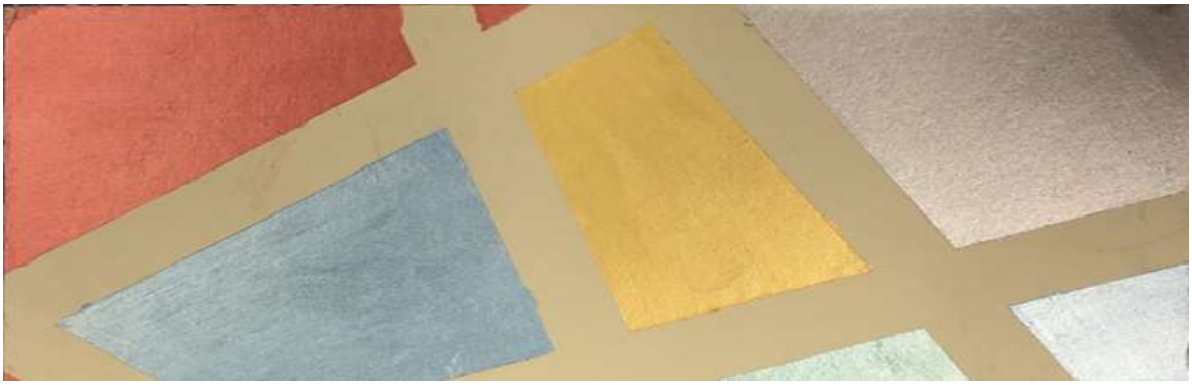
MENTAL CAPACITY REPORT: THE WIDER CONTEXT

November 2021 | Issue 117



Welcome to the November 2021 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: the Sexual Offences Act, care workers, and paying for sex; and obligations that cannot be avoided in the context of decisions about serious medical treatment;

(2) In the Property and Affairs Report: an important consultation on a scheme to enable access to funds held by financial institutions; and guidance about disclosure of medical records to attorneys and deputies;

(3) In the Practice and Procedure Report: a new training video on communication and participation, the use of the inherent jurisdiction overseas, and a systemic approach to unblocking entrenched relationships;

(4) In the Wider Context Report: the CQC's State of Care report, vaccination and children, and a new research report on accessible legal information;

(5) In the Scotland Report: an important reversal of course by the OPG for Scotland in relation to remuneration of professional guardians.

We also say a – temporary – farewell to Annabel Lee as she goes on maternity leave, and welcome to Nyasha Weinberg as the newest member of the team.

You can find our past issues, our case summaries, and more on our dedicated sub-site here, where you can also find updated versions of both our capacity and best interests guides.

If you want more information on the Convention on the Rights of Persons with Disabilities, which we frequently refer to in this Report, we suggest you go to the Small Places website run by Lucy Series of Cardiff University.

Editors
Alex Ruck Keene
Victoria Butler-Cole QC
Neil Allen
Nicola Kohn
Katie Scott
Arianna Kelly
Rachel Sulivan
Stephanie David
Nyasha Weinberg
Simon Edwards (P&A)

Scottish Contributors
Adrian Ward
Jill Stavert

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

Contents

Revocation of Schedule 21 to the Coronavirus Act

The DHSC has now revoked the operation of the powers granted to public health consultants in England under Schedule 21 to the Coronavirus Act to address potentially infectious persons, including by way of requiring them to self-isolate. This does not mean that there are no such powers available, but where required the provisions of the Public Health Act 1984 will be required. It should be noted that the powers under Schedule 21 (and those under the 1984 Act) were/are always of questionable use in relation to those with impaired decision-making capacity, relying as they did/do primarily upon the threat of criminal sanction: in reality an empty threat for a person who cannot understand that they are doing anything wrong.

CQC State of Care report

The Care Quality Commission's report 'The state of health care and adult social care in England 2020/21' was printed on 21 October 2021 and can be found here.

