid test and to bring clarity for families and frontline professionals. Without such clarity there is a risk that the Law Commission's proposals will become unworkable in the domestic sphere.

The Law Commission's proposals for independent review of authorisations for deprivations of liberty are in our view compliant with the European Convention on Human Rights. It would be disproportionate to establish a separate review body. Nonetheless, we recommend that the Code of Practice must set out clear guidelines to deal with potential conflicts of interest.

The Law Commission's proposals introduce the possibility of providing advance consent to care and treatment arrangements that would otherwise amount to a deprivation of liberty. This is not currently possible under the DoLS scheme. We consider that advance consent for care arrangements should be valid, as long as safeguards are in place to verify the validity of this consent.

The provision of advocacy helps to ensure that individuals can exercise their rights to challenge authorisations, as the advocate may initiate court proceedings. Unlike DoLS, which provided advocates on an 'opt in' basis, LPS provides advocates as of right. We support this enhancement of rights to advocacy. However, we recognize the shortage of advocates available and urge the Government to consider appropriate funding arrangements for adequate levels of advocates. We also suggest that an individual's right to participate in court ought to be codified and that responsibility for securing the individual's access to court should be prescribed clearly on the face of the Bill. Whilst

the individual's appropriate person and advocate should have a duty to appeal on behalf of the individual, the responsible body should be under a clear statutory duty to refer cases where others fail to do so, for example, when the individual objects or the arrangements are particularly intrusive.

The Law Commission proposes that the question of whether the Court of Protection (CoP) should retain jurisdiction to hear challenges or whether this should be transferred to the First Tier Tribunal (FTT) should be reviewed by the Lord Chancellor, the Lord Chief Justice and the Senior President of Tribunals. We consider that a tribunal system has serious merits for consideration.

At present, the Legal Aid Agency can refuse non-means tested certificates for challenges to DoLS where there is no existing authorisation. The current system has produced arbitrary limitations on the right of access to a court. Legal aid must be available for all eligible persons challenging their deprivation of liberty, regardless of whether an authorisation is in place, particularly given the vast number of people unlawfully deprived due to systemic delays and failures.

DoLS apply to those with a mental disorder. LPS will apply to persons of "unsound mind" to reflect the wording of Article 5. We recommend that further thought be given to replacing "unsound mind" with a medically and legally appropriate term and that a clear definition is set out in the Code of Practice.

The interface between the Mental Capacity Act (MCA) and the Mental Health Act (MHA) causes particular difficulties. Deciding which regime

should apply is complex, and causes the courts and practitioners difficulties. The Law Commission proposes to maintain the two legal regimes: the MHA would apply to arrangements for mental disorders; the LPS would apply to arrangements for physical disorders. Inevitably, problems will continue to arise at the interface between these two regimes. We are particularly concerned by two issues. Firstly, this proposal requires assessors to determine the primary purpose of the assessment or treatment of a mental or physical disorder—this is difficult where persons have multiple disorders. Secondly, we are concerned that there would be essentially different laws and different rights for people lacking capacity depending upon whether their disorder is mental or physical. We consider that the rights of persons lacking capacity should be the same irrespective of whether they have mental or physical disorders.

The Law Commission's proposals could form the basis of a better scheme for authorising deprivations of liberty, directing scrutiny to those who need it most. However, while it should be cheaper than the application of the current DoLS to all those falling within the *Cheshire West* definition, it is not cost free. We urge the Government to consider how this new scheme might be appropriately funded.

Comment

The JCHR report came too late for the Government to consider before introducing the MC Amendment Bill (although the very fact of the inquiry may, itself, been very helpful in ensuring that it introduced the Bill). It will be interesting to see whether the Government responds during the passage of the Bill to the recommendations made by the JCHR in relation

to the Bill – in particular in relation to the definition of deprivation of liberty.

Supreme Court news

The Supreme Court will hear the appeal in *MM* (concerning conditional discharge and confinement) on 26 July. It will hear the appeal in *PJ* (concerning the jurisdiction of the Mental Health Tribunal over human rights issues, as well as CTOs and deprivation of liberty) on 22 October.

The Supreme Court has also just granted permission to the Official Solicitor to appeal against the decision of the Court of Appeal in *Re D* [2017] EWCA Civ 1695. The hearing has been expedited and listed for 3 and 4 October. Anyone who wants to understand how the MCA 2005 is intended to interact with the Children Act 1989 will be well advised to keep a careful eye out for the judgment in due course.

We await, of course, the judgment in the *Y* case concerning the circumstances under which agreed decisions to withdraw life-sustaining treatment must be brought before the courts for sanction.

The headache of fluctuating capacity

RB Greenwich v CDM [2018] EWCOP 15 (Cohen J)

Mental capacity – assessing capacity – care – residence

This case concerned a 63 year old woman with a diagnosis of personality disorder and poorly

controlled diabetes.⁴ While there was a dispute between the applicant local authority and the Official Solicitor (on behalf of CDM) relating to her capacity to determine her residence and manage her property and affairs, both agreed that she did have capacity to make decisions about her care and treatment or, in the alternative, had “fluctuating capacity” so to do.

CDM lived alone with her pets following the death of her husband in 2014. The couple had had a number of dogs and cats which CDM referred to as her “babies”: concern was raised after CDM allowed the condition of both herself and her home to deteriorate. CDM had a history of poorly controlled diabetes as a result of which she sustained an amputation of the right toe and subsequently in May 2017, her lower right leg. Shortly prior to the amputation of her lower right leg, CDM fell and sustained a fracture to her hip.

Subsequent to the amputation, CDM was discharged home, but refused to engage with orthodox rehabilitation methods – she insisted on mobilising with an upside-down broom, rather than a walking stick or zimmer frame, and continued to sleep on the sofa rather than in the bedroom she had shared with her late husband. After a short period at home, she was discovered by the ambulance service sat in vomit and faeces and was taken first to hospital, and then to a nursing home. Throughout the proceedings that followed, CDM remained adamant that she wished to return home to her “babies”. Cohen J noted that she remained “fiercely independent, articulate and determined” and felt “erased” by her treatment.

The parties instructed an independent psychiatrist, Dr Series, to provide a report on CDM’s capacity, in which he concluded that there would be an “*inevitable variation*” in her mental state due to fluctuations in her blood glucose, both as a result of her poorly controlled diabetes, and in the context of a diagnosed personality disorder. Having concluded that the CDM had fluctuating capacity to determine where she should live, Dr Series revised this opinion in the course of his oral evidence, ultimately concluding that she lacked the requisite capacity.

Cohen J resisted the submissions of the Official Solicitor to the effect that questions of capacity have to be made prospectively in order that professionals responsible for P’s care are able to make decisions in their best interests without daily capacity assessments. Rather, he held that

50 [...] Paragraph 4.4 of the Code of Practice says that an assessment of a person’s capacity must be based on their ability to make a specific decision at the time it needs to be made and not their ability to make decisions in general.

51. I accept that in some examples, for instance, the capacity to consent to sexual relations the capacity albeit fluctuating will be one that will either be present or not present. But management of her diabetes is a different matter. It covers a wide range of different situations which may arise frequently or infrequently. The treatment required may be of very different natures. I cannot see that this particular form of fluctuating capacity can properly be managed other

⁴ Katie being involved in this case, she has not contributed to this report.

than by a decision being taken at the time that the issue arises.

Cohen J then extrapolated from this position to hold that, given that CDM's personality was regarded by Dr Series as aggravating her diabetes as it led to poor diabetic control which in turn led to the making of unwise decisions about her treatment and an inability to cooperate with professionals, "when making appropriate decisions she has capacity but when making manifestly inappropriate decisions she lacks capacity."

Comment

This decision goes to show precisely how difficult it is for the court to deal with fluctuating capacity.⁵ The approach taken by Cohen J was faithful to the time-specific nature of capacity but is more than a little problematic to apply in practice. In particular, it is difficult to see how professionals are left with an appropriate touchstone to decide when CDM is, and is not, making capacitous decisions about her diabetes medication.

Cohen J's decision is also one that (albeit for perhaps understandable reasons) comes very close to recasting the capacity test as an outcome-based test in a way that was expressly rejected by the Law Commission in its work leading to the MCA 2005. If the case goes further on appeal, it will be interesting to see whether the Court of Appeal sees this as a problem with the Act itself when it comes to

⁵ Although there is at least one case we know of where the judge has made 'contingent' declarations as to the circumstances under which P would lack capacity.

⁶ Who assessed his capacity on behalf of the local authority in the context of (it appears) renewing the standard authorisation; it would appear that she must

fluctuating capacity, or a problem with the way that it was applied on the facts of this particular case.

Capacity, Prader-Willi, and engaging with P

Re FX [2017] EWCOP 36 (District Judge Bell)

Mental capacity – assessing capacity – care – residence

Summary

This interesting decision from last year which recently appeared on Bailii is the first reported decision where consideration has been given to questions of capacity in the context of Prader-Willi Syndrome ('PWS'). Although a decision of a District Judge, which does not therefore have any precedent value, it is of particular interest for highlighting some of the complexities which arise in relation to this condition.

The question was whether a 32 year old man, FX, had capacity to make decisions in relation to residence and care. The man asserted throughout the s.21A proceedings (through his litigation friend) that he had capacity to make the decisions; the CCG (whom it appears must have been funding his care) asserted that he did not.

Both the BIA, SN,⁶ and the independent psychiatric expert, Professor Tony Holland, were restricted in their ability to assess capacity by a refusal by FX to discuss matters which directly related to his PWS. DJ Bell noted that "[t]his is a

have taken a different view to whomever it was had initially assessed his capacity because, as below, she concluded that FX had capacity, which would logically have meant that the original standard authorisation should not have been granted.

subject which FX finds embarrassing to talk of and which he fears may result in a deleterious outcome from his perspective. He has also expressed frustration about the number of professionals who have undertaken assessment work with him." DJ Bell reminded herself of a decision cited as *Re P* [2014] EWHC 119 COP⁷ in which Cobb J considered what conclusions should be drawn when a person deliberately avoids engaging or cooperating with the mental capacity assessment process thus "it seems to me that patient's lack of engagement or cooperation with the assessment may contribute in itself to a conclusion that a patient is unable to "understand the information relevant to the decision" (section 3(1)... a) and/or (perhaps more significantly, if the patient is shown to understand) unable to use or weigh that information as part of the process (section 3(1)(c))". DJ Bell held that she was "satisfied that his reluctance to discuss his PWS arises from embarrassment and frustration. This explanation does not, in itself, establish that he has relevant understanding."

