MENTAL CAPACITY REPORT: THE WIDER CONTEXT

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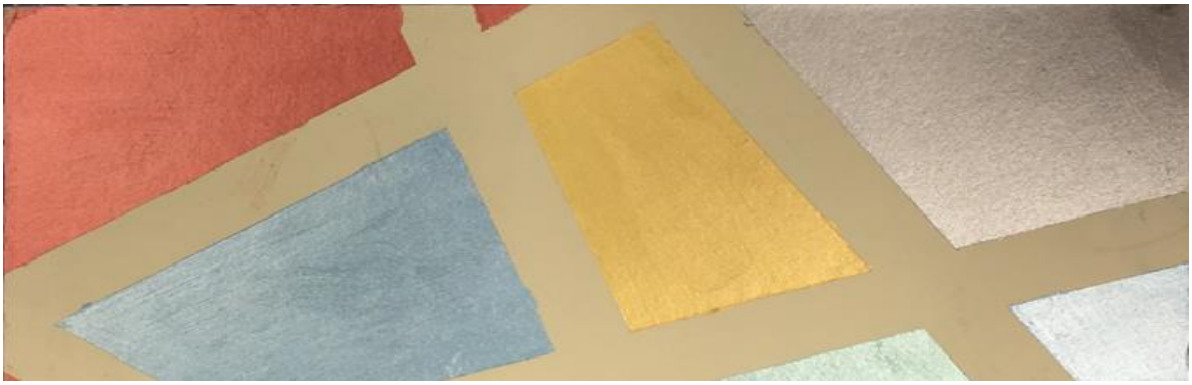

Welcome to the October 2019 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: the Supreme Court pronounces on confinement and 16/17 year olds and two important – and difficult – cases about sex;

(2) In the Property and Affairs Report: attorneys and gifts, and withholding knowledge of an application from P or another person;

(3) In the Practice and Procedure Report: the Court of Protection mediation scheme, and the inherent jurisdiction, necessity and proportionality;

(4) In the Wider Context Report: learning from a complex case about medical treatment for a child, the Irish Bournewood and an important shift from the CRPD Committee in the context of legal capacity;

(5) In the Scotland Report: developments in the context of the MHTS and sentencing in the presence of disability.

You can find all our past issues, our case summaries, and more on our dedicated sub-site here, where you can also find our new guidance note on the inherent jurisdiction.

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.

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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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ENGLAND, WALES AND NORTHERN IRELAND

SRA Guidance: Representing people who lack mental capacity

Ahead of the coming into force of the new SRA Code of Conduct on 25 November, the Solicitors Regulation Authority has issued new guidance on representing people who lack mental capacity, to be found here.

Short note: children, medical treatment and lessons to be learned

MacDonald J has considered in considerable detail ([2019] EWHC 2530 (Fam) the medical treatment and best interests of Tafida Raqeeb ('Tafida'), a five year old girl and loved member of a close Muslim family. A few months before her fifth birthday she suffered bleeding on her brain caused by a ruptured arteriovenous malformation (AVM), a rare condition which was undetected and asymptomatic in her. The ruptured AVM resulted in extensive and irreversible damage to Tafida's brain. At the point the matter was before the Court, Tafida was in hospital being provided with artificial ventilation, without which she would die. The Trust had concluded that it was in Tafida's best interests for that life-sustaining treatment to be withdrawn. The family did not agree and had secured an offer from a hospital in Italy to continue to treat Tafida. The Trust had refused to transfer Tafida to the Italian Hospital.

The court had before it two sets of proceedings:

(i) The first set of proceedings, concerned an application by Tafida for judicial review of the decision by the Trust not to agree to Tafida being transferred to a hospital in Italy for continued medical treatment pending the determination of an application to the High Court for a declaration regarding her best interests.