The data used in the report came primarily from the CQC inspections and the information obtained during that process from people who use services, their families and carers. The report examines people's experience of care and draw some depressing but not unexpected conclusions including that:

- The impact of the pandemic on many who use health and social care services has been intensely damaging.
- The pandemic has further exposed and exacerbated already existing inequalities for some groups in accessing high quality care.
- People with a learning disability have faced increased challenges as a result of the pandemic.
- The need for mental health care has increased, with children and young people particularly badly affected.
- The strain on carers has intensified.

- Health and social care staff are exhausted and the workforce is depleted, leading to serious consequences for providers and those they care for.

Of particular interest is the conclusion that while services have largely maintained levels of Deprivation of Liberty Safeguards during 2020/21, the CQC continues to have concerns about delays in authorisations, resulting in individuals being deprived of their liberty longer than necessary, or without the appropriate legal authority and safeguards in place.

There are of course no easy answers, but the forward to the report identifies a need for accelerated funding to be made available to target areas, a need for long term funding, and the development of new models for urgent and emergency care.

BPS guide to best interests decision-making

The British Psychological Society has published a helpful guide to best interests decision-making.

Alice in Wonderland, or using the Human Rights Act to extend the coercive powers of the MHA into the community

Cumbria, Northumberland Tyne & Wear NHS Foundation Trust & Anor v EG [2021] EWHC 2990 (Fam) (Lieven J)

Article 5 ECHR – deprivation of liberty

Summary[1]

When can a mental health patient lawfully remain in the community, rather than in hospital, but be deprived of their liberty in the community? In 2018, the Supreme Court in *MM* held that a restricted patient cannot be discharged from hospital under the MHA 1983 on conditions that amounted to a deprivation of liberty. The – sometimes odd – consequences of this decision continue to be felt, and have fallen again to be considered by Lieven J. As identified at the outset of her decision, the issues she had to consider were:

1. Whether s.72 MHA can be construed to allow the detention of a restricted patient in a community setting pursuant to s.17(3) MHA where that person has not resided in, or been treated by, a hospital for a considerable period of time; and

2. If it cannot, either by purely domestic statutory construction, or by recourse to the HRA 1998, can the same result be achieved by operation of the High Court's inherent jurisdiction?

As is the case in a number of the post-*MM* cases, EG's case concerned someone who had been conditionally discharged from hospital, whom it was considered by the clinical team and the Secretary of State (1) should remain in the community; (2) subject to conditions amounting to a deprivation of liberty; and (3) who had capacity in the relevant domains. He was therefore subject to a 'technical' recall by the Secretary of State – i.e. he was not actually required to return to hospital, but was immediately placed on s.17(3) MHA 1983 leave.

[1] Nb, Tor having been involved in this case, she has not contributed to this note.

He was automatically referred to the Mental Health Tribunal in consequence of his recall. The Tribunal found that there was no element of treatment in hospital at all, and, indeed, his team were actively avoiding a readmission to hospital because they thought it would bring about a deterioration in his mental state. It therefore felt it had no choice but to discharge EG because the criteria under s.72(1)(b)(i) were not met, even though this did not serve the interests of any party (including, it considered, EG) or the public. The Trust and the Secretary of State were granted permission to appeal, and Lieven J heard the appeal both as a judge of the Upper Tribunal (to consider the MHA construction point) and of the High Court (to consider the potential use of the inherent jurisdiction).