Unlike SN, Professor Holland found it difficult to engage with FX, DJ Bell noting that "[i]n undertaking his assessment Professor Holland considered records for FX from last year, he spoke with a senior staff member at Care Home C and met with FX on two occasions. On the first occasion for ten minutes and subsequently for forty minutes. Unfortunately, he established minimal rapport with FX and FX did not wish to engage with any discussion about his PWS."

Professor Holland concluded that FX lacked capacity in relation to residence and care; SN "could not conclude that FX lacks capacity in

respect of residence and care. She described her discussions with FX, he would not discuss his PWS but in every meeting he has discussed some of the factors of his care and treatment. She was unable to establish on the balance of probabilities that FX's PWS (or any other mental impairment) is affecting his ability to decide on receiving care and treatment and what that care and treatment should be."

The difficulty that Professor Holland had in engaging with FX fed into his report, discussed by DJ Bell thus (in passages that merit reproduction as demonstrating so many of the issues that so often come up in our experience of capacity assessments):

42. Professor Holland explained that the basis of his opinion was one third assessment time with FX, one third general knowledge of PWS and one third from records provided to him (over a year old at the time). He acknowledged the limitations that this placed upon his assessment and said that he would have been much more comfortable had he been able to spend more time with FX. He accepted that his opinion should be treated with a degree of caution.

43. There are other reasons to be cautious about the opinion of Professor Holland. In his evidence he demonstrated an obvious knowledge of PWS and great commitment to improving the lives of those who suffer from it. Unfortunately, this seems to have led Professor Holland to conflate best interests with capacity. He acknowledged that with respect to understanding of relevant information he had set the bar quite high and linked this to the consequences of uncontrolled

⁷ Interestingly, this is not, as far as we can see, a reported judgment – should anyone care to provide the

transcript for wider use, it would be much appreciated as this is a very useful paragraph!

symptoms of PWS upon sufferers and the benefits to them of a tightly controlled regime particularly with respect to food security. In addition, he failed to conduct a proper analysis of the presumption of capacity. In his analysis the burden was shifted to FX to demonstrate that he possesses capacity. He was unable to provide a satisfactory answer to Mr O'Brien's question 'what did FX say to lead you to the conclusion that he lacked capacity having regard to the test under section 3?' He did not consider whether any of FX's reported actions were unwise decisions rather than indications of lack of capacity.

44. There has been a lack of clarity about the particular decisions to be made by FX. Professor Holland's evidence has been relied upon to support the second respondent's assertions of lack of capacity. In his oral evidence Professor Holland was clear that FX has the capacity to decide between two environments, as that is a more "concrete" decision and one where he could decide which he prefers. However, where all options are open, in his opinion FX cannot incorporate in to his thinking an understanding of his PWS and then he does not have capacity. This echoes his opinion set out at paragraph 2 of his 2nd report:

'the question I asked myself is: if offered a free choice of any type of accommodation would FX be able to incorporate an understanding of the fact he had PWS into any decision he made about his residency? I conclude on the balance of probability that he would not. However, it is very likely that he would be able to

form a view between two possible options both of which had food security.'

45. FX does not have two options to choose between (as confirmed by LB). Following LBL v RYJ a decision is not to be made by P in general or in abstract. On the basis that Professor Holland is satisfied that FX has capacity to decide between two options it must follow, as matter of logic, that he has capacity to make decisions about the place where he currently resides.

46. SN takes a different view. She has different qualifications to those of Professor Holland and her assessment was not ordered for the purposes of these proceedings. However, she had the advantage of being able to meet more extensively with FX and was able to have more productive discussions with him. She conducted her assessment from the correct starting point of presuming that FX has capacity and applying the relevant statutory framework and guidelines.

47. When I consider those matters about which there is evidence of FX's understanding [...] I am satisfied that FX is able to understand, retain, use or weigh the relevant information set out in LBX v K & M and to communicate his decision. Professor Holland did not specifically address this with FX but confirmed in his oral evidence that he would expect FX to understand this. The assessment of SN reinforces this.

48. In addition, from the evidence of SN, I am satisfied that FX understands that he has PWS and that it is an eating disorder. He has identified that he needs support when going out in the community and

that he needs support with portion control. He understands that rejecting support at Care Home A caused him to gain weight. He understands that he is overweight and that this affects his health. He knows that losing weight would improve his sleep apnoea. He wishes to lose weight and he is trying to do so. He understands that staff try to help him by suggesting healthy options when out but that sometimes he rejects advice.

49. I am satisfied that FX has capacity to make the relevant decisions in respect of residence and care as are required at this time. Should a situation arise where there are complex decisions to be made it may be necessary to reconsider issues of capacity in light of those decisions.

Comment

Questions of capacity in the context of Prader-Willi can be extremely complex (as discussed in this paper prepared by the PWS Association [here](#)). On one view, the outcome in this case could be seen as coming perilously close to the somewhat problematic conclusion that “so long as FX is taking sensible decisions he has capacity” (see also in this regard *CDM* discussed here). On the other hand, the judgment stands as an object lesson in following the route map of the MCA with care: despite the superficial disparity in expertise in relation to PWS, SN’s care in following the route map of the MCA meant that her evidence carried greater weight than did that of Professor Holland.

DOLS rights – a simple guide

Tor’s new simple guide to DOLS, and the rights to which authorisations gives rise can be found [here](#).

Deprivation of liberty and participation – Strasbourg speaks

DR v Lithuania [2018] ECHR 548 (European Court of Human Rights (Fourth Section))

Article 5 ECHR – DOLS authorisations

Summary

A lady in her 60s was ordered by a court to be subject to a psychiatric assessment to consider her criminal responsibility for an alleged offence. She was taken in handcuffs by police to a court psychiatric centre around 110 kilometres away, assessed, and released the same day. This breached Article 5(1)(b) as the court order had not authorised that deprivation of liberty.

Two months later, the District Court ordered that she be involuntarily detained for compulsory psychiatric treatment and this decision was upheld on appeal by the Regional Court. These decisions were based upon psychiatric evidence showing her to be of unsound mind, namely chronic schizo-affective disorder with a type of mania. But she was not examined in person by the court and, although legally represented, she was effectively excluded from personally participating in the proceedings:

91 ... the Court underlines that the proceedings in question concerned the assessment of the applicant’s mental condition, and thus she was not only an interested party, but also the main object of the court’s examination. Her participation was therefore necessary not only to enable her to present her own case, but also to allow the judge to form a personal opinion about her mental capacity... It further notes that there is no indication that at the relevant time the

applicant's mental condition was of such a degree that her personal participation in the proceedings would have been meaningless ... The Court finds it particularly important to note that the applicant sent a letter to the Tauragė District Court, asking to be given an opportunity to attend the hearing in her case However, she did not receive any response from that court. No reasons - medical or otherwise - for disregarding the applicant's wish to participate at the hearing were provided in the Tauragė District Court's decision The Government were unable to provide an explanation as to why the Tauragė District Court had not replied to the applicant's letter"

It was held that the domestic courts did not adequately demonstrate that her condition was such as to require compulsory treatment when the decisions to hospitalise her were made. There was an at best superficial judicial analysis of the criteria for detention:

95. In this connection, the Court cannot fail to notice that the decisions of the Tauragė District Court and the Klaipėda Regional Court were each only a few pages long (see paragraphs 28 and 32 above). They essentially reiterated the conclusions of the psychiatric assessment, without providing any independent analysis of the necessity of the applicant's hospitalisation. The Court finds it especially disconcerting that the domestic courts did not in substance address any of the applicant's and her lawyer's arguments. In particular, the Klaipėda Regional Court stated that "the arguments in [the applicant's] appeal confirm[ed] that she [could not] critically assess her disorder [and did] not understand the danger posed by her

mental condition, nor the need for treatment" (see paragraph 32 above). In the Court's view, such circular reasoning - according to which a person's reluctance to undergo psychiatric hospitalisation demonstrates his or her inability to appreciate his or her condition and thereby yields yet another reason for involuntary hospitalisation - is incompatible with the principle of effective protection of Convention rights (see Plesó v. Hungary, no. 41242/08, § 67, 2 October 2012)."

As a result, the Court found that her rights under Article 5(1)(e) were also breached and she was awarded 7500 euros for the distress and frustration suffered.

Comment

This decision emphasises the importance of enabling the person to in judicial procedures which authorise their deprivation of liberty. Not only is this necessary to enable the person to present their own case if they wish to; it also enables the judge to form their own view of the person's mental capacity. Secondly, it illustrates how important it is for the court to independently analyse the necessity – and we would suggest the proportionality – of the proposed deprivation of liberty. Perfunctory scrutiny cannot be expected to be legally valid.

What are the implications, if any, for COPDOL11/Re X process? It certainly suggests that there should be clear reasons given as to why the deprivation of liberty is required – and throws into question whether the standard recitals on the face of the orders made suffice.

We would suggest that this decision does not automatically require Court of Protection judges

to personally examine P's mental capacity. But it does illustrate the importance of the consultation Annexes to Form COPDOL11. If P does wish to see the judge, or otherwise participate, this case demonstrates that P should not be excluded. Indeed, personal participation in detention proceedings would rarely, we suggest, be "meaningless". For if P wants to participate, participation has inherent meaning and the focus must be on making necessary arrangements to enable that to happen.

There is a passing reference by the court to Article 14 CRPD but nothing in the merits analysis. But what is of interest are the criticisms relating to the circular reasoning of the domestic courts. After all, how often is a person's denial of the need for treatment relied upon as a further reason to detain them? What some might call the "insight justification". Indeed, the court's reference to *Plesó* is a reference to the concept of insight, where the court previously held:

67 ... In this refusal [to undergo hospitalisation], [the domestic courts] perceived proof of his lack of insight into his condition – rather than the exercise of his right to self-determination – which, in those courts' view, entailed the risk of his health declining. For the Court, to accept this line of reasoning would be tantamount to acquiescing in a circular argument, according to which a person reluctant to undergo psychiatric hospitalisation would thereby demonstrate his inability to appreciate his own condition and the risk of its potential worsening – which would yield yet another reason for his involuntary treatment. The Court finds that this kind

of handling of such cases is incompatible with the principle of effective protection of Convention rights.

Insight, beware.

