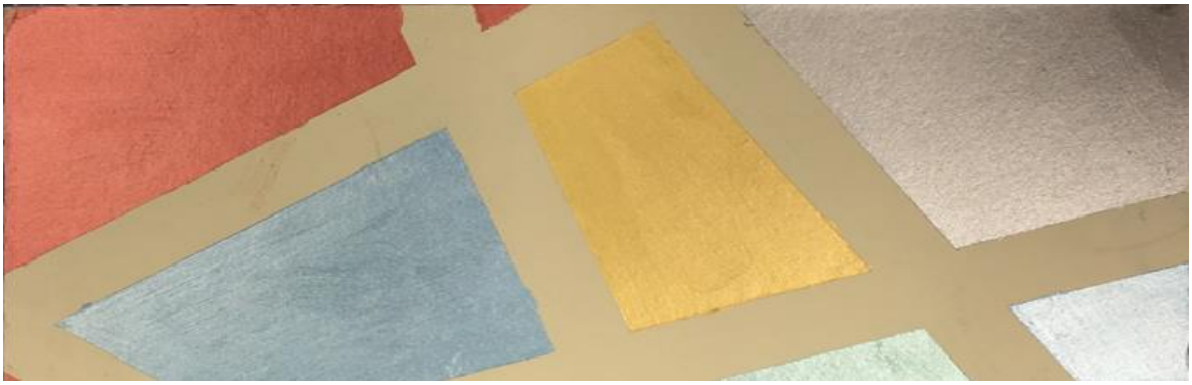
Essex CHAMBERS

MENTAL CAPACITY REPORT: COMPENDIUM

September 2019 | Issue 97



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

(1) In the Health, Welfare and Deprivation of Liberty Report: fluctuating capacity, and two important decisions on the scope of the inherent jurisdiction at the border of the MCA 2005;

(2) In the Property and Affairs Report: appointing a charitable trust corporation as a deputy and donating/tax-planning in PVS;

(3) In the Practice and Procedure Report: procedure in medical treatment cases; disclosure from proceedings to the police; and an update from relevant associations

(4) In the Wider Context Report: guidance on advance decisions and covert medication; alcohol, capacity and vulnerability; the FCA and vulnerable customers;

(5) In the Scotland Report: the Scott Review terms of reference; guardianship and (the failure of?) legal representation; and the apparent downgrading of the Mental Health Tribunal for Scotland.

You can find all our past issues, our case summaries, and more on our dedicated sub-site 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.

Editors
Alex Ruck Keene
Victoria Butler-Cole QC
Neil Allen
Annabel Lee
Nicola Kohn
Katie Scott
Katherine Barnes
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

HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

Fluctuating capacity – micro- vs macro-decisions

Royal Borough of Greenwich v CDM [2019] EWCOP 32 (Newton J)

Mental capacity – assessing capacity – care – medical treatment

Summary[1]

CDM was a 64 year old woman with a range of diagnosed personality disorders and physical health problems who was deprived of her liberty against her wishes in a care home. She was found by the court to have capacity to decide where to live and to make various other decisions, but to have fluctuating capacity with regard to the management of her diabetes. Readers may recall that CDM's case went to the Court of Appeal at the end of 2018 on the question of fluctuating capacity, but in light of fresh medical evidence the Court of Appeal decided that the matter needed to be dealt with fully by a first instance judge. This judgment is the decision of Newton J, in which the initial decision that CDM's capacity to manage her diabetes fluctuated as a result of her personality

[1] Both Katie and Alex having been involved with this case, this summary has been prepared by Tor.

disorder, was more fully considered, with the benefit of additional expert evidence.

Newton J summarised the issues before him as follows:

> *1. Whether the assessment of capacity to make decisions about diabetic management or "the matter" in relation to which CDM is being assessed is one macro-decision which encompasses all of the many micro-decisions that CDM is required to make when managing her diabetes, or, whether CDM's capacity should be assessed in respect of each micro-decision or group of micro-decisions.*
>
> *2. In the light of that determination, whether the presumption that CDM has capacity to make decisions about her diabetes has been rebutted, and if so on what basis.*
>
> *3. If I conclude that as a matter of fact CDM's capacity to make decisions about any aspect of her diabetes management fluctuates, what preparations the court can and should make to reflect that finding.*

The court heard long and complex evidence about CDM's capacity. In short, the two experts instructed (one a psychiatrist and one a psychologist) agreed that the management of CDM's diabetes had to be viewed at a macro level, or as a group of micro-decisions, because the decisions had to be consistent and coherent with each other over time, and because decisions at one time would be affected by decisions taken earlier. CDM did not understand that she was at risk of death when her insulin levels were very poorly controlled, and her emotional dysregulation as a result of her personality disorders was frequent, and affected her ability to retain and to weigh information. The conclusion of Dr Beck, the expert psychologist, was that:

