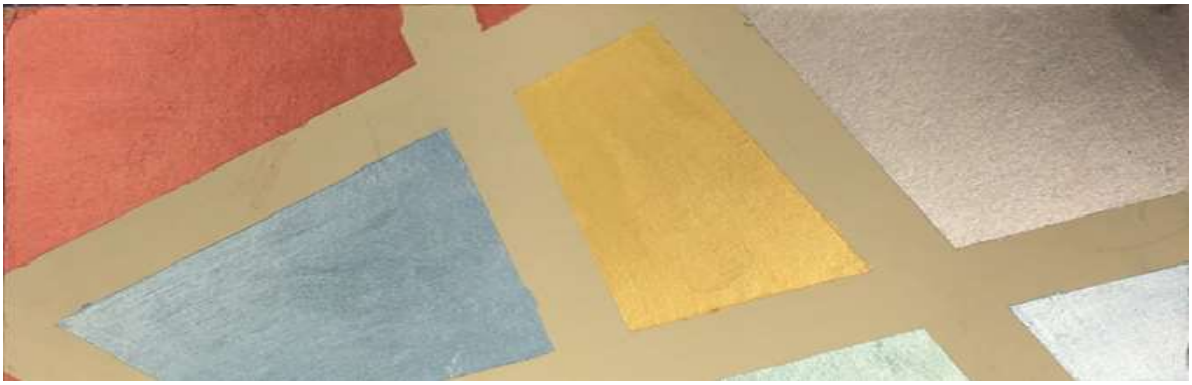
MENTAL CAPACITY REPORT:
HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

November 2020 | Issue 109



Welcome to the November 2020 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: updated DHSC MCA/DoLS COVID-19 guidance, an important LPS update, and the judicial eye of Sauron descends on new areas to consider (ir)relevant information;

(2) In the Property and Affairs Report: a complex case about when the settlement of an inheritance;

(3) In the Practice and Procedure Report: for how long does a Court of Protection judgment remain binding, and helpful guidance for experts reporting upon capacity;

(4) In the Wider Context Report: challenging reports about the disproportionate effect of COVID-19 upon those with learning disability, young people with learning disability and autism under detention, and capacity and public hearings before the Mental Health Tribunal;

(5) In the Scotland Report: discharge from hospital without proper consideration of ECHR rights.

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. We have taken a deliberate decision not to cover all the host of COVID-19 related matters that might have a tangential impact upon mental capacity in the Report. Chambers has created a dedicated COVID-19 page with resources, seminars, and more, here; Alex maintains a resources page for MCA and COVID-19 here, and Neil a page here. 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.

Contents

Updated DHSC MCA/DoLS Emergency Guidance

The latest iteration of the guidance (11 November) now updates the main and additional guidance to take account of the new (English) lockdown regulations as of 5 November. In respect of DoLS assessments, it reads as follows:

> *To carry out DoLS assessments and reviews, remote techniques should be considered, such as telephone or video calls where appropriate to do so, and the person's communication needs should be taken into consideration. Views should also be sought from those who are concerned for the person's welfare.*
>
> *Face-to-face visits by professionals, for example for DoLS assessments, are an important part of the DoLS legal framework. These visits can occur if needed, for example to meet the person's specific communication needs, in urgent cases or if there are concerns about the person's human rights.*
>
> *National restrictions begin in England from 5 November 2020. Further information about the new restrictions can be found here.*
>
> *During and after the national restrictions in England, visits by professionals can occur if needed. Decisions around visiting are operational decisions and ultimately for the providers and managers of individual care homes and hospitals to make. DoLS professionals should work closely with hospitals and care homes to decide if visiting in person is appropriate, and how to do this safely. Visiting professionals should understand and respect their local visiting policies, including for individual hospitals and care homes. The government's policy for family and friends visits to care homes has recently been updated and contains practical advice about how to facilitate safe visits, which will also be useful for DoLS professionals.*
>
> *Similarly, professionals in Wales are required to comply with any additional setting guidance or location specific*

guidance for Wales when considering professional DoLS visits.