(ii) The second set of proceedings concerned the application by the Trust for a specific issue order pursuant to s. 8 Children Act 1989, and an application for a declaration pursuant to the inherent jurisdiction of the High Court, that it was in Tafida's best interests for her current life-sustaining treatment now to be withdrawn, a course of

action that would lead inevitably to her death.

Perhaps the most interesting issues emerged from the application for judicial review:

(i) The judge had no difficulty finding that the decision of the Trust not to allow Tafida's parents to remove her from their hospital and take her to Italy was a public law decision that is amenable to judicial review;

(ii) The judge equally had little difficulty rejecting the submissions made to him that in taking this decision the Trust discriminated against Tafida pursuant to the Equalities Act 2010 (holding that the Trust did not apply a provision, criterion or practice which is discriminatory in relation to a relevant protected characteristic of Tafida or her parents) and that they failed to have regard to, or contravened the NHS Constitution;

(iii) However the judge held that the decision was on its face unlawful because in taking it the Trust did not give any consideration to whether that decision would interfere with Tafida's EU directly effective rights under Art 56 of the Treaty for the Functioning of the European Union (TFEU).[1]

The Judge however went on to conclude that had the Trust considered Tafida's Art 56 rights when making its decision not to agree to Tafida being transferred to the Italian Hospital, the Trust would have reached the same decision in any event:

(i) The decision of the Trust made it impossible for Tafida to benefit from her directly effective EU rights under Art 56 to receive medical treatment in another Member State and so was a plain interference with her directly enforceable article 56 rights;

(ii) However Regulation 2201/2003 ('Brussels IIa') confers jurisdiction for the use of the established national procedure in this jurisdiction for determining disputes between parents and doctors over whether a child should or should not continue to receive life-sustaining treatment (i.e. an application to the court). The Trust issued proceedings in the court (thus invoking the established national procedure).

(iii) Had the Trust considered Tafida's directly enforceable EU rights, the Trust would have come to the conclusion that the interference in Tafida's EU rights constituted by its decision was justified on public policy grounds and that the national procedure it chose to follow constitutes a justified derogation from Tafida's rights under Art 56.

Accordingly, MacDonald J refused to quash the Trust's decision as to do so would cause unacceptable delay and serve no purpose given

[1] The argument being run by Tafida and her parents (and accepted by the Court) was that article 56 of the TFEU protected the freedom to provide services and the corollary of that is the freedom to receive those services in another Member State, and the provision of intensive care, palliative care and end of life care by a hospital in another EU Member State constitute services for the purposes of Art 56 of TFEU read with EU Directive 2011/24

the conclusion the court had reached that, even if made lawfully, the Trust would have come to the same result.

MacDonald J then went on to consider the Trust's application as to whether it was in Tafida's best interests to withdraw life-sustaining treatment. He went through a very careful and detailed analysis of all the evidence before it and concluded that he would not grant the application. Cases concerned with the withdrawal of medical treatment are of course hugely fact specific, and this is no exception, accordingly we do not set out any detail of that analysis. What is interesting however about the best interest analysis conducted by the judge is that the matters weighed in the balance were essentially identical to those that would be weighed pursuant to an MCA decision for an adult, despite Tafida's very young age. The judgment is also of interest for the depth of the engagement with the fact that Tafida and her family were Muslim.

This case raises, by analogy two important issues for practitioners in the Court of Protection:

(1) They need to be aware as to when their decision making interferes with directly enforceable EU rights (at least for so long as they remain relevant). If such a right is engaged, the impact on the right will need to form part of the reasoning of the decision to ensure its lawfulness in public law terms.

(2) They need to be aware as to when they are making public law decisions which are amenable to judicial review, and when they are making best interests decision which are justiciable in the Court of Protection. In the medical treatment arena, the decision of the doctor to identify which treatments are clinically indicated for a patient and so can be offered to them is a public law decision. The choosing between those clinically indicated treatments by the doctor as the decision maker for an incapacitated patient is a best interests decision.