> *There may be some times when CDM makes a decision in relation to the management of her diabetes where she understands the elements of the decisions being made, retains the information, weighs it up without the defect of a dysregulated emotional state, and communicates this effectively. However, these times, if they occur, are infrequent and unpredictable. If this is fluctuating capacity, then CDM has fluctuating capacity to manage her diabetes.*

The Official Solicitor (on behalf of CDM) sought to argue that the diabetes management decisions should not be treated as one decision, as otherwise CDM would have her capacitous micro-decisions overridden. The Official Solicitor proposed that:

> *the appropriate way of "defining the matter", when assessing diabetic management, is not to accept the macro or micro-decision approach, but to group them together and consider whether CDM has the capacity:*
>
> *1. To make decisions about controlling her diabetes and diet.*
>
> *2. To make decisions about treatment for her diabetes, which is in turn subdivided into three separate decisions:*
>
> > *a. The capacity to make decisions about testing and the blood sugar at right glucose levels, which*

> *encompasses submissions about weighing and testing blood glucose levels.*
>
> *b. The capacity to make decisions about treatment being offered for her diabetes but falling short of life-saving treatment. Treatment by insulin as required. And,*
>
> *c. The capacity to make decisions about life-saving treatment for diabetes, which will include, in some cases, taking insulin or admitting herself and taking her to hospital.*

Newton J rejected this analysis, holding that:

> *a) on the assessment of capacity to make decisions about diabetes management, in all its health consequences, the matter is a global decision, arising from the inter dependence of diet; testing her blood glucose and ketone levels; administration of insulin; and, admission to hospital when necessary in the light of blood glucose levels. And*
>
> *b) that CDM lacks the capacity to make those decisions, and having regard to the enduring nature of her personality disorder which is lifelong and therefore unlikely to change.*

Newton J:

> *acknowledge*[d]*, as do the experts, that there may be occasions when CDM has the capacity to make micro-decisions in respect of her diabetes and occasions when she does not, i.e. that her capacity does in fact fluctuate. However, if the court accepts the expert's opinions, as I do, and approaches the matter on the basis of their conclusions, logically, legally and practically, it is a macro-decision, and CDM lacks capacity to take the macro-decision, the issue of fluctuating capacity simply does not arise.*

More broadly, Newton J did not think it:

> *necessary or helpful to draw inferences or parallels on examples of other conditions or other classes of individuals, since the interrelationship between the micro and macro-decisions still needs to be decided, having regard to a particular individual in particular circumstances, and having regard to their particular condition. No two people self-evidently are ever the same, their condition the same condition, or the circumstances the same. The elements in relation to CDM's own particular conditions are unique to her. CDM has diabetes which is not unique to her, being shared with many other millions of people in the United Kingdom, but as an individual the factors are unique.*

Comment

After a long route through the courts and a substantial volume of evidence, the conclusion for CDM was that she lacked capacity to manage her diabetes, viewed on a global basis, even though there would be times (which could easily be identified) when she could make individual decisions about aspects of the management of her condition with capacity.

This case could be contrasted with that of *United Lincolnshire Hospital NHS Trust v CD* [2019] EWCOP 24, in which Francis J held that where the circumstances under which the woman in question would lack capacity to make decisions about birth arrangements were sufficiently clear

that it was possible to make a 'contingent' declaration about what could then happen in her best interests at that point. In this case, however, Newton J noted that:

> during the course of evidence, Dr Beck was asked for more guidance as to the signs when CDM becomes emotionally dysregulated and whether she has lost capacity in respect to either of the micro-decisions but, Dr Beck was simply unable to do so, because it was impossible to do so.

In CDM's case, therefore, every action in relation to the management of her diabetes would fall to be considered by reference to her best interests, taking into account, of course, her wishes and feelings.

On the facts of the case before Newton J, the practical benefits of taking this global approach were obvious – clarity about the ability to intervene to provide treatment to CDM to prevent her from becoming seriously ill, or to ensure that she was admitted to hospital when her condition is so serious that she might die.

However, as Newton J identified, the decision was highly fact-specific; it is also unlikely to be capable of easy application to other scenarios.

The limits of the inherent jurisdiction (1)

Wakefield MDC and Wakefield CCG v DN and MN [2019] EWHC 2306 (Fam) (Cobb J)

Inherent jurisdiction – mental capacity – deprivation of liberty

Summary[2]

DN was a 25 year old man described as having a severe form of autism, a general anxiety disorder and traits of emotionally unstable personality disorder. He was '*not significantly intellectually impaired*' and was '*capable of clear thinking*'. He had previously been detained under s.3 MHA 1983 and received s.117 aftercare. He was vulnerable to exploitation, and liable to have 'meltdowns', during which he would lose the capacity to manage his behaviour and make considered decisions.