Lieven J held that it was not possible to conclude, applying domestic principles of construction absent s.3 of the Human Rights Act 1998, that the Tribunal erred in law:

> *52. In EG's case he does not need to be detained in hospital for treatment. He has been receiving treatment with no connection whatsoever to a hospital for 7 years. The evidence shows that being in hospital, even as an out-patient, is positively counter-therapeutic for EG. As such, it is not merely that his treatment has no significant connection with hospital, rather it had and has, no connection at all. It is true that since his technical recall, his treatment has been supervised from hospital. But that is not because it is appropriate for him to be liable to be detained in a hospital for medical treatment, it is because that is the only way he can be deprived of his liberty after the Supreme Court's decision in MM. Therefore, the liability that is being created is not because his mental disorder makes it appropriate for him to be detained in hospital for treatment.*
>
> *53. In my view, the FTT applied the caselaw impeccably. They did not confuse the tests under s.20 and s.72. They applied that caselaw to the facts of EG's case and the evidence that not merely did he not need to be in hospital for treatment, but that it was actually harmful for him to receive treatment in hospital. It is noteworthy that in all the cases where the s.72 test was met, the patient was receiving some treatment in hospital, including some visits to hospital. For these reasons, in my view there was no error of law in the Tribunal's analysis of s.72, absent applying s.3 of the Human Rights Act.*

Lieven J therefore turned to consider whether the HRA came to the rescue, in circumstances where everyone before her agreed that she should seek to avoid the outcome by which EG would be forced to return to hospital. On the specific facts of his case, she was satisfied that there would be a breach of Article 5(1)(e) ECHR if EG was forced to return to hospital:

> *64.* […] *The evidence is entirely clear that it is strongly against his therapeutic interests for him to be treated in hospital, even by going there as an outpatient. As the FTT record at paragraph 32 of its decision, the clinical team have been actively avoiding readmitting EG because it would bring about a deterioration of his mental health. This is not a situation where the State cannot meet EG's therapeutic needs because of lack of resources, or the way services are organised. An appropriate therapeutic milieu is available, but the law, as*

construed above, does not allow EG to be detained there.
65. I accept Ms Butler-Cole's broad proposition that Rooman does not require a person to be detained in the least intrusive way. The focus of paragraph 208 is on the situation where a person's detention is being justified under Article 5(1)(e), but they are not receiving suitable therapy. Here, the evidence shows that in hospital EG would not be being given suitable therapy, however broadly one interprets that phrase. The situation EG would find himself in if he was returned to hospital would fall within the terms of [208] of Rooman.

66. Ms Paterson now seeks to rely on Article 5(1)(a) [i.e. on the basis that any deprivation of liberty followed a conviction of a competent court. Therefore, the detention would be justified on the basis of risk to the public, not therapeutic benefit.] *That reliance does not in my view work in law. The detention of EG is under s.72 of the Mental Health Act. He was made subject to a s.37/41 MHA order in January 1994 and was conditionally discharged to The Care Home by the FTT in April 2004. It is not now open to the Secretary of State to say that the tests in the MHA do not apply and the Court should consider the matter under Article 5(1)(a) instead.*

Lieven J therefore asked herself whether she could interpret s.72 MHA 1983 so as to prevent a breach of EG's Article 5 ECHR rights, and found that she could:

69. A Convention compliant outcome on the present case is one that allows EG (and others in his position) to be made lawfully liable to a deprivation of their liberty when they are in the community, so that there is no breach of Article 5(1)(e) as construed above. Mr Mant argues that to allow a restricted patient to be deprived of their liberty in the community on long term s.17 leave, without any part of their care plan involving treatment in hospital, is possible without straining the legislation beyond that permitted in Gilham.

70. In my view it is possible here to adopt the same logical approach that was taken in Gilham. The natural construction of s.72(1(b)(i) is that set out above. However, that leads to a Convention non-compliant outcome as I have explained. It is therefore possible to read the sub-section that makes "liable to be detained" mean liable in law to be detained for treatment, even where that treatment is being provided in the community, so long as it could lawfully be provided in hospital.

71. In my view, such a construction would not go against the grain of the legislation. The grain of this part of the statute might be said to be two-fold. Firstly, to allow the patient to be detained in a less restrictive setting, and secondly, to ensure that the protection of the public and an appropriate level of detention can be met. By construing the sub-section in this way, both purposes are met.