NHS Community Mental Health Framework

NHS England and the National Collaborating Centre for Mental Health have published a Community Mental Health Framework for Adults and Older Adults, seeking to

> *drive a renewed focus on people living in their communities with a range of long-term severe mental illnesses, and a new focus on people whose needs are deemed too severe for Improving Access to Psychological Therapies (IAPT) services but not severe enough to meet secondary care "thresholds", including, for example, eating disorders and complex mental health difficulties associated with a diagnosis of "personality disorder".*

Capabilities Statement for Social Work with Autistic Adults

The British Association of Social Workers have published a Capabilities Statement for Social Work with Autistic Adults. Commissioned by the Department of Health and Social Care, the Statement is supported by a set of resources.

CQC State of Care report

Making thoroughly depressing reading, the CQC's latest State of Care report was published

on 15 October. Of particular concern were the findings in relation to mental health care, the CQC noting that

> *Some people are struggling to get access to the mental health services they need, when they need them.*
>
> *This can mean that people reach a level of 'crisis' that requires immediate and costly intervention before getting the care they need, or that they end up in inappropriate parts of the system.*
>
> *Some people are detained in mental health services when this might have been avoided if they had been helped sooner, and then find themselves spending too long in services that are not suitable for them.*
>
> *Too many people with a learning disability or autism are in hospital because of a lack of local, intensive community services.*
>
> *We have concerns about the quality of inpatient wards that should be providing longer-term and highly specialised care for people.*
>
> *We have shone a spotlight this year on the prolonged use of segregation for people with severe and complex problems – who should instead be receiving specialist care from staff with highly specialised skills, and in a setting that is fully tailored to their needs.*
>
> *Since October 2018, we have rated as inadequate 14 independent mental health hospitals that admit people with a learning disability and/or autism, and put them into special measures.*
>
> *This is an unacceptable situation. A better system of care is needed for people with a learning disability or autism who are, or are at risk of, being hospitalised, segregated and placed in overly restrictive environments. We must all work together to make this happen.*
>
> *We also know that people with the most severe and enduring mental ill-health do not always have access to local, comprehensive rehabilitation services and are often in inappropriate placements far from home. This weakens support networks and the ability of family and commissioners to stay in close contact, sometimes with devastating consequences.*
>
> *We are seeing issues with the availability of care. There has been a 14% fall in the number of mental health beds between 2014/15 and 2018/19. While this is in line with the national policy commitment to support people in the community, it is vital that people in crisis can access support when needed.*
>
> *All of this is underpinned by significant issues around staffing and workforce.*
>
> *Our inspectors are seeing too many mental health and learning disability services with people who lack the skills, training, experience or clinical support to care for patients with complex needs. In the majority of mental health inpatient services rated as inadequate or requires improvement since October 2018, the inspection reports identified a lack of appropriately skilled staff as an issue.*

DoLS delayed in Northern Ireland

In a setback both for rights protection and for fusion enthusiasts, it has been announced that the deprivation of liberty provisions in the Mental Capacity Act (Northern Ireland) 2016 has been delayed from 1 October until 2 December 2019 (the commencement date for research provisions remains 1 October).

In what might be seen as a warning for England & Wales ahead of the implementation of LPS on 1 October 2020, we understand that the reason for the delay was that the relevant processes and personnel within the HSC Trusts (the combined health and social care bodies) could not be put in place.

For more detail (and also the Code accompanying the DoL provisions, weighing in at a slimline 90 or so pages of core Code), see the Northern Ireland Department of Health dedicated MCA website here.

INTERNATIONAL DEVELOPMENTS

The Irish Bournewood?

In *AC v Patricia Hickey General Solicitor and Ors & AC v Fitzpatrick and Ors* [2019] IESC 73, the Irish Supreme Court has grappled (inter alia) with what deprivation of liberty means in the Irish context in relation to an elderly lady with dementia prevented from leaving hospital. The case makes fascinating reading for those steeped in the English debates, who may read the sentence (at para 330) that "'[d]*eprivation of liberty' is not a particularly complex concept*" with something of a hollow laugh. They may also be interested to see that the Irish Supreme Court were invited by the Irish statutory authorities to distinguish *Cheshire West* on the basis that "*it is inconsistent with and goes further than the Convention approach because it applies an "acid test" designed to avoid the need to consider the details of the factual situation*" (para 115).