Similar guidance is given in relation to IMCAs and RPRs (helpfully expressly referring to unpaid RPRs) in the additional guidance.

LPS update – goodbye care home managers (and hello some ideas about draft regulations)

In the minutes of the LPS Steering Group meeting held on 13 October 2020, published as part of the new LPS documentation page, it was revealed that the Government has decided that it would **not** bring these provisions into force in April 2022. The minutes of the LPS Steering Group meeting on 13 October 2020 explain the position:

> *DHSC officials acknowledged that the role of the care home manager in the MC(A)A2019 has always been contentious. They explained that the Government has heard representations from across the sector, both for and against this role, and considered its potential very carefully. The Government has decided not to implement this aspect of the MC(A)Ain England, for now. The relevant provisions in the Act will therefore not be commenced in April 2022.*
>
> *The care home manager role was originally designed so that people who know the person and understand their wishes and feelings, could lead the LPS process, with the added benefit of reducing the burden on local authorities and CCGs. These aims are still valid, but the Government has decided that now is not the right time to introduce the role. Instead, the Government will focus on introducing all other aspects of the LPS; and working productively with stakeholders to ensure that implementation in 2022 is a success. Staff who care for the person every day and therefore know them best will, alongside the person's family and friends, still play a vital role throughout the assessment process and during the consultation stages of the LPS process, in particular by helping decisions makers to establish the person's wishes and feelings. The Government will keep the case for the role under review as it prepares for LPS, and as the system is implemented. The Government's thinking on this issue will also be informed by responses to the public consultation on LPS, planned for 2021.*

Our view is that this is an eminently sensible decision (and not just because the care home manager proposal had not appeared in the underlying Law Commission proposal). It caused deep unease amongst many – including many care home managers who felt that they were put in an impossibly conflicted position. It also looked like, in many cases, simply being unworkable because of the need to provide so many restrictions upon whom the care managers could call upon that it would have ended up being more complicated and more expensive than simply having the responsible body coordinate the assessment process.

The minutes of the meeting set out DHSC's position as to what five of the six anticipated sets of regulations will cover:

- The Independent Mental Capacity Advocate (IMCA) role under LPS will be set out in regulations. These regulations will amend existing IMCA regulations set out under the

MCA. IMCAs will, for example, have the power to prepare a report in relation to the arrangements or proposed arrangements for the Responsible Body.

- Eligibility criteria and statutory training needed to be an Approved Mental Capacity Professional (AMCP) under LPS will be set out in a distinct set of regulations. Required training will include a conversion course for Best Interests Assessors (BIAs) under the Deprivation of Liberty Safeguards (DoLS) to become AMCPs under LPS. The regulations will explain which bodies will deliver the required training for the AMCP role. Practicing Social workers, nurses; Speech and Language Therapists, psychologists and occupational therapists will be eligible for the AMCP role. These regulations will also include a definition of a prescribed connection to a care home. Individuals who meet that definition will not be able to act as an AMCP in certain cases.

- A set of transitional regulations will set out the legal framework for LPS and DoLS to run alongside each other for the first year of implementation. This will ensure that people who are subject to a DoLS authorisation or a Court Order, that runs into the first year of LPS implementation, are still able to access the necessary safeguards until their authorisation or Order ends.

- A set of assessments regulations will set out who is able to carry out assessments and determinations under LPS.

- A set of consequential regulations will amend other pieces of legislation that will need updating as a result of the MC(A)A2019.

- The policy decisions needed to inform drafting of the sixth set of regulations governing monitoring and reporting of LPS in England would work are still being made. The policy decisions needed to inform drafting of the sixth set of regulations governing monitoring and reporting of LPS in England would work are still being made. The draft regulations will from part of the public consultation in Spring 2021 and the Government will take into account the outcome of that consultation before it takes final decisions about the design of LPS.

The next major milestone is likely to be the publication of the revised Impact Assessment in Autumn 2020. This assessment will cover the policy at the time of the primary legislation and will not take account of policy detail set out in the draft regulations (these will be covered by future impact assessments).

Alex's LPS resources page has been updated to take account of these developments, as has his guide to LPS.