72. It is important to bear in mind that the very nature of the s.3 exercise is that the court is reaching an interpretation which does not accord with the meaning of the statute applying normal domestic canons of construction. The caselaw makes clear that is a broad power which allows something very close to re-writing as long it does not cut across "the grain".

> *73. It is therefore possible to construe s.72 as to not require the Tribunal to discharge, even where the link to the hospital is tenuous (as here), where such a construction is necessary in order to avoid a breach of Article 5. I will leave the parties to formulate a declaration that achieves this effect.*

Having reached this conclusion, Lieven J did not strictly need then to consider the question of whether (as a High Court judge) she could or should use the inherent jurisdiction. However, as she had been addressed fully upon it, and the issue was an important one, she set out her (obiter) conclusions. After a detailed review of the (contradictory) authorities, she expressed the very clear view that the jurisdiction does not extend to depriving a person with capacity of their liberty for two fundamental reasons.

> *90.* [….] *Firstly, whether under Article 5 or the common law, the right to liberty is jealously protected and should only be removed in carefully understood and constrained circumstances. This has recently been reflected by the Grand Chamber in Ilnseher v Germany (Application No 10211/12) [2019] MHLR 278, drawing together dicta from earlier decisions of the court, stated (at para 129):*
>
> > *"the permissible grounds for deprivation of liberty listed in article 5(1) are to be interpreted narrowly. A mental condition has to be of a certain severity in order to be considered as a 'true' mental disorder for the purposes of sub-paragraph (e)"*
>
> *91. Although the legal issue being considered in Ilsenher at [129] concerned the scope of the grounds for lawful deprivation of liberty under Article 5, the underlying point that Article 5 rights have to be carefully protected, and any interference with those rights must be strictly construed, are relevant to the issue before me. The problems outlined by the Grand Chamber in HL v United Kingdom in respect of the lack of clear principles and appropriate legal safeguards to the use of the inherent jurisdiction continues to be the case. If anything, the breadth of the use of the inherent jurisdiction in the light of Re SA and the wide and potentially unlimited categorisation of a "vulnerable adult" serves to increase the concern about the unprincipled extension of the inherent jurisdiction into the area of deprivation of liberty. This analysis is not undermined by Re T, both because that case concerned children, and because of the role of the positive obligations under Articles 2 and 3.*
>
> *92. A further reason for rejecting the argument that EG can be deprived of his liberty under the inherent jurisdiction is that the domestic caselaw, principally stemming from DL, shows that the use of the inherent jurisdiction in respect of vulnerable adults is a facilitative rather than a dictatorial one. It is to be used to allow the vulnerable person to have the space, away from the factor which is overbearing their capacitous will, to make a fully free decision. An order which deprives that person of their liberty is a dictatorial order which severely constrains their freedom, however well meant, rather than allowing them the space to reach a freely made decision.*

Interestingly, and helpfully, the judgment then includes the order actually made.

Comment

The Supreme Court in *MM* (and, relatedly in *PJ*) made very clear that they considered that, if Parliament wanted to extend the coercive powers of the MHA 1983 into the community, it should make this clear. We are currently in the distinctly unsatisfactory situation where increasingly heroic and complicated hoops are being jumped through to address the situation of those in the position of EG (and/or those who would be in their position but for a finding that they lack capacity, at which point a parallel and arguably equally unsatisfactory set of provisions are being deployed). It is laudable, at one level, that all concerned are seeking to find ways in which to secure that those in the position of EG are not being recalled to hospital, but are being maintained in the community. But a real problem with judicial fire-fighting of the nature that Lieven J was being invited to undertake here is that it raises the potential for yet further unanticipated consequences arising out of the solution crafted to meet the particular problem before the court. In the circumstances, it is to be hoped that Parliamentary time will allow for measures to be brought forward as part of the reform of the MHA 1983 to allow (1) a proper debate about how far the coercive powers of the MHA 1983 should actually extend into the community; and (2) what safeguards are required in consequence.