DN had been convicted of a range of public order offences, and sentenced to a community order with a 2 year mental health treatment requirement under s.207 of the Criminal Justice Act 2003, and had then committed further offences. As part of that order he was required to live at a supported living placement. Other elements of his care plan meant that the objective element of a deprivation of liberty was satisfied. The statutory bodies took the view that DN could not give free and meaningful consent to the confinement, and since the CJA does not contain any power to deprive a person of their liberty, sought an order authorising the deprivation of liberty from the High Court under the inherent jurisdiction. The MCA 2005 was not relied on because it was accepted that DN did not lack capacity – the position of the statutory bodies was that he was a vulnerable adult in the *Re SA/Re DL* sense. It appears that by the time of the hearing, the statutory bodies had accepted that the court could not authorise DN's deprivation of liberty but still sought the court's authorisation of the interference in his Article 8

[2] Neil having been involved in the case, he has not contributed to this summary.

rights caused by the arrangements for his care.

Cobb J held that DN was not a person of unsound mind nor a 'vulnerable adult'. He was able to give genuine consent to the arrangements for his care, even though the choice he was faced with was stark – if he did not consent, the criminal court may say that he would have to serve his sentence in prison. Despite concluding that DN was not of unsound mind, the court accepted that at times when DN was having a 'meltdown' he would lack capacity under the MCA 2005 and his deprivation of liberty could be authorised in advance by the court, presumably on the basis that at these limited times he would be a person of unsound mind by reason of his temporary lack of capacity.

Cobb J took the view that the inherent jurisdiction was a potentially arbitrary mechanism for authorising a deprivation of liberty, and that there were '*strong judicial dicta*' that it should primarily be used as a facilitative rather than a dictatorial jurisdiction. Differing from the judgment in *Hertfordshire County Council v AB* [2018] EWHC 3103 (Fam), Cobb J concluded that the inherent jurisdiction should not be used to deprive a capacitous person of their liberty. The net result was that the restrictions in place for DN would have to be reduced as there was no lawful basis on which he could be deprived of his liberty.

Comment

There have been a number of decisions in recent times about young people and adults and the use of the inherent jurisdiction to authorise deprivations of liberty where there is no statutory framework in place. It is clear from this judgment that different judges have different views about the appropriateness of relying on the inherent jurisdiction in such circumstances, as a matter of principle, and different interpretations of the Court of Appeal's decision in *Re DL*. It seems likely that at some stage, the appeal courts will have to decide whether the inherent jurisdiction does extend to the deprivation of liberty of a capacitous person, or a vulnerable adult, and if so, in what circumstances.

The limits of the inherent jurisdiction (2)

Redcar and Cleveland BC v PR and others [2019] EWHC 2305 (Fam) (Cobb J)

Summary[3]

In this case, Cobb J was concerned with a 32 year old woman who had recently been affected by mental health problems which had resulted in admission to hospital as a voluntary patient. During her admission she made allegations against one of her parents and was extremely anxious about returning to live with them (to the point of threatening to take her own life). When she was ready to be discharged, the local authority considered that it was required to safeguard her by applying to the High Court for orders under the inherent jurisdiction preventing PR from returning to live with her parents. Interim orders were granted, initially without notice, and were kept in place for around 4 weeks. Ultimately, PR decided she did not want to return to live with her parents, and they in turn agreed to have limited contact with her and not to try to persuade her to return home, and the

[3] Alex having been involved in this case, he has not contributed to this summary.

inherent jurisdiction orders were discharged. The issues for Cobb J were whether the interim orders should have been made, and whether there was a proper basis for withholding disclosure of certain information from PR's parents.

Cobb J found that:

1. The interim orders should not have included an injunction against PR herself (restraining her from going to live with her parents) as the evidence was that she was sufficiently unwell that she would not have been able to make an informed decision whether to comply with the order, and it would not have been appropriate for any enforcement action to be taken if she had chosen to return home. Cobb J recommended that

> *'before a local authority makes an application under the court's inherent jurisdiction which is designed to regulate the conduct of the subject by way of injunction, particularly where mental illness or vulnerability is an issue, it should be able to demonstrate (and support with evidence) that it has appropriately considered:*
>
> > *i) whether X is likely to understand the purpose of the injunction;*
> > *ii) will receive knowledge of the injunction; and*
> > *iii) will appreciate the effect of breach of that injunction.*
> > *If the answer to any of these questions is in the negative, the injunction is likely to be ineffectual, and should not be applied for or granted as no consequences can truly flow from the breach.'*

2. PR should have been given permission in the initial without notice order to apply to the court to vary or discharge the order without requiring notice to be given, to ensure her access to justice was not impeded.