PROPERTY AND AFFAIRS

Office of the Public Guardian – Mediation Pilot

[We are pleased to be able to publish here an article from the Office of the Public Guardian for England & Wales about the new mediation pilot that he has launched]

Alan Eccles, the Public Guardian for England & Wales, has launched a pilot aiming to reduce intra-familial disputes in cases where there is a lasting power of attorney (LPA), an enduring power of attorney (EPA) or a court-appointed deputy. Such disputes can risk the protection of a person who is vulnerable because they may not retain mental capacity to make all necessary decisions themselves.

Specifically, the pilot will assess whether OPG offering the service maximises safeguards.

This article is intended simply for information; the results of the pilot will be reported in due course: late 2018/ early 2019.

There is research which says the root cause of many problems is in the relationships, so repairing broken or damaged relationships is often effective and proportionate. Following a House of Lords Select Committee report on the Mental Capacity Act, which said mediation prior to court proceedings appeared beneficial, OPG ran a telephone pilot. This chimed with the alternative dispute resolution strategy of OPG's parent department, the Ministry of Justice.

The quality of the telephone mediation provided was high and the agreements reached were beneficial; participants rated highly that mediation had allowed them to re-focus on the

person they were protecting, rather than the dispute. There were some issues:

- the absence of face-to-face was judged by mediators not to be ideal
- difficulties in getting people who were in dispute to agree to be mediated was a significant challenge, meaning case numbers were lower than desired.

Overall, the telephone pilot did not substantiate long-term conclusions, further work would be necessary.

OPG's safeguarding model looks for timely and proportionate interventions, maximising protection while minimising disruption. This chimes with the MCA principles, as well as HRA requirements to minimise state intervention. OPG sometimes sees fraught dynamics in the support network around someone who may be losing their mental capacity, someone whose personality as a senior figure in the family may be altering. This can place unhelpful additional pressure on the attorney.

Mediation removes the adversarial win/lose aspect of disputes, hones general discontent and dispute down to the core issue, and addresses that issue in the best way and in the best interests of the person. It promises to be timely and proportionate.

OPG lawyers have reported that, when family members see each other outside the court, perhaps for the first time in a little while, they remember who they are, they remember who they are trying to protect, and they start being rational and reasonable again. Mediation seeks to engineer that meeting earlier in the process

than the day of a court hearing, and to facilitate it systematically.

The new pilot will be provided by an independent mediation service which offers experienced, skilled mediators located across England & Wales. At the time of writing, the contracts were on the point of signing, so names have been omitted here. The new pilot will be face-to-face as far as possible, in a location close to the LPA donor and their family, agents and friends. Other channels will be available to involve anyone who is geographically remote.

OPG investigators will initiate the mediation, attorneys or concern raisers are not being invited to do so.

Mediation is unlikely to be appropriate if there is evidence of abuse or neglect.

OPG is bearing the cost of these pilot mediations as they are felt to offer good value safeguards. If OPG providing a long-term service is judged to be beneficial, the charging question will be decided: options include from P's assets, from the parties, from OPG's fee income.

It is anticipated that mediations in this pilot will occur where the person has been assessed as not having capacity to deal with the specific concerns raised, or to ask their attorney to account, or to revoke, suspend or apply to cancel the EPA or LPA.

The involvement of the donor is important - the second MCA principle requires people to be supported to a decision - so their wishes will be obtained whenever possible, whether by attendance, written statements, video, or via a representative such as an independent mental

capacity advocate. We seek to empower the person as far as that can be done

It is hoped that the new pilot will show that OPG investigations can safely be scaled down because the issue is a dispute rather than abuse or neglect and that this can be resolved by mediation. In turn it is hoped that OPG applying to the Court of Protection for specific performance or, in the worst case, removal of an attorney, can be less frequent. These outcomes will benefit the person, the parties, and free up the court. Finding a way to resolve issues and also preserve P's choice of attorney must be apt.

Initially, OPG does not plan to include deputyships in the pilot, because our deputyship case management can contain a degree of informal mediation already and the risks are therefore lower, but this may change.

Mediations in this pilot will not run simultaneously with court proceedings: ideally it will be either/or. In some cases, if mediation is unsuccessful, a court application may be needed.

There is a Court of Protection mediation scheme being mooted; OPG will liaise to ensure lessons are learned and that all interventions contribute to the best interests of the vulnerable person; but the OPG pilot has an explicit aim to avoid court proceedings if possible.

The detail of the mediation discussions will be confidential, and the presumption will be that professionally-facilitated agreements reached will be in best interests, but the Public Guardian will retain responsibility for judging that, and all current resolution routes will remain open.

Duration: the first referral is expected in July, and it is anticipated the pilot will run for the rest of the year – no hard deadline. Proof of long-term durability of agreements reached is unlikely to be possible during that timeline.

Success? Evaluation will be done on every case and will be pulled together as early as a meaningful picture emerges. We will seek to establish, from the mediation provider and the parties involved, whether mediation was helpful and improved protections in a good value, timely and proportionate way; and whether OPG providing a badged service, rather than simply signposting to external providers, increases effectiveness. These things will inform charging decisions.

If a long-term service is approved, this would be by a full OJEU procurement, advertised in the usual way and open to all.

The incapacity crisis

Solicitors for the Elderly have [published](#) research that shows how few of us are preparing for the risk that at some stage we will lack the capacity to make decisions for ourselves.

SFE commissioned independent research from Centre for Future Studies (CFS), a specialist think tank, to forecast the disparity between the number of people who risk developing dementia or other forms of mental incapacity, and the number of people planning ahead for this eventuality by getting a H&W LPA in place.

CFS' research shows that there are currently 12.8 million people over the age of 65 who run the risk of developing dementia, yet there are only 928,000 H&W LPAs currently registered with the Office of the Public

⁸ Editorial view: DNR orders are dreadful, and their continued use should not be perpetuated: see, instead, the [ReSPECT process](#) for how advance care planning should be done in this context in conjunction between

Guardian (OPG) across England and Wales. This suggests that almost 12 million of those people that are at high risk of future incapacity haven't planned ahead to ensure their wishes are followed.

SFE highlight a number of common myths:

Myth: *47% of people believe that a Do Not Resuscitate (DNR) order is issued by your doctor and is placed on your medical records for every future decision.*

Fact: *A DNR order does not travel with you. Each time you move locations (ie. to a different hospital or to a care home), a new DNR order needs to be created.⁸ However, if you embed a DNR request in a H&W LPA, it makes your wishes known wherever you are as your attorney can show the document to all the professionals involved in your care.*

Myth: *65% of people believe their next of kin can make their medical and care decisions for them, should they not be able to.*

Fact: *Only doctors acting in your best interest have the authority to make the final medical and care decisions for you, with or without the consent of your spouse/relatives, should you not be able to make them yourself. Any disputes will be referred to the Court of Protection.*

And some disconnects between desires and reality.

- *70% of Brits would want their family to make their medical and care decisions on their behalf if they were unable*

healthcare professionals and the person (or, where they lack capacity to participate, their proxies/those concerned with their welfare).

to make them themselves, and 79% of Brits haven't discussed their medical or care wishes or later life with their loved ones.

- *58% of Britons believe that by being on the NHS organ donor register ensures that organs are donated. This is a myth; it's important to speak to family and friends about organ donation preferences – if they do not know you have opted to donate, it may not happen. Embedding your decision in a H&W LPA confirms your wishes in writing.*

PRACTICE AND PROCEDURE

Baker J appointed to Court of Appeal (and please can we have a Vice-President)

It is with mixed emotions that we report that Baker J has been appointed to the Court of Appeal. Whilst we congratulate him heartily and know he will make an excellent appellate level judge, we will miss his wisdom at first instance, and had also secretly been hoping that he would be appointed to be Vice-President of the Court of Protection.

We very much hope – by the way – that a Vice-President will be appointed in short order because the ad hoc Rules Committee remains in limbo without one...

Court of Protection statistics

The latest [statistics](#) from the MOJ for January to March 2018 show:

Continued increasing trend in applications and orders made in relation to deprivation of liberty

There were 1,213 applications relating to deprivation of liberty made in the most recent quarter, up 25% on the number made in January to March 2017. Of these, 113 were applications for orders under s.16 MCA 2005, 331 s21A applications, and 769 for *Re X/COPDOL11* applications.

Record numbers of applications and orders made under the MCA 2005

There were 8,089 applications and 10,262 orders made in January to March 2018, up 3% and 15% respectively – the highest quarterly volumes seen since the start of the series.

CoP application and appeal fees reduced (a bit)

The snappily named [Court of Protection, Civil Proceedings and Magistrates' Courts Fees \(Amendment\) Order 2018](#), coming into force on 25 July, will reduce the fees for applications from £400 to £385, and for appeals from £400 to £320.

The reduction to these fees follows, according to [Parliamentary Under Secretary of State for Justice Lucy Frazer QC MP](#), "*a thorough and detailed review undertaken by officials in the Ministry of Justice into the cost of these proceedings. Our review has identified a number of cases where the fees charged were above full cost recovery levels.*" It is not clear at this stage whether those who have been charged the higher sums in the CoP will also benefit from the refund scheme that is being applied in relation to excess fees identified in other areas.

Human rights claims, the CoP and statutory charges

In a document linked to the judgment in *Northamptonshire County Council & Anor v The Lord Chancellor (via the Legal Aid Agency)* [2018] EWHC 1628 (Fam), the Legal Aid Agency has set out how it is possible to bring a HRA 1998 claim linked to family proceedings without attracting the statutory charge in relation to the linked proceedings (and hence losing all the damages that might be recovered in the HRA claim to the statutory charge. As the LAA puts it:

*[I]f the judicial guidance [in *H v NCC and LAA* [2017] EWHC 282 (Fam) and *Re W (Children) (Convention Rights Claim: Procedure): Practice Note* [2017] 1 WLR 3451] is followed and HRA damages are obtained outside of the care or other family law proceedings (e.g. within separate civil proceedings, or by means*

of a settlement outside of the care or other family law proceedings), only the legal aid expenditure incurred in respect of pursuing an HRA claim will be treated by the LAA as provided in connection with it. If the LAA is asked to give an early indication as to whether the statutory charge will apply to any HRA damages in these circumstances, it will request undertakings from the provider and counsel in the care proceedings that they will not make a claim for costs in respect of any HRA work carried out as part of the care or other family law proceedings. Once the undertakings have been received, the LAA will be able to confirm that the statutory charge will not extend to the legally aided care costs. Note that, unless a certificate or amendment to a certificate specifically authorising an HRA claim has been granted, there could be no valid claim for such costs in any event.