Short note COVID-19, vaccination and children

In C (Looked After Child) (Covid-19 Vaccination) [2021] EWHC 2993 (Fam), Poole J started to approach some of the difficult questions that may be posed in relation to vaccination in respect of children. The case concerned a 12 year old boy, C, who was looked after by the Applicant Local Authority following a care order made in 2015. He wanted to be vaccinated with the Covid-19 and winter flu vaccines. He was supported by his Guardian and Local Authority who both considered it to be in C's best interests to have the vaccinations. His father had given his support for C's decisions. However, C's mother was strongly opposed to her son being vaccinated.

Poole J declined to embark upon an investigation of any competing theses as to whether national programmes of vaccination in relation to this age group were justified. He identified at paragraph 19 that:

> *In cases that concern vaccines that are part of national programmes, the question of whether expert evidence is necessary will only arise if there is an identifiable, well-evidenced, concern about whether, due to their individual circumstances, a vaccine is contraindicated for a particular child, or if there is, as MacDonald J put it in M v H, "new peer-reviewed research evidence indicating significant concern for the efficacy and/or safety" of one or more of the vaccines that is the subject of the application…". Even if such new research were available, I have serious reservations about whether an individual expert or individual judge could or should engage in a wholesale review of the evidence behind an established and continuing national vaccination programme. However, perhaps an expert could assist the court as to the quality and relevance of such new research. In the present case the issue does not arise - mere assertion that a vaccine is unsafe, however strongly expressed, does not meet either of the conditions under which*

> *expert evidence might be considered necessary to assist the court.*

Applying the decision of the Court of Appeal in *Re H (A Child) (Parental Responsibility: Vaccination)* [2020] EWCA Civ 664, Poole J observed that

> *21. In the absence of any factors of substance that might realistically call into question whether the vaccinations are in an individual child's best interests, decisions for the child to undergo standard or routine vaccinations that are part of national vaccination programmes are not to be regarded as "grave" decisions having profound or enduring consequences for the child.*

Poole J gave one important qualification to this concerning the role of *Gillick* competence (which he had previously recalled was child- and decision- specific: see paragraph 13):

> *22. There is one qualification that I would make to the general principles stated above. The Court of Appeal in Re H was concerned with vaccinations for infants or very young children. In this case, C may well be Gillick competent to make the decisions to be vaccinated. I have not undertaken an assessment of his Gillick competence because I consider it unnecessary to do so to answer the primary question raised in this case. The view of a Gillick competent, looked after child of C's age deserves due respect when considering any question of their best interests. Given that C consents to the vaccinations, there is no conflict between him and the Local Authority. If, however, such a child refused vaccination, that would raise different questions, namely whether the local authority with parental responsibility could override the child's decision and whether the issue should be brought before the court. As I noted in the brief review of the law above, it is established that the court may override a Gillick competent child's decision. Those questions do not arise in this case. There is advantage in this being a short and clear judgment and so I shall not indulge in an academic exercise.*

Poole J therefore confirmed that a local authority did not need to make any application to court in circumstances where: (i) such vaccinations are part of an ongoing national programme approved by the UK Health Security Agency, (ii) the child is either not Gillick competent or is Gillick competent and consents, and (iii) the local authority is satisfied that it is necessary to do so in order to safeguard or promote the individual child's welfare. There is no requirement for any application to be made for the court to authorise such a decision before it is acted upon. In the great majority of cases, therefore, even those involving parental objection, cases would not need to come to court. Poole J did, however, reiterate that s.33(3) CA 1989 does not give local authority carte blanche to proceed to arrange and consent to vaccinations in every case:

> *25.* […] *Firstly, it is acknowledged that local authorities should not rely on s.33(3)(b) in relation to grave decisions with enduring or profound consequences for the child. I cannot discount the possibility that an individual child's circumstances might make such a decision "grave". Secondly, pursuant to s.33(4) a local authority must make what has been termed "an 'individualised' welfare decision in relation to the child in*

question prior to arranging his or her vaccination." (per King LJ, Re H at [33]). Thirdly, as King LJ observed in Re H at [99] in the event that a local authority proposes to have a child vaccinated against the wishes of the parents, those parents can make an application to invoke the inherent jurisdiction and may, if necessary, apply for an injunction under section 8 Human Rights Act 1998 to prevent the child being vaccinated before the matter comes before a court for adjudication.