More for the files on (ir)relevant information for important decisions

A Local Authority v GP (Capacity - Care, Support and Education) [2020] EWCOP 56 (HHJ Christopher Dodd)

Mental capacity – care – education

Summary

In this case, HHJ Dodd helpfully turned the eye of Sauron onto three areas of capacity that have not previously been the subject of judicial consideration. The court had to consider whether

a young man, aged 19, had capacity to make a decision to accept or refuse care and support, and also to make decisions in relation to education. HHJ Dodd broke down each aspect in turn.

Refusal of assessment of care and support needs pursuant to s.11 Care Act 2014

HHJ Dodd identified this was the correct formulation of the decision in issue for purposes of s.15(1)(a) MCA 2005. Drawing upon the agreed position of the Applicant local authority and the Official Solicitor on behalf of GP, HHJ Dodd held that the information relevant to the decision will include:

a. *A local authority has a statutory duty to meet a person's eligible care needs, which may be to prevent or delay the development of needs for care and support or reducing needs that already exist.*
b. *The assessor may speak to other adults or professionals involved in GP's care and that GP may refuse to consent to this.*
c. *The local authority will assess how GP's wellbeing can be promoted and whether meeting these needs will help GP achieve his desired outcomes.*

HHJ Dodd disagreed that relevant information included that "[t]*he importance of GP participating as fully as possible in decisions related to the assessment of his needs and how those needs can be met*," holding (at paragraph 22) that:

> *In my view, this is a value judgment rather than information relevant to GP's decision to refuse a Care Act assessment and is in any event too nebulous to amount to "the reasonably foreseeable consequences of deciding one way or another".*

To make decisions as to his care and support

HHJ Dodd noted that guidance on what information is relevant to this decision was formulated by Theis J in *LBX v K, L and M* [2013] EWHC 3230 (Fam) and approved by the Court of Appeal in *B v A Local Authority* [2019] EWCA Civ 913, namely: (a) with what areas GP needs support; (b) what sort of support GP needs; (c) who will provide such support; (d) what would happen without support, or if support was refused; and (e) that carers may not always treat GP properly, and the possibility and mechanics of making a complaint if GP is not happy.

The Applicant suggested, in addition, that in GP's case the relevant information would include:

a. *why having a support worker is important to GP to access the community;*
b. *the importance of structure and routine in GP's day;*
c. *the importance of regular access to the local community to build and maintain his confidence in daily life and independence and to avoid a deterioration in his anxiety;*
d. *the importance of developing relationships with others outside of his close family to build and maintain his confidence in daily life and independence and to avoid a deterioration in his anxiety, to avoid a dependency upon his close family members and to develop his own interests and opportunities for a social life with peers;*
e. *the opportunities that may be available to engage in training, education, volunteering or*

employment.

However, HHJ Dodd observed that:

> *26. With one exception, these additional factors strike me as comprising (or at least incorporating) not facts but somewhat nebulous value judgments. The desire to ensure that GP takes full advantage of the services potentially available to him is laudable but has resulted, in my view, in the tail of welfare beginning to wag the dog of capacity.*
>
> *27. The exception is: "e. the opportunities that may be available to engage in training, education, volunteering or employment." This is certainly information, but it is not a salient feature of a decision about care and support.*

To request an EHC needs assessment under section 36(1) of the Children and Families Act 2014

HHJ Dodd observed that this formulation of the question was better than that advanced by the applicant ("to request or refuse an assessment of his education and health care needs for an education, health and care plan (EHC plan) pursuant to s.36 (1) of the Children and Families Act 2014"), because, as he held at paragraph 28, this had "*the attraction of greater simplicity and the omission of the reference to GP deciding to refuse an EHC assessment: as I understand it, if the obligation to carry out such an assessment is triggered under s.36, GP would not be entitled to decide that it should not be carried out*."