Giving the judgment of the court, O'Malley J declined this invitation:

> *333. On the assumption, for the purposes of this part of the discussion, that Mrs. C. wanted to leave and had capacity, I think it would be impossible to conclude that she was not deprived of her liberty in that she was physically prevented from acting on that wish. She was not free to leave. The President commented that the position of the hospital was clear – they would discharge her only if satisfied with the care arrangements. Accordingly, whether one applies the Dunne v Clinton analysis* [case-law from Ireland]*, the Guzzardi/Stanev criteria or the Cheshire West "acid test", she was not free to leave. The measures taken involved restraint, pursuant to which she was kept in the hospital for an indefinite period under the control and supervision of those caring for her.*
>
> *334. The next question is whether that finding – that Mrs. C. was in fact detained – is in any way altered if it is assumed that she did not have capacity. In my view it cannot be, for the reasons identified in the ECtHR jurisprudence and by the UK Supreme Court in Cheshire West (and indeed, in some of the comments made by members of the House of Lords in HL). Firstly, I consider that the constitutional guarantee of the right to liberty protects mentally impaired persons to the same extent as everyone else – deprivation of liberty must in all cases be in accordance with law. To hold that persons cannot be found to be "detained" if they are not capable of making a valid decision to*

> *leave for themselves, or if they are not aware of or able to object to their situation, would not simply permit restrictions on their freedom of movement for their own protection. It would also have the far-reaching consequence of denying to vulnerable persons in this category the benefit of the constitutional guarantee that they will not be deprived of their liberty otherwise than in accordance with law. It is possible for a person of full capacity to be detained without necessarily being conscious of that situation, and, equally, it is possible in the case of a person with impaired capacity. Both are entitled to legal protection.*
>
> *335. For the same reason, a benevolent or protective motivation or purpose for whatever measures have been taken cannot be considered to alter the legal fact of detention. I agree with the doubts expressed by Lord Nolan in HL and the analysis of Lady Hale in Cheshire West in this regard. If benevolent intentions meant that there was no deprivation of liberty, and therefore no grounds for inquiry into the legality of deprivation of liberty, there would be no legal basis upon which the courts could ask whether the measures taken were justified and were in fact in the individual's best interests. This would, in fact, leave vulnerable people without legal protection against arbitrary or unnecessary detention. The persons or institution that takes charge of them would thereby appoint themselves as a substitute decision-maker without legal process. Neither the Convention nor the Constitution permit of this result.*

Interestingly, however, O'Malley J then went on to grapple with the question of what a hospital is to do in the context of discharge where it appears that such would put the person at risk (in the instant case, it was feared, from the actions of her son). These issues, she considered, demonstrated

> *344* […] *an essential difference between the cases involving police detention under statutory power and the issues that may arise in the context of discharge from hospital. In the former, the issue is binary – the person has been either lawfully or unlawfully arrested and detained. Consent is generally irrelevant to the lawfulness of an arrest (as opposed to some of the examples found in the cases of voluntary attendance for questioning), and therefore the validity or effect of consent does not arise as an issue. However, in a healthcare system founded on the principles of voluntarism and the duty of care, hospitals will frequently have to deal with far more complex and nuanced situations. The problem in this case was how to reconcile those two fundamental principles.*

Her conclusions, explained in detail in the paragraphs that follow, were then summarised as follows:

> *391. In the course of my analysis I have concluded that a hospital faced with a situation such as the one that arose in this case, giving rise to a concern for the welfare of a patient, should take the following steps.*
>
> *392. The first question is whether the patient truly wants to leave, or is in reality being removed by third parties in circumstances where there is a real risk to her health and welfare. If it is a case of removal, rather than a wish to depart, the*

hospital's duty of care extends to protecting her against such third parties. If she does indeed wish to go, and has capacity to make that decision, all that the hospital can do is attempt to persuade her that it is in her own interests to stay.