Short note: deprivation of liberty and children in unregulated placements – the saga continues

It was previously decided in *Tameside MBC v AM & Ors (DOL Orders for Children Under 16)* [2021] EWHC 2472 (Fam) that it is open to the High Court to authorise, under its inherent jurisdiction, the deprivation of liberty of a child under 16 in an unregistered placement, subject always to the rigorous application of the President's Practice Guidance. The Court of Appeal is due to hear an appeal on 16-17 November 2021. This case before MacDonald J concerns a further question: whether it is still open to authorise such placements where a placement either will not or cannot comply with the Practice Guidance. The answer is:

> *"62. Having regard to the comprehensive submissions made by leading and junior counsel, and the legal provisions set out above, I am satisfied that an unwillingness or inability to comply with the terms of the President's Practice Guidance does not act per se to oust the inherent jurisdiction of the High Court to authorise the deprivation of a child's liberty in an unregistered placement confirmed in Re T.*
>
> 63. However, I am equally satisfied that compliance with the Practice Guidance is central to the safe deployment of that jurisdiction and to its deployment in a manner consistent with the imperatives of Art 5. Within this context, whilst accepting that an unwillingness or inability on the part of a placement to comply with the terms of the President's Practice Guidance is a factor that informs the overall best interests evaluation on an application under the inherent jurisdiction, and that each case will turn on its own facts, I am satisfied that the court should not *ordinarily* countenance the exercise the inherent jurisdiction where an unregistered placement makes clear that it will not or cannot comply with the requirement of the Practice Guidance to apply for registration …" (emphasis in original)

The continuing fallout of *Cheshire West* coupled with an acute shortage of secure accommodation in relation to under 16s continues unabated. Care providers are often unwilling to register holiday parks, private Air B&B properties, caravans and canal boats as children's homes with Ofsted. As a result, children are exposed to sub-optimal placements that are beyond the statutory regulatory regime designed to safeguard them. But the squeeze may now be on regarding the litany of cases coming before the courts. The combination of (i) the Care Planning, Placement and Case Review (England) (Amendment) Regulations 2021 (which prohibits the placement of looked after

under 16s in arrangements other than a children's home or foster care placement), and (ii) the High Court not ordinarily countenancing its exercise of the inherent jurisdiction should, you would expect, reduce the number of children falling into this vulnerable situation. Whether it will do remains to be seen. It is also far from obvious how parallel problems in relation to those over 16 are going to be solved.

Short note: psychiatric detention, psychiatric treatment and medical evidence

R.D. and I.M.D. v. Romania (Application no. 35402/14) saw the European Court of Human Rights looking sceptically at compulsory psychiatric confinement in the Romanian context, but with observations with a wider resonance.

Two people were arrested after allegedly striking a police officer. The prosecution obtained psychiatric reports in 2011 which stated they were both suffering from persistent delusional disorders and outpatient treatment was recommended. Given their lack of criminal responsibility there was no case to answer.

In 2013, a court ordered compulsory treatment based on those reports and when the individuals did not attend, in 2014 the court made a compulsory confinement order to a psychiatric hospital based on the 2011 reports. Sedatives and antipsychotic medication were administered (and still are). In 2017, both were also placed under guardianship; for IMD it was her mother, and for RD it was the deputy mayor. Although subsequent medical reports in 2018 verified that the mental disorders persisted, they did not indicate that an assessment had effectively been made of the level of danger they potentially posed to themselves or to others.