Although the LAA's position does not formally apply to proceedings before the Court of Protection, we anticipate that it will apply the same approach as these are so similar to family ones (and it should undoubtedly be asked to do so).

When to join?

Re Z [2018] EWHC 1488 (Ch) (Norris J)

Practice and procedure (Court of Protection) – other

Summary

Although given a Chancery Division neutral citation, this was a procedural application in existing Court of Protection proceedings concerning the capacity of an elderly man (Z) to manage his property and affairs and the validity

of a lasting power of attorney (LPA) apparently granted by Z.

Z was a successful business man who carried out some of his ventures jointly with his brothers (X and Y). X was still alive but Y was deceased. X was a party to the proceedings. The other parties to the main proceedings were Z's wife, CD, and two of their four children, EF and GH. CD and X each had different views on whether Z had capacity to manage his property and affairs and whether a valid LPA had been granted.

The applicant, OO was Y's son and Z's nephew. OO asserted that over the years he has spent an enormous amount of time with Z and that they had a very close relationship that was "akin to a father-son relationship". He also alleged that Z had promised to pay him a sum of money arising from business dealings with his late father, Y. He supported X's stance regarding the issues of Z's capacity and validity of the LPA. OO was concerned that CD was trying to take control of Z's estate for herself and her children to prevent Z from fulfilling the promise which he had made concerning payment of the sum of money.

Although the judge found that OO had relevant evidence to give, he also considered that OO had a commercial interest of his own and that it would not be helpful to give that commercial interest any prominence in the main proceedings. The judge decided that it would not be appropriate to join OO as a party to the proceedings for five reasons:

1. It was of the utmost importance for the proceedings to be resolved speedily. Anything that had the potential to delay or prolong the resolution of proceedings had to be avoided;

2. OO had produced sufficient material to support a serious argument that he had a “sufficient interest” in the “best interests” aspects of the proceedings as he was a family member with some insight into Z’s character and to whom Z may have expressed some intentions. OO had relevant evidence to give on those matters and that his evidence should be admitted into the proceedings so that it was before the court to be tested. However, OO did not need to be a party for that purpose;
3. OO had a separate commercial interest and it would not be helpful to give that commercial interest any prominence in the proceedings;
4. OO was adopting the same position as X who was already a party to the proceedings;
5. Standing back and weighing the pros and cons of joining OO as a party, the need for a just and proportionate determination of the issues meant that it was not desirable to permit it.

Comment

The outcome of this application is somewhat surprising. It may reflect the cultural differences between those brought up in the Chancery Division and those brought up on welfare cases in the Court of Protection. Rarely (in our experience) does the Court of Protection refuse to join a family member as a party where they explicitly wish to be joined. This is all the more so where it is acknowledged by the court that the family member has close relationship with P so as to have a “sufficient interest” in P’s best interests, and that they have has relevant evidence to give on P’s circumstances and

wishes and feelings which needs to be tested by the court.

The court’s concern about not giving prominence to OO’s financial interests (as the proceedings are about Z’s best interests) is understandable. However, the Court of Protection regularly deals with contested matters of best interests (both financial and welfare) where it may be necessary to delineate P’s best interests from the separate interests of any family members. This is routine. We would expect that any judge would be astute enough to ensure to that the proceedings focused on Z’s best interests rather than OO’s commercial interests.

The court’s desire to avoid further delay and expense by joining another party is also understandable. However, the court has available to it a plethora of case management tools including limiting the amount of evidence that a party is permitted to file and the amount of time that is allocated to each party at any hearing. It is difficult to immediately identify from the judgment any insurmountable difficulties that could not have been overcome with robust case management directions to ensure that proceedings were dealt with fairly and proportionately.

Notwithstanding the outcome of this case, we suggest that it would ordinarily be very rare for the Court of Protection to refuse an application by a family member to be joined as a party to the proceedings where it is clear that they have a “sufficient interest” in P’s best interests and have relevant evidence to give on P’s circumstances including P’s wishes and feelings.

THE WIDER CONTEXT

ENGLAND AND WALES

Lady Hale speech

In a fascinating [speech](#) to the Royal College of Psychiatrists on 24 June on whether it is a time for another Mental Health Act, Lady Hale ranged widely over a whole host of issues of relevance to readers of this report, giving her reflections not just on the evolution and possible future of mental health law, but also on *Cheshire West* and the implications of the CRPD for both the MHA and the MCA. It is essential reading for all concerned with this area.

Deprivation of liberty and children (again)

Northumberland County Council v MD, FD and RD [2018]EWFC47 (Cobb J)

Article 5 ECHR – Deprivation of liberty

Summary

The issue in this case was whether RD was deprived of her liberty for the purposes of Article 5. RD was 14½ years old and accommodated in a residential placement referred to as Lennox House in Scotland. She did not have the capacity or Gillick competence to give her consent to the care arrangements. Nor could her parents or the local authority do so as she was under an interim care order. The only issue was whether the arrangements satisfied the acid test.

Lennox House was a large detached house in a

rural setting accommodating six young people, with a staff ratio of 4:6. Mr Justice Cobb set out the key information:

- i) *RD is given a wake-up alarm call each morning, and then is left to her own devices to dress/wash and prepare for the day;*
- ii) *She has her own room; there is a lock on the door which she can use to lock herself in, or to lock when she leaves for school (or otherwise) so that her belongings are safe; the staff have a master key;⁹ I have the impression that the lock is for RD's benefit not the staff's. RD is never locked in her room by the staff, nor are internal doors locked to manage her (or others') behaviour;*
- iii) *RD helps around meal times "which are similar to many households" (per social worker) and she can choose to have free time after her supper with her peers and staff;*
- iv) *RD can move around Lennox House as she chooses; there are generally staff around the communal areas to support the young people; it is said that the staff do not supervise the young people or place them "under surveillance";*
- v) *In her leisure time, RD has the freedom to watch television in a communal area; she can have time*

⁹ "I make the important point here that the presence or absence of a lock on the door is not determinative of the issue: see *Ashingdane v United Kingdom* (A/93): (1985) 7 E.H.R.R. 528 at [41]; a compulsory patient is deprived of his

liberty in the hospital where he is detained, irrespective of the openness or otherwise of the conditions there." (footnote in original)

in her room when she wishes to be alone;

vi) *RD enjoys attending a boxing club; she is taken there (with another young person from Lennox House) by a member of staff;*

vii) *RD enjoys shopping and is taken into town by a member of staff who remains with her in town; she enjoys spending time with an animal therapist and enjoys horse riding;*

viii) *RD can go out into the grounds of Lennox House alone, but her visits outside the building are monitored by a member of staff watching (generally from within the house); if RD goes outside into the grounds in a group, a member of staff accompanies them to monitor/supervise;*

ix) *When RD was more settled, she was trusted to make short excursions in daylight hours from Lennox House alone to a local shop in the village; this opportunity has been denied her lately given her recent abscondences;*

x) *RD travels the hour to school by car or minibus with the other young people from Lennox House, accompanied by a member of staff. The staff member remains at the school during the hours in which RD is receiving her education, in case there are behavioural issues which require resolution; the member of staff is not generally in the classroom with her;*

xi) *RD enjoys fortnightly visits from her family; these visits often take place in the presence of staff, for both supervision and support – there are practical reasons for staff involvement: transport / unfamiliarity of the locality to the family. The family say that they welcome the staff on the visits, and have indicated that they would like this arrangement to remain in place until they feel more familiar with contact taking place in the community, which is unfamiliar to them;*

xii) *RD enjoys and seeks out opportunities for adult 1:1 time with a staff member; RD will often try to isolate a member of staff out to obtain this sole attention;*

xiii) *RD currently does not have her own mobile telephone (I believe a choice of her parents taken with her), but she can access the house phone at any time and make calls, which are not supervised; she does indeed call her parents most days, and calls her social worker when she feels the need to do so; there is no restriction (so I understand) on RD having a mobile phone;*

xiv) *Internet is available in the unit, but it is regulated by a safety feature which blocks social media and inappropriate sites; RD has access to an iPad on site; iPad use is not supervised; search histories are checked randomly.*

In relation to the acid test, his Lordship noted:

29 ... Two phrases fall for scrutiny under the 'acid test': (1) "complete supervision and control" and (2) freedom or lack of freedom "to leave the place where she lives". The second of these phrases on these facts has no application. 'Free to leave' does not mean leaving for the purpose of some trip or outing approved by those managing the institution; it means leaving in the sense of removing herself permanently in order to live where and with whom she chooses. It is accepted wisdom that a typical fourteen or fifteen-year old is not free to leave her home.

The core issue, therefore, was whether RD was under 'complete or constant supervision and control'. The court's view was "that 'complete' or 'constant' defines 'supervision' and 'control' as indicating something like 'total', 'unremitting', 'thorough', and/or 'unqualified'" (para 31). After helpfully setting out the important passages from the case law at para 32, his Lordship made "a finely balanced decision" (para 35), comparing the arrangements with the notional circumstances of the typical child of the same age, station, familial background and relative maturity who is free from disability:

38. *The impression I have formed from the statements and reports is that the regime at Lennox House is boundaried, yet supportive. Naturally the staff keep watchful eyes on the young residents, particularly when they cluster, but I do not discern that this level of monitoring is any more intense or overt than a parent's watchfulness over young adolescent people in a domestic setting, in similar circumstances. The presence of staff in the home is, I am satisfied, in significant measure to give the young people support and attention. These young*

people, because of their needs, require 1:1 attention and support at times; this is qualitatively different from 1:1 supervision. RD avowedly craves this kind of attention. Contrary to the submission of Mr. Wilkinson, I am not persuaded that the staff ratio indicates of itself that the residents are subject to complete or constant supervision and control.