393. If, however, the hospital is concerned that the patient lacks capacity to make the decision, that issue must be addressed. Persuasion will not necessarily be the appropriate legal solution, since the lack of capacity implies an inability to process the information provided and to make decisions upon it. The hospital is entitled to take some brief period of time to make its assessment of capacity. It may be helpful if some person can be found who has not been involved in any dispute concerning the patient and who can act as her intermediary or advocate. If it is concluded that the patient has capacity, no further issue arises. If she lacks capacity, the hospital must bear in mind that it has no general power of detention and no general right to make itself a substitute decision-maker. It must therefore seek the assistance of the courts, if it is felt that the patient is at risk. In my view, the doctrine of necessity permits the hospital to detain the patient, in the interests of her personal safety, provided that such detention lasts no longer than is necessary to take appropriate legal steps. It is essential to bear in mind that compliance on the part of a patient who lacks capacity will not on its own amount to justification, since if the patient cannot give a valid consent then some other lawful authority is necessary if other persons are to make decisions for her.

394. From the courts' point of view also, it must be borne in mind that a patient's lack of capacity to make a decision is not, in itself, an answer to a complaint of unlawful deprivation of liberty. People with impaired mental abilities are protected by the same constitutional guarantee as any other person – that they will not be deprived of liberty otherwise than in accordance with law. Similarly, the fact that the measures taken by the hospital are in the best interests of the patient is a matter that goes to the justification of deprivation of liberty, and not to the question whether there is detention in fact. In determining whether a person has been unlawfully deprived of liberty, in breach of the constitutional guarantee, the court must start with the factual circumstances and ask whether the individual has in fact been deprived of liberty. In this case, that question is answered by the finding that Mrs. C. (if she wanted to leave) was physically prevented from so doing and was subjected to complete control and supervision.

395. The second part of the court's analysis will then focus on the justification offered for the deprivation of liberty. If the hospital has acted in accordance with the process I suggest, then there will in my view have been no unlawful deprivation of liberty. It will then be for the court to determine whether the situation requires protective orders, in the best interests of the patient, which affect the right to liberty. Such orders must, of course, respect the substantive and fair procedure rights of the individual.

The judgment also contained detailed – and critical – considerations of the operation of the wardship jurisdiction in Ireland, which will (within

the foreseeable future) be swept away by the Assisted Decision-Making (Capacity) Act 2015.

It is curious, one might think, that the Supreme Court placed reliance upon the doctrine of necessity as a lawful basis for deprivation of liberty in the context with which they were concerned, rather than examining what was (on the face of it) the rather more obvious question of whether the confinement to which the person in question would be subject would cross the line into being for a 'non-negligible' period of time. If it did not, then, at least through the prism of Article 5 ECHR, there would be no issue. It is particularly curious that the Supreme Court relied upon necessity on the basis that it had been approved by Strasbourg in *HL* (at para 349) as grounding a lawful deprivation of liberty, at least in the context of short-term detention. The plain reading of *HL* does not appear to support this, Strasbourg making clear that did not suffice to avoid arbitrariness (see para 119), making no distinction between short-term and long-term detention.

The dilemmas that are exposed in the passages set out above apply equally in England & Wales, where the legal basis for preventing a person leaving in emergency situations is, at present, questionable (see the discussion in our guidance note on deprivation of liberty in the hospital setting). The law will become much clearer as of 1 October 2020 with the introduction of the new s.4B Mental Capacity Act 2005, allowing for deprivation of liberty in the emergency context. The Irish Government is still wrestling with its own legislative solution to the whole issue of deprivation of liberty (see the discussion of the Department of Health's public consultation report on its legislative proposals in our July report). In that, they are grappling with the implications of the Convention on the Rights of Persons with Disabilities – it is striking that the Supreme Court in *AC*'s case makes essentially no reference to it, and none to the bar that the Committee assert exists to deprivation of liberty in the presence of mental impairment. It would be particularly interesting to know what the Committee would consider would be the appropriate response to the dilemmas outlined in the case.