HHJ Dodd endorsed the agreed position as to the following information being relevant:

a. *An EHC plan is a document that says what support a child or young person who has special educational needs should have;*
b. *Other people will be consulted during the assessment process including parents, teachers and other professionals;*
c. *If assessed as requiring an EHC the young person has enforceable right to the education set out within their plan.*
d. *An EHC plan is only available up to the age of 25 years.*

HHJ Dodd did not agree with two further pieces of information suggested to be relevant by the applicant local authority:

a. "If assessed as requiring an EHC plan, social care and health needs may be included on the plan and this may be advantageous to GP in having his needs met:" HHJ Dodd held that this added nothing to (a) above;

b. "The local authority would agree to 'lapse' GP's EHC plan this year, and he may reconsider next year but it may be difficult to seek an EHC plan after that:" HHJ Dodd found that the possibility (of uncertain extent) that "it may be difficult to seek an EHC plan" is too nebulous to amount to relevant information.

To make decisions as to his education

HHJ Dodd agreed with this formulation rather than that advanced by the applicant (i.e. "to make decisions about his education and health care needs pursuant to the Children and Families Act 2014").

On this issue, there was not agreement between

the appellant and the Official Solicitor as to the relevant information; HHJ Dodd did not resolve the disagreement, but indicated that, in the event that the parties could not agree, the formulation of the relevant information advanced by the Official Solicitor, namely:

> a. *The type of provision.*
> b. *The type of qualifications, if any, on offer.*
> c. *The cohort of pupils and whether P would match the profile of other pupils at the provision.*
> d. *That P has additional rights up to the age of 25 because of his special educational needs.*

The independent expert, Dr Rippon, had said in evidence:

> *I think education is broader than just qualifications. I think education also has an important component in supporting a YP's social and emotional needs. YP who are having education via remote working are missing a key component of what school is. It is about supporting their development as an individual and it supports their emotional wellbeing in addition to just being somewhere you gain qualifications.*

HHJ Dodd indicated that in this regard he had found helpful:

> *37.* […] *the following passage from the decision of Macur J (as she then was) in In LBL v RYJ and VJ [2010] EWHC 2665 (at paragraph 58)*
>
> > *"In Dr Rickard's view it is unnecessary for his determination of RYJ's capacity that she should understand all the details within the Statement of Special Educational Needs. It is unnecessary that she should be able to give weight to every consideration that would otherwise be utilised in formulating a decision objectively in her 'best interests'. I agree his interpretation of the test in section 3 which is to the effect that the person under review must comprehend and weigh the salient details relevant to the decision to be made. To hold otherwise would place greater demands upon RYJ than others of her chronological age/ commensurate maturity and unchallenged capacity."*
>
> *38. Whilst I do not doubt the accuracy of Dr Rippon's observation that "education is broader than just qualifications" (indeed, it is almost a cliché), I fear that to require GP to understand and weigh the nature and extent of the social and personal development opportunities which might be available to him would be to do precisely what Macur J decided against, namely placing greater demands upon him than others of his chronological age/commensurate maturity and unchallenged capacity.*

On the facts of the case, HHJ Dodd found that GP did not have capacity in any of the relevant domains.

Comment

This is a very useful addition to the canon of

cases which give guidance as the categories of information which is likely to be relevant (or irrelevant) to particular decisions – although such cases should always be read subject to the injunction in *B v A Local Authority* that the guidance must always be tailored to the specific situation of the individual in question.

As a further point, it was extremely helpful that this judgment gave an indication in its title as to what it was about; this practice, common in family proceedings, could usefully be more widely adopted in Court of Protection cases as we otherwise drown in an ever greater deeper alphabet soup.

Severe depression and medical treatment

University Hospitals of Leicester NHS Trust v TC & Ors [2020] EWCOP 53 (Cobb J)

Capacity – best interests – medical treatment

Summary

In this case, Cobb J was required to consider an urgent application for a best interests decision with respect to carrying out chemoradiotherapy and an endoscopic resection and/or tracheostomy (as well as authorising any deprivation of liberty).

TC was a 69-year old with advanced cancer of the larynx, which was only diagnosed on 7 September 2020 and had become increasingly life-threatening. She suffered from longstanding anxiety for which she took anti-depressant medication. The deterioration in her health meant that she required hospital admission on 6 October 2020.