39. *It is the issue of supervision or surveillance and/or control which gives rise to the most difficult question on the facts of this case: i.e. to what extent the 'supervision' of the staff over RD is different from the watchful eye or supervision of a reasonable parent? It is not immaterial to my assessment that RD is described as a 14-year old who appears younger than her chronological age (see [14] above). It is fair to reflect that the degree of supervision may well be greater for her given her 'younger' presentation or late evolving maturity than it would be for a more mature 14-year old. Nor is it immaterial that RD herself does not feel "watched" all the time (see [16] above), which in itself is a reflection of the actual extent of the supervision.*

40. *The monitoring of RD as she ventures out into the grounds of Lennox House ([18](viii) above) is, it seems to me, ordinary quasi-parental good sense. The fact that Lennox House stands on a busy road would be a matter of concern to any parent; a rash and unthinking excursion onto the road by any young person would place them at risk. As I have earlier indicated, the fact that the staff accompany RD and her parents on some but not all of her contact visits ([18](xi) above) is more by way of support than*

supervision, particularly given that the parents have struggled with RD's behaviours in the past; moreover, and not insignificantly, the parents are unfamiliar with the local area, and without transport on their visits.

41. There are restrictions on RD's movement, for sure. She does not enjoy the freedoms to wander in to a town as a 14½ year old young person may have the opportunity to do if living in an urban area. This restriction at least in part (perhaps a significant part) arises because of the geographic location of Lennox House – its distance from the local town and village, its distance from school, and is not in my finding because it is a function of any 'complete control or supervision' of the State. Restrictions of movement in this way do not engage considerations of 'deprivation' under Article 5 (see Guzzardi above). I am satisfied that when the staff regard it as safe for RD to be able to pay a visit independently to the local village shop (involving a walk along the A road in daylight), they let her do so, much as a parent may well do.

42. Plainly when RD's behaviour (her abscondences, disobediences, and/or her distress) justify some restrictions on her movement, these are appropriately applied and enforced; but every 14-year old is liable to appropriately imposed boundaries and sanctions. One of the obvious consequences of behaviourally acting out (for whatever reason) has been, for RD, the increase in the level of supervision, albeit for a short time. This is not altogether surprising; just as parents may temporarily 'ground' a teenager, or a boarding school head may impose limitations or tighter restrictions on a

pupil's ability to leave the campus, there is an element of 'teaching a lesson' as well as promoting future safety (see *Re K* at [32] above). Generally, RD has the freedom to wander around the home, and it seems to me that she enjoys a significant degree of autonomy about her recreation there while not at school."

When RD had temporarily absconded, she returned voluntarily or by persuasion and, not being distracted by the protective or "comparative benevolence" of Lennox House and RD's general compliance with its regime, the court held:

45. All children are, or should be, as I have discussed subject to some level of restraint, adjusted to their degree of maturity; so too is RD. It is against that background that I assess RD's situation. Having reviewed all the circumstances, and for the reasons which I have set out above, I have reached the conclusion, on a fine balance, that the regime at Lennox House does not possess the "degree or intensity" of complete control or supervision of RD which justifies the description of 'deprivation' of her liberty. In my judgment, insofar as the staff impose limits or boundaries on her movements and freedoms, these represent restrictions of the type which a child of her age, station, familial background and relative maturity would have placed upon her.

Accordingly, there was no deprivation of liberty so it was not necessary to present a petition to the *nobile officium* of the Court of Session in Scotland (i.e. the exercise of the equivalent of the inherent jurisdiction) for its authorisation.

Comment

This is the latest in a series of cases which have tackled the implications of the *Cheshire West* decision for those under 18. One of the most challenging aspects of the law is in identifying the “notional circumstances of the typical child of the same age, station, familial background and relative maturity who is free from disability”. The level of detail provided in this judgment helpfully enables practitioners to determine those circumstances for someone aged 14, with other general rules of thumb for 10-12 year olds available in *Re A-F* [2018] EWHC 138

When, and why, does false imprisonment not equate to deprivation of liberty?

R (Jollah) v Secretary of State for the Home Department [2018] EWCA Civ 1260 (Court of Appeal (Davis LJ; Hickinbottom LJ; Sir Stephen Richards))

Article 5 ECHR – Damages

Summary

This case concerned an award of damages for false imprisonment in the context of immigration detention. The Secretary of State appealed against an award of damages for false imprisonment of a foreign national (IJ) arising out of the imposition of a curfew. IJ cross-appealed against the quantum of damages.

Following his release from prison, IJ was detained in an immigration detention centre. He was granted bail by the First-tier Tribunal and the bail conditions included a requirement that he reside at a specific address. When the bail came to an end, the Secretary of State imposed a curfew between 11pm and 7am every day and IJ was fitted with an electronic tag from 3 February 2014 and 14 July 2016. IJ challenged the

lawfulness of the curfew and the Secretary of State accepted that he had no power to impose a curfew. The judge determined that IJ was entitled to damages for false imprisonment quantified at £4,000.

On appeal, the Court of Appeal emphasised that the concept of deprivation of liberty was not identical to the tort of false imprisonment; in fact, whilst recognising that “*the underpinning rationale is similar in each case*”, nonetheless, “*the approach to be adopted with regard to Article 5.1 claims is significantly different from that to be adopted by domestic courts in dealing with claims in false imprisonment.*” The court explained at paragraph 30 that:

...in Article 5.1 cases the courts tended to look at the restraint in question in the context of the whole picture: a distinction between deprivation of liberty and restriction on liberty was maintained, involving an assessment of the whole range of factors present including nature, duration and effects of the restraint, and the manner of implementation and execution and so on. Thus, even extensive curfew requirements... might not necessarily involve an infringement of Art 5...

There could therefore be deprivation of liberty without false imprisonment and vice versa. What had occurred in this case constituted imprisonment for the purposes of the tort of false imprisonment and IJ was right not to have pursued a claim by reference to Article 5(1).

As to the quantum of damages, the Court of Appeal noted that many cases involving an assessment of damages for false imprisonment in an immigration detention context have

eschewed the setting of a general tariff and each case was left to be decided by reference to its own facts and circumstances. In this case, the restrictions on IJ's liberty were not complete or total, and there was no finding that the curfew interfered with IJ's chosen lifestyle in some kind of wholesale way. The Court of Appeal concluded that the award of £4,000 was not plainly wrong such that it should be interfered with.

Comment

Although this is not a decision heralding from the Court of Protection, it is nonetheless interesting for its discussion of the principles separating unlawful deprivation of liberty for the purposes of Article 5 and the tort of false imprisonment at common law. It is also relevant to the vexed issue of damages.

Although the Court of Appeal resolutely maintained the distinction between false imprisonment and deprivation of liberty, it was interestingly suggested that an argument could be advanced that the concept of imprisonment for the purposes of the tort of false imprisonment could be aligned with the contempt of deprivation of liberty for the purposes of Article 5. However, this argument was not pursued although the Secretary of State reserved his position to argue it elsewhere. For the time being, false imprisonment and deprivation of liberty continue to be treated differently. We note that this means that it is entirely possible, therefore, that a self-funder in a private care home/hospital may well have no recourse against the care home/hospital which does not seek a DOLS. If they do not meet the rather tighter test for false imprisonment, they could not bring a claim for deprivation of liberty

under the HRA 1998 against the care home/private hospital. It is not obvious why this gap in protection is justified.

In relation to damages, the Court of Appeal in this case, like many courts previously, declined to lay down any general guidelines for quantum of damages, but rather recounted the mantra that *"each case is left to be decided by reference to its own facts and circumstances."* Whilst this does provide flexibility for litigants to argue for or negotiate damages relatively unconstrained by prior cases, it does pose difficulties for practitioners attempting to advise on what damages might be awarded by a court if a claimant is successful at trial. The inherent uncertainty in assessing quantum of damages for false imprisonment and unlawful deprivation of liberty claims will likely continue.

Short Note: Assisted dying

On 27 June, the Court of Appeal rejected ([\[2018\] EWCA Civ 1431](#)) Mr Conway's appeal against the Divisional Court's determination that the ban in s.2(1) Suicide Act 1961 did not represent a disproportionate interference with his rights under Article 8 (1) ECHR. An application for permission to appeal to the Court of Appeal has been lodged.

Short Note: Article 2 procedural obligations, medical treatment and dementia

R (Parkinson) v HM Senior Coroner for Kent [\[2018\] EWHC 1501 \(Admin\)](#) was an application for judicial review of the decision by a Coroner that the death of an elderly woman in hospital did not engage Article 2 ECHR. Mrs Parkinson was 91 years old at the time of her death, and had a diagnosis of dementia. She was diagnosed with a chest infection and taken to hospital. On

arrival, the treating doctor formed the view that Mrs Parkinson was dying.¹⁰ Mrs Parkinson's son disagreed and wanted further tests and investigations to be conducted. The judgment reports that he attempted to give her mouth to mouth resuscitation. At the inquest, he argued that his mother had been subject to neglect and that Article 2 ECHR was engaged. The Coroner found that Mrs Parkinson had been at an advanced stage of dying when she arrived at hospital and that it would have made no difference if further investigations and tests had been carried out. Her son challenged the Coroner's decision on various grounds, including that Article 2 was engaged, but his claim was rejected by the High Court.

Giving judgment, the court helpfully summarised the principles that are now to be applied in respect of Article 2 in medical treatment cases following the decision of the Grand Chamber of the ECtHR in *Lopes de Sousa Fernandes v Portugal* [2017] ECHR 1174:

82. Article 2 imposes both substantive positive obligations on the state and procedural obligations.

83. The primary substantive positive obligation is to have in place a regulatory framework compelling hospitals, whether private or public, to adopt appropriate measures for the protection of patients' lives.

84. The primary procedural obligation is to have a system of law in place, whether criminal or civil, by which individual failures can be the subject of an appropriate remedy. In the law of England

and Wales that is achieved by having a criminal justice system, which can in principle hold to account a healthcare professional who causes a patient's death by gross negligence; and a civil justice system, which makes available a possible civil claim for negligence. We note that, in the present case, there is in fact an extant civil claim which has been brought by the Claimant against the NHS Trust which ran the hospital (which is the First Interested Party in the present judicial review proceedings).

85. The enhanced duty of investigation, which falls upon the state itself to initiate an effective and independent investigation, will only arise in medical cases in limited circumstances, where there is an arguable breach of the state's own substantive obligations under Article 2.

86. Where the state has made adequate provision for securing high professional standards among health professionals and the protection of the lives of patients, matters such as an error of judgment on the part of a health professional or negligent coordination among health professionals in the treatment of a particular patient are not sufficient of themselves to call the state to account under Article 2.