The European Court held that their compulsory confinement was based on a lack of recent medical evidence contrary to Article 5 ECHR. Their forced administration of medication breached Article 8 ECHR because the legal provisions did not adequately regulate the provision of treatment. They did not, for example, provide patients with a right to appeal against a doctor's decision to administer medication against their will. Nor did the guardianship procedures provide sufficient safeguards in this regard. The Strasbourg court found that there was a serious interference with private life inherent in administration of medication against their will, and that it was not "in accordance with the law" as required by Article 8(2). Romania was to pay them EUR 16,300 for nonpecuniary damage and EUR 5,150 in respect of costs and expenses.

This case may be of interest to both MHA and MCA reformers. Concerns remain as to whether compulsory treatment under MHA s.63 provides adequate safeguards for Article 8(2) purposes, hence the proposals in the White Paper seeking to tighten these up. Conversely, the court did not hold that medication absent informed consent would always be unlawful, as at least some would read the Convention of the Rights of Persons with Disabilities as requiring.

LPS-ers will be interested to see that medical evidence more than 3 years old was not sufficiently recent to justify confinement. The second LPS renewal can last for 3 years so "sufficiently recent" will be something to look out for in due course, particularly perhaps in relation to the necessity and proportionality assessment.

For now, the European Court's view as to what is "sufficiently recent" is that this will depend on the specific circumstances of the case.

Research corner

We highlight here recent research work of interest to practitioners. If you want your article highlighted in a future edition, do please let us know – the only criterion is that it must be open access, both because many readers will not have access to material hidden behind paywalls, and on principle. This month, we highlight the publication of the CLARiTY Project report 'Making Legal Information Accessible: Lessons from the CLARiTY Project,' available from the website of the Everda Capacity project. An easy read report is also available to download.

The CLARiTY Project was a public legal education initiative for people with learning disabilities and family carers that Professor Rosie Harding ran in 2020/21 with Sophie O'Connell (Wolferstans Solicitors) and Philipa Bragman OBE, in collaboration with Bringing Us Together. The project was funded by the ESRC Impact Acceleration Account at the University of Birmingham and supported by Wolferstans Solicitors and the Leverhulme Trust.

The aim of the CLARiTY project was to increase access to justice and address areas of unmet legal need relating to mental capacity and health and social care law during the coronavirus pandemic. The CLARiTY Project hosted six free, interactive, online sessions for people with learning disabilities and family carers about legal topics including understanding the coronavirus lockdown rules; visiting friends and family in hospitals and care settings; supported decision-making; best interests under the Mental Capacity Act 2005; Lasting Powers of Attorney and Deputyship; challenging Care Act decisions, and using the Ombudsman service. Plain language and easy read summaries of the topics covered in the sessions were published on the project website.

Through delivering these CLARiTY sessions, we discovered a high level of unmet need for introductory, accessible legal information. In our report, the authors make recommendations for legal service providers and regulators about the need to increase the availability of high-quality accessible legal information, and suggestions of how to achieve this.

Alex talked to Rosie about her work from the shed in a video available here.

Editors and contributors

Alex Ruck Keene: **alex.ruckkeene@39essex.com**

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 and the European Court of Human Rights. He also writes extensively, has numerous academic affiliations, including as Visiting Professor at King's College London, and created the website www.mentalcapacitylawandpolicy.org.uk. To view full CV click here.

Victoria Butler-Cole QC: **vb@39essex.com**

Victoria regularly appears in the Court of Protection, instructed by the Official Solicitor, family members, and statutory bodies, in welfare, financial and medical cases. Together with Alex, she co-edits the Court of Protection Law Reports for Jordans. She is a contributor to 'Assessment of Mental Capacity' (Law Society/BMA), and a contributor to Heywood and Massey Court of Protection Practice (Sweet and Maxwell). To view full CV click here.