Following her diagnosis on 7 September 2020, she was offered two treatment options – surgery or chemotherapy ("CRT"). The surgery would involve a total laryngectomy (removal of TC's voicebox) and bilateral neck dissections (surgical removal of lymph nodes in both sides of her neck). Depending upon the histology following surgery, she might still require radiotherapy. At that stage on 7 September 2020, and following discussions, TC made a capacitous decision to undergo a course of CRT.

On 9 September 2020, TC presented as confused and her anxiety levels were noted to be higher, which was not unusual given the diagnosis. Her presentation, however, deteriorated; and her behaviour became increasingly erratic. On 16 September 2020, she met with the consultant oncologist; and discussed the proposed treatment again. She signed the consent form for CRT. She attended a planning appointment on 22 September 2020 and no concerns were raised. She was able to discuss the treatment and side effects. After that appointment, however, there was a gradual decline in TC's physical and mental health. She was unable to discuss the proposed treatment and she behaved irrationally. She refused to eat and drink and became too weak to get out of bed.

TC was assessed as lacking capacity to make decisions regarding the proposed treatment as a result of her depression and chronic anxiety on 7 October 2020. The capacity evidence before the court concluded that the impairment of TC's mind was such that she was unable to make a decision to proceeding with a treatment option, namely the CRT. She was also unlikely to regain capacity in the short term, and particularly within the relevant timescales, given the urgency of the treatment – the progression of her condition meant that, if nothing were to be done, she would

die within the next few weeks.

The Official Solicitor obtained and presented a second opinion to the court on TC's mental capacity. That opinion concluded:

> *TC has demonstrated that she is able to understand and retain information in regard to her diagnosis and the treatment interventions available. She is also able to communicate her decision. However, as a result of her depressive illness, she is experiencing symptoms of hopelessness and does not consider that she has a future. As is typical in severe depression she is experiencing catastrophic thinking. As a result, she is unable to weigh up the information she has been given in order to make a capacitous decision. It is therefore my view that TC lacks capacity to make decisions about her medical treatment*. (emphasis added)

On the basis of the evidence before him, Cobb J was satisfied that TC lacked capacity to make a decision about this medical treatment.

Regarding the treatment options, the surgery and CRT offered a 60% chance of being curative (meaning that TC had a 60% chance of overall survival for 5 years after treatment; thereafter a patient's odds of longer term survival are significantly improved).

The options had, however, been rendered more complicated because the tumour had grown significantly. Preparatory work was therefore required that would debulk the tumour (either through a micro-debrider, last treatment, or treatment that vaporises the tumour). If one of these procedures failed, then a tracheostomy would be required. It was acknowledged by all the treating doctors and the family that TC would not what this, but it was necessary to ensure the integrity of the airway before CRT is commenced.

The expert evidence indicated that the long-term cure rate was in the region of 60-70%. He also laid out the survival rate if all treatment were refused, as well as the risks and complications associated with the procedures.

In terms of TC's views, she had signed a written consent form to the treatment on 16 September 2020 (when she was capacitous), but she subsequently refused the treatment. Her family supported the treatment.

In considering best interests, Mr Justice Cobb started with the presumption that it was TC's best interests to stay alive (*Aintree v James* [2013] UKSC 67); and observed that without the proposed treatment TC would die, and soon. He was entirely satisfied that the proposed treatment was in her best interests; and that it was the least restrictive and/or interventionist. He observed that the treatment proposed was the closest to what he found TC's wishes to be, even though it is not exactly what she consented to when she was capacitous. He was satisfied that it was in TC's best interests to secure her airway before beginning the CRT.

Comment

The case shows the importance of promptly obtaining expert evidence (with the court's permission) in cases such as this, even when the application is urgent. The expert evidence on capacity, in particular, was able to explain to the court's satisfaction how TC had gone from being able capacitously to decide upon her medical treatment to now being in a position where she lacked that capacity – i.e. how, as a result of the

catastrophic thinking (associated with her severe depression) she was unable to weigh up the information relevant to the decision in question.