87. However, there may be exceptional cases which go beyond mere error or medical negligence, in which medical staff, in breach of their professional obligations, fail to provide emergency medical treatment despite being fully aware that a person's life would be put at risk if that treatment is not given. In such

¹⁰ For a direct but sensitive discussion of the realities of natural dying and in particular the effect on

breathing, read the excellent new book "[With The End in Mind](#)" by Dr Kathryn Mannix.

a case the failure will result from a dysfunction in the hospital's services and this will be a structural issue linked to the deficiencies in the regulatory framework. At the risk of over-simplification, the crucial distinction is between a case where there is reason to believe that there may have been a breach which is a "systemic failure", in contrast to an "ordinary" case of medical negligence.

It was submitted on behalf of the son that since Mrs Parkinson had dementia and "*lacked mental capacity*," she was in the same position as a vulnerable mental health patient and so within the scope of Article 2. That submission was quickly rejected by the High Court. The High Court also rejected any suggestion that because a DNACPR notice was put in place at the hospital, this was evidence of a denial of appropriate medical treatment. The High Court noted that "*It was a matter for the clinical judgement of [the treating doctor] but it will be readily apparent that the administration of CPR can be harmful to the interests of a patient, in particular an elderly patient.*"

‘Seni’s Law’ passes Third Reading in Commons

After an unexpected hitch, Steve Reed MP's [Mental Health Units \(Use of Force\) Bill](#) has progressed through its Third Reading in the House of Commons and now moves to the Lords. Named ‘Seni’s law’ in memory of Olaseni Lewis, who died in September 2010 after being restrained by 11 police officers at Bethlem Royal Hospital in south-east London, this Private Member’s Bill is supported by the Government so has a realistic chance of becoming law. It makes provision about the oversight and management of use of force in relation to

patients in mental health units and similar settings, introducing introduce statutory requirements in relation to the use of force in mental health units; and require service providers to keep a record of any use of force, have a written policy for the use of force, commit to a reduction in the use of force, and provide patients with information about their rights. In the case of death or serious injuries following the use of force, the Bill would require mental health units to have regard to all relevant NHS and Care Quality Commission (CQC) guidance. This would have the effect of putting NHS England’s Serious Incident Framework on a statutory footing.

The Bill also places a new duty on the Secretary of State to produce an annual report on the use of force at mental health units. At present, data on this is not routinely published.

In addition to provisions on the use of force in mental health units, the Bill also includes provisions on the use of body cameras worn by police officers who attend mental health units for any reason.

Acquired Brain Injury debate

Towards the end of last month, and shortly after Brain Injury Awareness Week, the House of Commons held a [debate](#) on acquired brain injury (“ABI”) chaired by the parliamentary under-secretary of state for health and social care (Steve Brine). As the debate noted, the number of people currently living with ABI is thought to be between 500,000 and 1 million with some 1500 patients with traumatic brain injury attending A&E departments in the UK each day. The “total cost” of brain injury, however that is calculated, is estimated to be at least £1 billion.

In an interesting debate, in which a large and

perhaps surprising number of MPs volunteered very personal experiences of ABI, the prevalence of ABI was discussed as well as the need for better rehabilitation.

MPs noted the research of the United Kingdom Acquired Brain Injury Forum which calculates that the average cost of the initial rehabilitation programme for ABI is offset by savings in the cost of ongoing care within just 16 months and that this leads to an average saving over a lifetime in care costs of £1,475,760. Neuro-rehabilitation was accordingly described as *“one of the most cost-effective services the NHS provides and one of the few services in medicine that result in long-term decreased costs to the economy.”*

It was also observed that research carried out at HMP Leeds showed that when screening of every prisoner arriving in through the door was carried out, 47% were discovered to have an ABI, that 76% of those had several and that 30% of those had more than five brain injuries. There was also discussion of figures showing that five children in every primary school class in this country will have an ABI, with some research suggesting this figure is between 3 and 4.3 times higher in poorer areas

The government expressed recognition of the fact that *“neglecting rehabilitation is a false economy”* and highlighted its current investments in ABI:

- £100 million over 5 years in biomedical research in Cambridge;
- £5 million to co-fund the surgical reconstruction and microbiology centre in partnership with the Ministry of Defence

- £2 million over three years through NIHR’s global health research group on neurotrauma

In the context of national health budgets, these sums are, of course, fairly limited.

Transforming Care programme debate

In an embarrassingly poorly-attended back bench debate brought by Norman Lamb MP on 5 July, detailed consideration was given by those MPs present of the current – very problematic – state of the Government’s Transforming Care programme, designed to secure the move from hospitals such as Winterbourne View into the community of those with learning disability and autism. At the end of the debate, those MPs expressed the view that:

this House is concerned at the slow progress made under the Transforming Care programme, which was set up to improve the care and quality of life of children and adults with a learning disability and/or autism who display behaviour that challenges; recognises that a substantial number of people with learning disabilities remain trapped in, and continue to be inappropriately admitted to, Assessment and Treatment Units rather than living with support in the community; is further concerned at the lack of capacity within community services; notes evidence of the neglect, abuse, poor care, and premature deaths of people with learning disabilities; believes that the Transforming Care programme is unlikely to realise the ambitions set out in the Building the Right Support strategy before it ends in March 2019; calls on the Government to establish, prioritise, and adequately resource a successor programme that

delivers a shift away from institutional care by investing in community services across education, health and social care; and further calls on the Government to ensure that such a programme is based on lifelong support that protects people's human rights and promotes their independence and wellbeing.

Dementia Guidance

The Government has published new guidance (with an easy read version) in relation to people with dementia and learning disabilities and the need to make reasonable adjustments. It notes that age-related dementia of all types is more common at earlier ages in people with learning disabilities than in the rest of the population and that those with Down's syndrome are at particular risk of early onset dementia. It also notes that data from GPs has suggested dementia in the general population is 5.1 times the number anticipated.

INTERNATIONAL DEVELOPMENTS OF RELEVANCE

Council of Europe report: Powers of attorney and advance directives for incapacity

[Adrian Ward has recently completed a major report as consultant to the Council of Europe reviewing Recommendation CM/Rec(2009)11 on principles concerning continuing powers of attorney and advance directives for incapacity, looking both at how powers of attorney and advance directives are operating in practice across member states in the Council of Europe, and making proposals suggestions for future action. We reproduce below the executive summary, edited to remove cross-references, but strongly recommend reading the report in full both to see how states across the

Council use (or do not use) these tools, and also – importantly – for how they can be re-tooled to make them more effective and more compliant with the principles of the CRPD.]

Across Europe, implementation of Recommendation CM/Rec(2009)11 is work-in-progress. Achievements to date by member states are commendable. Much has been done, and continues to be done, by member states towards promoting self-determination for their citizens, by providing and refining voluntary measures, and encouraging their use.

The picture across Europe is however that outcomes envisaged by the Recommendation are only at an early stage of development, leaving most member states still with much to be done. It is also a picture of diversity, ranging from unavailability of continuing powers of attorney ("CPAs") and/or advance directives, through to relatively wide-ranging provision for CPAs, and at least some provision for advance directives. There is also diversity in that some member states have legislation in force and in full operation, some have passed legislation which is not yet in operation, some have proposals before their legislatures, and some have proposals which are not yet before their legislatures. [...] Where CPAs and advance directives are available to citizens, there is diversity among member states as to the length of time for which they have been available, and remarkable diversity in the extent to which – so far as statistics have been provided – they are used. [...]

As at 1 September 2017, nine member states currently had in force all of the areas of relevant provision of (1) CPAs to cover economic and financial matters, (2) CPAs to cover health,

welfare and other personal matters, and (3) advance directives as defined in Principle 2.3 of the Recommendation. One more state will have all of those areas of provision when legislation already passed comes into force. Only one member state, when legislation already passed comes fully into force, will have implemented all of the Principles identified as fundamental in this report.

Completed questionnaires [...] were received from 26 member states. They contributed a wealth of information, which has been correlated and analysed in this report. These responses to questionnaires ("Responses") reflect great care and enthusiasm with which member states have analysed and addressed relevant issues in recent years. In addition to Responses, one abbreviated form, and further information from two further member states, were received [...].

The Principles in the Recommendation remain highly relevant. In a time of dynamic development across our continent, guided by the common Principles in the Recommendation, this report seeks to provide a starting-point for further collaborative progress. Member states are encouraged to continue to share information, initiatives and experience. Member states are encouraged to contact the Secretariat to the Directorate General of Human Rights and Rule of Law ("DGI Secretariat") with proposals for joint projects, conferences and the like.

As well as the general need to continue collaboratively the work of full implementation of the Recommendation, particularly significant conclusions emerging from this review include:

- Provision for advance directives, compared with CPAs, is under-developed. Nowhere is

there clear legislative provision maximising the scope of self-determination by advance directives, so as, in conjunction with CPAs, to maximise the total range of provision for self-determination.

- There are insufficiently strong requirements to ensure that, in accordance with the UN Convention on the Rights of Persons with Disabilities, during operation of CPAs granters are informed and consulted, and their wishes and preferences identified and respected.
- Europe-wide, there is insufficient clarity as to how to balance expressions of self-determination when voluntary measures are created, with inconsistent expressions when they are subsequently in operation.
- Promotion of self-determination requires not only availability in legislation of voluntary measures, but availability of fully inclusive forms of document and procedures to establish them; proactive promotion of use of voluntary measures; and removal of barriers to their effective operation, both within member states and in cross-border situations. All of these aspects require to be developed further in many member states.

This report contains six proposals designed to address the foregoing issues, and 30 suggestions [...], four of them directed to both Council of Europe and member states, and the remainder to member states. Some of those suggestions are at least partly supplementary to the proposals. The majority are free-standing.

The proposals set out below, and the suggestions appearing later in this report, have been drawn by the consultant from the

information provided in this report, and from matters within his own knowledge. These proposals and suggestions are solely those of the author and do not necessarily reflect the views of CDCJ, the Council of Europe or its member states.

The proposals are:

PROPOSAL 1:

(A) – That all member states should, on an ongoing basis, continue to review and develop provisions and practices to promote self-determination for capable adults in the event of future incapacity by means of CPAs and advance directives.

(B) – That in doing so, member states should have regard to such assistance as may be provided by the solutions to issues, and experience in practice, of other states as described in this report; should continue to share information, initiatives and experience; and should where appropriate, and in conjunction with Council of Europe, promote joint projects, conferences and the like.

PROPOSAL 2:

(A) – That member states consider, in particular, developing provision for advance directives, as a component in the overall promotion of self-determination in conjunction with CPAs, having regard to the full potential scope of application of advance directives to all health, welfare and other personal matters, to economic and financial matters, and to the choice of a guardian should one be appointed; and with appropriate distinction between the categories of instructions given and wishes made.