Neil Allen: **neil.allen@39essex.com**

Neil has particular interests in ECHR/CRPD human rights, mental health and incapacity law and mainly practises in the Court of Protection and Upper Tribunal. Also a Senior Lecturer at Manchester University and Clinical Lead of its Legal Advice Centre, he teaches students in these fields, and trains health, social care and legal professionals. When time permits, Neil publishes in academic books and journals and created the website www.lpslaw.co.uk. To view full CV click here.

Nicola Kohn: **nicola.kohn@39essex.com**

Nicola appears regularly in the Court of Protection in health and welfare matters. She is frequently instructed by the Official Solicitor as well as by local authorities, CCGs and care homes. She is a contributor to the 5th edition of the *Assessment of Mental Capacity: A Practical Guide for Doctors and Lawyers* (BMA/Law Society 2019). To view full CV click here.

Katie Scott: **katie.scott@39essex.com**

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. To view full CV click here.

Rachel Sullivan: **rachel.sullivan@39essex.com**

Rachel has a broad public law and Court of Protection practice, with a particular interest in the fields of health and human rights law. She appears regularly in the Court of Protection and is instructed by the Official Solicitor, NHS bodies, local authorities and families. To view full CV click here.

Stephanie David: **stephanie.david@39essex.com**

Steph regularly appears in the Court of Protection in health and welfare matters. She has acted for individual family members, the Official Solicitor, Clinical Commissioning Groups and local authorities. She has a broad practice in public and private law, with a particular interest in health and human rights issues. She appeared in the Supreme Court in *PJ v Welsh Ministers* [2019] 2 WLR 82 as to whether the power to impose conditions on a CTO can include a deprivation of liberty. To view full CV click here.

Arianna Kelly: **arianna.kelly@39essex.com**

Arianna has a specialist practice in mental capacity, community care, mental health law and inquests. Arianna acts in a range of Court of Protection matters including welfare, property and affairs, serious medical treatment and in matters relating to the inherent jurisdiction of the High Court. Arianna works extensively in the field of community care. To view a full CV, click here.

Nyasha Weinberg: **Nyasha.Weinberg@39essex.com**

Nyasha has a practice across public and private law, has appeared in the Court of Protection and has a particular interest in health and human rights issues. To view a full CV, click here.

Simon Edwards: **simon.edwards@39essex.com**

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

Scotland editors

Adrian Ward: **adw@tcyoung.co.uk**

Adrian is a recognised national and international expert in adult incapacity law. 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; honorary membership of the Law Society of Scotland; national awards for legal journalism, legal charitable work and legal scholarship; and the lifetime achievement award at the 2014 Scottish Legal Awards.

Jill Stavert: **j.stavert@napier.ac.uk**

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. 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

Members of the Court of Protection team are regularly presenting at webinars arranged both by Chambers and by others.

Alex is also doing a regular series of 'shedinars,' including capacity fundamentals and 'in conversation with' those who can bring light to bear upon capacity in practice. They can be found on his website.

Advertising conferences and training events

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

Our next edition will be out in December. 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.

Sheraton Doyle
Senior Practice Manager
sheraton.doyle@39essex.com

Peter Campbell
Senior Practice Manager
peter.campbell@39essex.com

Chambers UK Bar
Court of Protection: Health & Welfare
Leading Set

The Legal 500 UK
Court of Protection and Community Care
Top Tier Set

clerks@39essex.com • DX: London/Chancery Lane 298 • 39essex.com

LONDON
81 Chancery Lane,
London WC2A 1DD
Tel: +44 (0)20 7832 1111
Fax: +44 (0)20 7353 3978

MANCHESTER
82 King Street,
Manchester M2 4WQ
Tel: +44 (0)16 1870 0333
Fax: +44 (0)20 7353 3978

SINGAPORE
Maxwell Chambers,
#02-16 32, Maxwell Road
Singapore 069115
Tel: +(65) 6634 1336

KUALA LUMPUR
#02-9, Bangunan Sulaiman,
Jalan Sultan Hishamuddin
50000 Kuala Lumpur,
Malaysia: +(60)32 271 1085