Short Note: the court and dental clearance

Livewell Southwest Community Interest Company v MD [2020] EWCOP 57 is another case on full-dental clearance following very shortly after the *United Lincolnshire Hospitals NHS Trust v Q* [2020] EWCOP 27 case.

The *Livewell* case concerned MD, a morbidly obese 24 year old man with learning disabilities, paranoid schizophrenia and ADHD and a possible diagnosis of autism. Rather surprisingly, given his significant mental impairments, the judgement records that MD is voluntarily accommodated in a residential home for men with mental health problems.

In a hearing before Mostyn J it was detailed how, by virtue of his sweet tooth and resistance to dental hygiene, MD's teeth had reached a state where they were considered to pose a risk of infection, sepsis and even death if untreated. Due to MD's resistance to intervention and his significant size, the applicant sought orders that would authorise both sedation in the community, soft handcuffing if necessary, and transfer to hospital. This was all in the context of MD having expressly indicated an unwillingness to have any teeth removed – albeit that the evidence pointed to this being due to concerns regarding the pain that might involve, rather than aesthetic ones.

Mostyn J had no difficulty making declarations as to MD's lack of capacity to conduct proceedings and make decisions regarding his dental treatment, having been provided with a full psychiatric report.

As to best interests, he determined that it was in MD's best interests to undergo treatment commenced covertly (ie without warning MD he was going to be taken to hospital) and with the use of chemical and physical restraint not least because he concluded, "if MD were to have a brief window of capacity, I am sure that he would consent to intervention as a necessary measure to avoid pain" (para 17).

Interestingly, the care plan proposed for MD's treatment included the enlisting of third party care givers, previously unknown to him, in order to maintain the relationship of trust with his current team. Mostyn J also determined, having considered the proportionality of the same, to make a declaration in favour of full rather than partial treatment on the basis that, given the evidence of MD's inability to comply with elementary dental hygiene, any residual teeth would inevitably decay and result in an identical application and procedure in future (see para 22).

DoLS statistics for England

The DoLS statistics for England for 1 April 2019 to 31 March 2020 were published on 12 November 2020. They are likely to be the last set published before DoLS starts to be wound down in April 2022 which show how DoLs was (or was not) working in non-pandemic conditions.

In headline terms:

- There were 263,940 applications for DoLS received during 2019-20, relating to 216,980 people. The number of applications has

increased by an average of 13.9% each year since 2014-15.

- The number of applications completed in 2019-20 was 243,300. The number of completed applications has also increased each year, by an average of 31.2% each year since 2014-15.
- The reported number of cases that were not completed as at year end was 129,780. This is the first year since reporting began in 2015-16 that the number of cases not completed at year end has fallen, by 1.2%, from 131,350 at the end of 2018-19.
- The proportion of completed applications in 2019-20 that were not granted was 51.0%. The main reason was given as change in circumstances, at 62.0% of all not granted cases.
- The proportion of standard applications completed within the statutory timeframe of 21 days was 23.6% in 2019-20. The average length of time for all completed applications was 142 days (down from 147 days in 2018-9).

Advocacy: a call to arms

A report published in October, Valuing voices: Protecting rights through the pandemic and beyond report, highlights that disabled people and care home residents have seen their human rights breached, and access to independent advocacy and health and social care reduced, during the coronavirus pandemic. It also sets out a call to arms to ensure that the same result does not occur as we go through second (and further) waves).

The report is the result of a survey of nearly 450 advocates. Advocacy organisations across the UK, including VoiceAbility and n-compass, worked in partnership to run the survey and launch the report. The project was supported by NDTi.

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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 Visiting Professor at King's College London, and created the website www.mentalcapacitylawandpolicy.org.uk. 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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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.

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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.

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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.

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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; 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.

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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.

Jill Stavert's Centre for Mental Health and Capacity Law (Edinburgh Napier University)'s Autumn 2020/January 2021 webinar series will include a contribution by Alex on 2 December 2020 at a webinar about Psychiatric Advance Statements. Attendance is free but registration via Eventbrite is required. 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 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.

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