(B) – That Council of Europe should consider promoting research and consideration at a European level, and issue of guidance or recommendations, with a view to assisting member states in implementing Proposal 2 (A).

PROPOSAL 3:

That member states review laws relating to CPAs to ensure –

(A) That in relation to all acts and decisions in their role as attorneys, attorneys are required to take all practicable steps to ascertain the will and preferences of the granter, or failing that the best interpretation of the will and preferences of the granter.

(B) That in their acts and decisions on behalf of the granter attorneys are required to give effect to the will and preferences of the granter (or best interpretation thereof) except only where stringent criteria for doing otherwise, set forth in law, are satisfied. (C) That the requirement to inform and consult the granter on an ongoing basis includes a requirement (i) to present to the granter, in the form that the granter is most likely to understand, the information necessary to enable the granter to formulate and communicate his or her will and preferences, (ii) to provide the granter with all reasonable support towards enabling the granter to formulate and communicate the granter's will and preferences, and (iii) to keep the granter informed of acts and decisions taken and implemented.

PROPOSAL 4:

That Council of Europe give consideration to promoting discussion and research with a view to clarifying matters relevant to situations of

conflict between the terms of a continuing power of attorney or advance directive, on the one hand, and on the other the apparent will and preferences of the granter at time of exercise of powers conferred by a CPA, or of implementation of instructions in an advance directive, or when wishes expressed in an advance directive are to be followed.

PROPOSAL 5:

(A) – That member states facilitate and encourage the use of continuing powers of attorney and advance directives in forms helpful to people with disabilities, including in easy-read form, and the maximisation of support to enable people with disabilities to exercise their legal capacity by granting CPAs and issuing advance directives.

(B) – That member states facilitate and encourage the incorporation of supported decision-making and co-decision-making provisions in continuing powers of attorney.

(C) – That Council of Europe develops and issues guidance or recommendations to assist member states in implementing Proposals 5 (A) and (B).

PROPOSAL 6:

That member states should:

(A) – Educate citizens about CPAs and advance directives, and proactively promote the granting of CPAs and the issue of advance directives.

(B) – Assess whether financial savings achieved by higher levels of uptake of CPAs and advance directives would make it economically prudent to fund such public education and promotion, and/or to subsidise the costs of granting CPAs

and issuing advance directives.

(C) – Review whether all available involuntary measures comply with international human rights requirements, and whether they avoid inhibiting uptake of voluntary measures.

(D) – Review and address any barriers, internally or in cross-border situations, to the full recognition and effectiveness in practice of CPAs and advance directives.

Can values, wishes and beliefs determine the meaning of death?

In June 2018, the Ontario Supreme Court (not the highest appellate court in Ontario) gave judgment in *McKitty v Hayani*, a tragic case concerning a 27 year old woman who suffered serious brain damage following a drug overdose and was declared to be brain stem dead by doctors. In Ontario, as in many other places, there is no statutory definition of death, but the diagnosis of death is generally left to medical professionals. Ms McKitty's parents argued that where a person's religious beliefs conflicted with the medical definition of death, those religious beliefs should prevail, and that "[t]he determination of death requires an assessment of not only medical considerations but also the values, wishes and beliefs of the individual patient."

There are different ways in which death can be described – the cessation of the circulatory system (the heart and lungs) and the cessation of neurological function. In contrast to a prolonged disorder of consciousness, in brain stem death, there is no flow of oxygen to the brain and so no brain activity, even at the level of reflex. The heart of the brain stem dead person can continue to beat and, if supported by ventilation, the person can continue to be kept

'alive' for a period of time.

In Ms McKitty's case, a number of doctors had assessed that she was dead by applying neurological criteria – there was no flow of oxygen to the brain and no electrical activity in the brain. She had displayed some movements which were documented by her family, but the court accepted that these were spinal reflexes not mediated by any brain activity.

In the course of its judgment, the court considered the position in the UK, observing that "*The common law of the United Kingdom recognizes death by neurologic criteria, which is defined as death of the brainstem.*" Overall, the court summarised the global jurisprudence in the following terms:

Courts have made findings of death when cardiorespiratory function has been maintained by mechanical ventilation;

- Courts have accepted brain death as death;
- This definition of death has evolved from a traditional reliance on cardio-respiratory failure as a result of scientific and medical advancements;
- It is left to the medical community to determine the criteria or guidelines to establish brain death;
- There is no decision where the court has found that an individual's views, wishes and beliefs must be considered as part of the determination of death;
- There is no decision where the court has found that a body that may be physiologically and biologically functioning, in the presence of brain death, is alive.

The court, unsurprisingly, followed this approach and determined that Ms McKitty was dead. The court was anxious about the wider implications of the family's position:

126. The applicant is proposing a radical and significant change to the definition of death and, in essence, the concept of life. It is not the role of this court to engage in a social policy analysis that engages significant bioethical and philosophical considerations regarding the recognition of physiological functioning of the body as life.

127. There are also policy issues that would have to be considered which are beyond the role of this court. For example, according to Dr. Baker and Dr. Truog, given medical technology, a body can be maintained for an indefinite period of time after a declaration of brain death. That could have a significant financial impact on the health care system if a body that is biologically or physiologically functioning is to be maintained on mechanical ventilation until such time as the heart stops beating, at the request of the individual or their family, based on their personal values and beliefs. There could also be an indirect impact on those who require medical services or treatment if staffing and medical resources are required to maintain those who believe that a biologically functioning body is life. Lastly, there could also be adverse consequences to the organ donation system in Canada. Although no evidence was led regarding any possible impact on the organ donation system, a reasonable conclusion is that if more individuals are maintained on mechanical ventilation beyond the determination of brain death, there could be fewer possible

donors. *This ripple effect of consequences flowing from a recognition of biological functioning as life requires careful consideration by the legislature.*

128. *Furthermore, if a choice can be made that a physiologically functioning body must be maintained on mechanical ventilation, do medical services have to extend to providing other interventions to maintain that functioning body? For example, if Ms. McKitty's kidney function fails, will dialysis be required? Should she be treated with antibiotics to fight infection? If her bowels fail, should there be interventions to provide her with a colostomy for so long as her heart is beating? If her heart stops beating, is medical intervention required to attempt to restart the heart? What medical services and to what extent must those services be provided to maintain a physiologically functioning body if that is considered life? These are all issues that cannot be resolved by this court but are best dealt with by the government which is well-suited to address such policy issues. Unlike the court, legislatures are better able to determine questions with many diverse input factors that affect a variety of constituencies in the decision-making process.*

The court also found that the Canadian Charter did not apply to Ms McKitty as it applied only to living persons, but held that in any event, the principles of the Charter were not inconsistent with an approach to brain death which did not factor in the religious beliefs of the individual.

Comment

There are two reported decisions in England and Wales concerning brain stem death – *Re A* [1992] 3 Med LR 303 and *Re A (A child)* [2015]

EWCA 443 (Fam). In both, the mainstream medical approach was accepted. The uncertainties involved in this area, including the persistence of movement and the recording of electrical activity after the cessation of brain function, may well mean that the issue arises again. The recent case of *Jahi McMath* has highlighted that different regions in the USA have a different approach to religious objections to brain stem death. Greater public knowledge of this option could lead to a situation where permission is sought to take a child or adult out of the jurisdiction for continued ventilation in another country.

SCOTLAND

Adults with Incapacity Reform

Responses to the most recent consultation by Scottish Government on “Adults with Incapacity Reform” closed on 30th April 2018. With commendable speed, the Scottish Government team dealing with this review of legislation (“the SG team”) crunched all the numbers, carried out an initial analysis of the content of all 316 responses to the consultation, and presented the results to a meeting in Edinburgh, hosted by the SG team, on 28th June. Of particular interest were the indications given about the road ahead for the reform process. It appears that the SG team intend to maintain the same remarkable rate of progress over the next few weeks to produce a full report on the responses to consultation, with the SG team’s own comments and analysis. It seems possible that this could even be issued in time for us to cover it in the next (September) issue of the Mental Capacity Report. Beyond that, it is intended that three short-term working groups will be established to deal with particular aspects, while the SG team will itself continue work in-house on other aspects of reform. The working groups will address (a) deprivation/restrictions on liberty, (b) graded guardianship and the forum for the AWI jurisdiction, and (c) support and training for attorneys and guardians. The balance of responses would appear to favour proceeding with all these aspects of reform, but doing much further work on them. The SG team stress the importance of involving service users, carers and relevant professionals as being essential in order to achieve appropriate outcomes. There will be further consultation with stakeholders on proposals in the early part of 2019, with the aim

of introducing legislation in the current parliamentary session. It is reasonable to comment, however, that such legislation will in some respects be the beginning rather than the end of the story. If proposals for a unified tribunal are to be advanced, that will almost certainly take significantly longer, and the ultimate aim of fused legislation for adult incapacity, mental health, and adult support and protection provisions is likely to be some years beyond that.

We are grateful to the SG team for permitting us to provide a [link](#) to the slides which accompanied their initial presentation on 28th June. As the SG team acknowledged, that presentation simply referred to numbers of responses, without any qualitative analysis of arguments presented in favour of particular views, and no differentiation between responses from individuals, and collective responses from large organisations, generated by significant numbers of people with substantial knowledge and experience. The SG team itself acknowledges that “numbers are just numbers”. For more than that, we must await the report from the SG team which is to follow.

The crude numerical approach has inevitably produced some odd results. It would appear that the highest number of responses (249 in total) replied to the question: “Should there be clear legislative provision for advance directives in Scotland or should we continue to rely on common law and the principles of the AWI Act to ensure people’s views are taken account of?”. The vote on this was 239 in favour and 10 against. As legislative provision for advance directives was one of the topics included in the draft Incapable Adults Bill annexed to the 1995 Scottish Law Commission Report which led to

the Adults with Incapacity (Scotland) Act 2000, but which was dropped in the legislation, it is certainly to be hoped that this deficit will be made good, along with the similar “disappearance” of provisions on withholding or withdrawing life-sustaining treatment, and the requirement for specialist sheriffs – the latter is still urgently required even if the jurisdiction were to be transferred to a tribunal in due course.