The CRPD Committee and legal capacity – a step forwards?

The CPRD Committee issued its most recent concluding observations in September 2019 on Albania, Australia, Ecuador, El Salvador, Greece, India, Iraq, Kuwait, and Myanmar. For those wanting a primer about the CRPD and the role of the Committee, see here; for those who have been following the debate over the past few years in relation to precisely what Article 12 CRPD means, the concluding observations upon the second report of Australia upon its compliance with the CRPD make very interesting reading indeed. In material part, the concluding observations read as follows:

> *Equal recognition before the law (art. 12)*
>
> *23. Despite the recommendations of the Australian Law Reform Commission, the Committee is concerned about the lack of progress to abolish the guardianship system and substituted decision-making regime, particularly in decisions concerning forced psychiatric treatment, and at the lack of a timeframe to completely replace that regime with supported decision-making systems.*

> *24. Recalling its general comment No. 1 (2014), on equal recognition before the law, the Committee recommends that the State party:*
>
> *(a) Repeal any laws and policies, and end practices or customs, which have the purpose or effect of denying or diminishing the recognition of any person with disabilities as a person before the law;*
>
> *(b) Implement a nationally consistent supported decision-making framework, as recommended in the Australian Law Reform Commission's 2014 report, "Equality, Capacity and Disability in Commonwealth Laws".*

What is particularly interesting about this is that the Australian Law Reform Commission's report does not recommend supported decision-making in the form set out in General Comment 1. Paragraph 27 of General Comment 1 (in the corrected form issued in 2018) provides that:

> *27.Substitute decision-making regimes can take many different forms, including plenary guardianship, judicial interdiction and partial guardianship. However, these regimes have certain common characteristics: they can be defined as systems where: (a) legal capacity is removed from a person, even if this is in respect of a single decision; (b) a substitute decision maker can be appointed by someone other than the person concerned, and this can be done against his or her will; or (c) any decision made by a substitute decision maker is based on what is believed to be in the objective "best interests" of the person concerned, as opposed to being based on the person's own will and preferences.*

The ALRC report advocates a model that moves to respect for rights, will and preferences, but ultimately does allow for (1) a decision-maker to be appointed by another, and to take that decision on their behalf; and (2) allows overriding of a person's will and preferences. The Commission proposes four National Decision-Making Principles and Guidelines to guide reform of the legal framework:

> *Principle 1: The equal right to make decisions*
>
> *All adults have an equal right to make decisions that affect their lives and to have those decisions respected.*
>
> *Principle 2: Support*
>
> *Persons who require support in decision-making must be provided with access to the support necessary for them to make, communicate and participate in decisions that affect their lives.*
>
> *Principle 3: Will, preferences and rights*
>
> *The will, preferences and rights of persons who may require decision-making support must direct decisions that affect their lives.*
>
> *Principle 4: Safeguards*
>
> *Laws and legal frameworks must contain appropriate and effective safeguards in relation to interventions for persons who may require decision-making support, including to prevent abuse and undue influence.*

For present purposes most materially, recommendation 3(3), the guideline for wills, preferences and rights, contains the following

> *(2) Representative decision-making*
>
> *Where a representative is appointed to make decisions for a person who requires decision-making support:*
>
> *(a) The person's will and preferences must be given effect.*
>
> *(b) Where the person's current will and preferences cannot be determined, the representative must give effect to what the person would likely want, based on all the information available, including by consulting with family members, carers and other significant people in their life.*
>
> *(c) If it is not possible to determine what the person would likely want, the representative must act to promote and uphold the person's human rights and act in the way least restrictive of those rights.*
>
> *(d) A representative may override the person's will and preferences only where necessary to prevent harm.*