Strangely, that figure of 249 contrasts with a maximum of 138 on the possibility of establishing an “official supporter” (though many alternative terms were offered); 143 on issues related to assessment of capacity; and 149 on the hugely important topic of introduction of graded guardianship. The numerical advantage was in favour of all of those proposals on a “yes/no” basis, but with many relevant comments on both sides.

Some of the largest numerical majorities were in favour of repealing access to fund provisions and management of residents’ finances provisions, in favour of incorporating such arrangements in a new guardianship scheme.

Likewise, there were substantial numerical majorities in favour of a tribunal model for the forum, rather than continuation of the sheriff court, though rather oddly discussion still appears to refer to using the Mental Health Tribunal for the adult incapacity jurisdiction, whereas the original proposal from the Law Society of Scotland in response to previous consultation was for a new unified tribunal.

Another substantial numerical majority was in favour of changing the way in which guardianships are supervised, generally to a more targeted and risk-based system, though

one has to point out that the Office of the Public Guardian has already made substantial moves in that direction in its supervision of financial guardianships.

Further significant numerical majorities were in favour of providing better advice and support for guardians and for attorneys.

Numerical majorities broadly favoured the overall approach in the consultation document to addressing proposed “significant restrictions on liberty” but with many qualifications and comments demonstrating the need for further work. Underlying themes included the need to find a balance between protecting and upholding people’s rights, and at the same time providing a viable system of care, avoiding the major problems and drains on resources which have hampered the deprivation of liberty safeguards scheme in England. The same could be said of a general need for adjustments to provisions for medical authorisation and authorisation of research, with a clear need for further work on these topics as well.

The story appears to be broadly similar on the need for adjustment to the section 1 principles of the 2000 Act, including introduction of new principles: yet again, a clear recognition of the need for strengthening the principles in order better to achieve compliance with the requirements of the UN Convention on the Rights of Persons with Disabilities, but no consensus yet on what the adjusted and new principles should be, beyond general concerns that they should be more robust, and create enforceable duties.

For an interesting comparison with the broad sense of direction towards which we are moving

in Scotland, and one which I would suggest is not incompatible with ours, see the report in The Wider Context section of this report of a speech recently given by Lady Hale, President of the Supreme Court.

This report is not intended to be a comprehensive account even of the matters addressed on 28th June. There is without doubt a clear need for substantial reform, and wide-ranging support for such reform, but the next step will be to see the fuller analysis of responses to the consultation which is now expected by way of a report from the SG team.

Adrian D Ward

Sandra McDonald Reflection

[We are very pleased to publish here an article from Sandra McDonald, who is shortly to retire as the Public Guardian for Scotland reflecting on her time in the office]

It is a privilege to have been invited to reflect on my 14 years as Public Guardian for Scotland as I face retirement, early, I hasten to add. Hopefully it doesn't feel too much like writing my own obituary.

On 1st August 2004 I became the second Public Guardian for Scotland, I took the reins at a difficult time as my predecessor, who had established the office, had died in traumatic circumstances; I took as a credit to his character and ability the immense passion and loyalty of his team, so it was with some trepidation that I stepped into those shoes, but the team were warm, welcoming and supportive.

I was given about six weeks settling in before my first presentation, to the Law Society of Scotland

– I recall feeling very green and being extremely nervous, but there was nothing to have worried about the solicitors were very gentle with me, and I can honestly say from that point forth I have had what, for me anyway, has been the most fulfilling relationship with the solicitors who specialise in the adult incapacity field – well some have been easier than others to be honest, but no names mentioned. It is with some irony that my last presentation was also for the Law Society of Scotland; a full cycle.

The Adults with Incapacity (Scotland) Act 2000 (AWI) was 4 years old when I took post, my predecessor had embedded all of the early processes, so I was thinking my main task was stabilising things after his loss – that was until Scottish Government decided to have a 5year review of the Act; so it was in at the deep end with consultation on possible amendments. As I complete my OPG career, Scottish Government has just announced further amendments to the AwI, following a public consultation exercise – another full cycle.

The 5 year review led to the 2007 changes that we have been working with since. This was my first exposure to Parliamentary process, I hadn't realised how loong it took from concept to commencement. Particularly daunting was appearing before a Parliamentary Select Committee, which I have had the 'pleasure' of three times now for various things, being challenged on the efficacy of the service we wished to develop; it feels like you against the world, but it (I) must have 'passed muster' as the developments were always given the go ahead.

Now for the stats bit – when I took up post we had 45 staff and 14,000 powers of attorney per annum, hard to credit now. Power of attorney

volumes have increased year on year, totalling a 440% increase over the 14 years. Guardianship usage has also increased by 400%, although of lower volumes; with a total increase in staffing of 78%. Not surprising then that the now aged IT system which supports the OPG processes is creaking and we have just about outgrown the building – both are on the cards for a review as I vacate post.

The post of Public Guardian is unique in the country, so can be isolating and offers nothing against which to benchmark one's service. Consequently Scotland, as the first public guardianship service, established a public guardianship community with the equivalent leaders in the other home nations; I hope I can speak for my public guardian colleagues when I say we have enjoyed a very productive relationship since. The networking has grown into a biennial Public Guardianship Conference, hosted by each of the nations in turn and, judging by the numbers who wish to attend, must be filling an important role.

It has been a pleasure to work with a number of other countries to support their development of their public guardianship service, Singapore, Malta, Norway, South Korea to name a few – but it is with regret that, apart from Malta, I failed spectacularly in getting 'an away match'.

The changes that most stick in my mind are launching an electronic power of attorney registration system; facing a High Court challenge on the efficacy of the power of attorney format, which had it succeeded would have threatened about 75% of the then registered PoAs; getting a proposal for a form of graded guardianship to public consultation; developing a UN compliant tailored supervisory

regime for guardianship and getting some traction on cross border recognition for powers of attorney through the arguments I suggested be advanced in 'the Airdrie case'.

I felt hugely flattered to be invited to sit as an observer member of the Law Society of Scotland's Mental Health and Disability subcommittee and to be asked to Chair the Law Society of Scotland annual conference - the down side of which was staying in one of the nicest hotels in St Andrews with what I can only assume was a privileged room for the Chair – tough job!!

I took part in the Essex Autonomy 3 jurisdictions review and am on the expert advisory group for the Centre for Mental Health and Capacity Law, a professorial led unit at Edinburgh Napier University, such a dedicated academic centre gives enormous legitimacy to the specialism.

But all this has to be for a reason – I met Jason, a 21 year old with a serious acquired brain injury, who was on a one year financial guardianship order to enable his parents to sort his affairs out to allow him to live as independently as was possible thereafter; I asked Jason what his wishes were for his future, to which he replied "to be normal", I asked him what that meant for him, as everyone's idea of normal may be different, he told me he wanted a job and to have a baby (with this girlfriend, who had stood by him post-accident). Within the lifetime of the guardianship Jason gained employment, then about 5 years later, out of the blue, I received a picture of Jason holding a baby, there was no covering letter with it, simply the words on the back of the picture "Jason is normal". To this day I have that picture in my desk drawer and on occasions when I'm totally hacked off by the bureaucracy of it all, I

look at that picture and remember, that's what it's all about.

So on the 31st July, exactly 14 years after I started, another full cycle, I complete what has been the most challenging but, by a country mile, the most satisfying role of my career. Its only on looking back that one appreciates just how much has been achieved in that time but it's not me, it's we, that have achieved what we have, the many passionate and tireless people I have been so privileged to work with throughout Scotland, as well as the most dedicated and committed team, who are so regularly commended when I'm out and about, their enthusiasm and loyalty has never wavered. Fiona Brown, my current Deputy, will take over as Public Guardian for Scotland, at a time when the office is facing significant operational demands, as a result of which the role has been refocused to allow Fiona to concentrate on leading the internal operational change, for which I know she will have the support of a fantastic team and can only hope the role is as fulfilling for her as it has been for me.

As for me, you don't get rid of me that easily, I may be taking retirement but I'm not retiring, I'm establishing myself as an independent advisor and trainer in the capacity field, under a company name of EX-PG, so I'm a hand for hire, if you have, or know of, a piece of work for which an Ex-Public Guardian may be suitable then my contact details are Email: sandra@ex-pg.com: Tel 07503 555672: Website sandraexpg.com. I am on Twitter at [@sandraexpg](https://twitter.com/sandraexpg) and shall in due course be operating a LinkedIn site; bearing in mind that I all of these are only 'live' from 1st August 2018.

So I close by thanking you ALL for your support over what has been the best 14 years of my career and saying Adieu rather than farewell as I hope very much that I can continue to work with you, supporting the very obvious commitment you have to furthering the mental capacity agenda.

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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 has experience in a wide range of issues before the Court of Protection, including medical treatment, deprivation of liberty, residence, care contact, welfare, property and financial affairs, and has particular expertise in complex cross-border jurisdiction matters. She is a contributing editor to 'Court of Protection Practice' and an editor of the Court of Protection Law Reports. She sits on the London Committee of the Court of Protection Practitioners Association. 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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Katie advises and represents clients in all things health related, from personal injury and clinical negligence, to community care, mental health and healthcare regulation. The main focus of her practice however is in the Court of Protection where she has a particular interest in the health and welfare of incapacitated adults. She is also a qualified mediator, mediating legal and community disputes, and is chair of the London Group of the Court of Protection Practitioners Association. 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](#).



Adrian Ward: adw@tcyoung.co.uk

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



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Jill Stavert is Professor of Law, Director of the Centre for Mental Health and Capacity Law and Director of Research, The Business School, Edinburgh Napier University. Jill is also a member of the Law Society for Scotland's Mental Health and Disability Sub-Committee, Alzheimer Scotland's Human Rights and Public Policy Committee, the South East Scotland Research Ethics Committee 1, and the Scottish Human Rights Commission Research Advisory Group. She has undertaken work for the Mental Welfare Commission for Scotland (including its 2015 updated guidance on Deprivation of Liberty). To view full CV click [here](#).

Conferences

Conferences of interest

Costs and summer drinks reception

On 26 July a training event and summer drinks reception will be hosted by London CoPPA in association with Hardwicke Chambers covering hot topics in the world of Court of Protection costs. For more details, see [here](#).

Towards Liberty Protection Safeguards

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

5th International conference on capacity: ageing, sexuality & human rights

Capacity Australia is hosting this fascinating-looking conference in Rome on 3 October. For more details 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.

We are taking a summer break (from this, but not from the world of mental capacity law, which is going to be a very busy one over the next few months). Our next edition 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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