The ALRC considers that the last of these reflects the human rights approach, and is

> *consistent with the CRPD in that, for example, art 17 of the CRPD may require the representative to make a decision that protects the person's 'physical and mental integrity', notwithstanding the decision conflicts with the person's expressed will and preferences. A qualification of this kind tests the limits of autonomy, particularly where the limitation concerns harm to oneself. Examples are seen usually in the context of mental health legislation: to save a patient's life, or to prevent a patient from seriously injuring themselves or others. Safeguards may be included in terms of ensuring that the course of action proposed is the 'least restrictive' option.*

The ALRC's report is – by some measure – the most detailed law reform proposal advanced to date to seek to 'operationalise' the CRPD. That the Committee endorses the ALRC's proposals as compliant with the CRPD is a major change in their position (possibly reflecting the fact that there has been a change in its composition since the Committee that promulgated General Comment 1). It is also very helpful in terms of progressing law reform efforts for two reasons:

(1) They are detailed and 'gritty,' and can be contrasted with those reforms which lead to laws asserting full legal capacity but which, on further analysis, offer very much less, for instance because they maintain 'emergency' provisions in 'general health laws' (Peru is a very good example of this);

(2) They represent a set of principles and guidelines which build upon but take forward laws in jurisdictions such as England & Wales in which 'hard cases' are brought before the courts for determination on an almost daily basis. They therefore are capable of 'selling' to policymakers in such jurisdictions on the basis that are providing responses to those hard questions.

Finally, by recommending the implementation of the ALRC proposals, the CPRD Committee might be thought tacitly have to accepted the force of the ALRC's observation (at para 3.48 of its report) that, contrary to the position adopted in General Comment 1:

> *with appropriate safeguards, and a rights emphasis, there is no 'discriminatory denial of legal capacity' necessarily inherent in a functional test* [of decision-making capacity, or 'ability' as the ALRC proposed] *—provided the emphasis is placed principally on the support necessary for decision-making and that any appointment is for the purpose of protecting the person's human rights.*

It is a long way, of course, from law reform proposals to actual law reforms, but it may just be that we now have some clear endorsement of the path to take.

RESEARCH CORNER

We highlight here recent research articles 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 an interesting article on video advance directives by Hui Yun Chan.

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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), 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 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. 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. 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 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.

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Katherine has a broad public law and human rights practice, with a particular interest in the fields of community care and health law, including mental capacity law. She appears regularly in the Court of Protection and has acted for the Official Solicitor, individuals, local authorities and NHS bodies. Her CV is available here: To view full CV click here.

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

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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; 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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Conferences

Conferences at which editors/contributors are speaking

AWI, guardianship and elder law conference

Adrian is giving the keynote address for the Law Society of Scotland's conference on this subject in Glasgow on 30 October. For more details, and to book, see here.

Adult incapacity law

Adrian is delivering a lecture at Edinburgh Napier University on 13 November on "Adult incapacity law: visions for the future drawn from the unfinished story of a new subject with a long history." For more details, see the website of the Centre for Mental Health and Capacity Law.

Taking Stock

Neil is giving the keynote speech at the annual national conference on 15 November jointly promoted by the Approved Mental Health Professionals Association (North West England and North Wales) and the University of Manchester. For more information, and to book, see here.

Mental Capacity Law Update

Neil is speaking along with Adam Fullwood at a joint seminar with Weightmans in Manchester on 18 November covering topics such as the Liberty Protection Safeguards, the inherent jurisdiction, and sexual relations. For more details, and to book, see here.

Other conferences of interest

The Court of Protection Bar Association will be holding a seminar, open to members of the Association, on 28 October at 39 Essex Chambers in London addressing recent developments in mental capacity law. 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.

Our next edition will be out in November. 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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