3. It was, however, proper for the judge who had made the interim orders against PR's parents to invoke the inherent jurisdiction on an interim basis. The other statutory provisions which could potentially have been invoked (such a non-molestation orders, an order under the Serious Crime Act 2015 section 76 which creates a criminal offence of controlling or coercive behaviour where A and B live together and "are members of the same family", or the Protection from Harassment Act 1997) would not have offered PR sufficient protection and would have required her active co-operation which would have been difficult given her mental health problems and her susceptibility to coercion and control.

4. PR had not been deprived of her liberty. She had been content to move to the placement identified by the local authority on discharge from hospital. Even if the inherent jurisdiction could be used to deprive a capacitous person of their liberty as an emergency measure, such authorisation would only last a short time – probably not more than 6 weeks having regard to the decision in *Winterwerp v Netherlands*.

5. The question of whether documents should have been disclosed to the parents did not have to be determined as there was to be no

> further involvement of the court, but even though PR had not chosen to issue proceedings and was sufficiently anxious about disclosure to her parents that it was affecting her willingness to participate in therapeutic activities, the parents would have had '*a powerful case…to see relevant documents in order to able to participate effectively and fairly in the proceedings so far as they relate to them.*'

Comment

This judgment will provide some reassurance to statutory bodies faced with difficult and urgent situations concerning safeguarding people with capacity that the courts will exercise their powers, at least on a temporary basis, to assist in protecting vulnerable adults. In PR's case, temporary court orders were all that were needed to prevent PR returning home and to support her to move to alternative accommodation. Had PR subsequently decided she wished to return home, it is much less clear whether the court would have found a way to stop that from happening, given Cobb J's view that the inherent jurisdiction ought not to be used to deprive capacitous people of their liberty.

Medical decision-making and the law

Tor recently gave a talk at Green Templeton College, Oxford University, on medical decision-making and the law, as part of the Sheila Kitzinger programme. A summary of her talk, and a full recording of it, can be found here.

PROPERTY AND AFFAIRS

Donating and tax-planning in PVS

Re MJL [2019] EWCOP 31 (DJ Sarah Ellington)

Best interests – property and affairs

Summary

In 2007, when P was 54, he suffered a cardiac arrest and fell into PVS. He had an estate of over £17 million and no dependents, and was cared for in hospital funded by the NHS.

He was a supporter of the Labour Party and other left leaning organisations and, prior to the onset of PVS had made modest annual donations to such causes. He had also made substantial charitable donations.

The court had previously authorised the making of a statutory will that benefited his, independently wealthy, siblings and charities. The deputy had continued the payments to the Labour Party and left leaning causes.

The Deputy applied for retrospective authorisation of the political donations and for tax planning donations to the siblings and charities that benefitted under the will.

The Official Solicitor supported the former but not the whole of the latter, arguing that any large donations should only be made from excess income and not capital.

The court performed the usual checklist balancing exercise making it clear that there was no default position from which the court would start and that, in relation to tax planning, affordability was only a necessary condition not a sufficient one.

In the end, the court had no difficulty authorising the past and future modest donations to political causes, there was ample evidence of P's pre incapacity desire to benefit those causes.

As regards tax planning, evidence of a desire so to do was absent and, ultimately, the court decided that it was only in P's best interests to make donations out of surplus income (both accrued and for the future).

Comment

This case illustrates that the availability of capital is a necessary condition for tax planning donations but not sufficient. What will be sufficient will depend on each case but an inclination pre incapacity of the desire so to do will go a long way.

Short Note: charities as deputies

In *Re TWAH* [2019] EWCOP 36 the court considered an application by a trust corporation which was a registered charity (Allied Services Trust), a company limited by guarantee, to be appointed the deputy for property and affairs of an incapacitated person.

The court approved the application after satisfying itself that adequate insurance arrangements were in place and considering whether or not regulation by the Charity Commission was a sufficient safeguard (and deciding it was).

The court went on to set out the procedure to be followed in such cases (similar to trust corporations linked to legal practices). They include declarations/undertakings (to be filed as an additional page to the COP4 filed with the

application) that:

a. The proposed deputy (the trust corporation) is a trust corporation within the meaning of s.64(1) Mental Capacity Act 2005 and can lawfully act as such; and the trust corporation will notify the Public Guardian if that ceases to be the case.

b. The trust corporation will comply with the Public Guardian's published standards for professional deputies.

c. The trust corporation is regulated by the Charity Commission; and will notify the Public Guardian immediately if that ceases to be the case. The trust corporation undertakes to maintain insurance cover that:

   (i) includes indemnity in respect of all work undertaken by the trust corporation, including discharging the functions of deputyship; and

   (ii) provides a sum insured for any one claim (exclusive of defence costs) no less than £3 million.

d. The trust corporation will lodge a copy of the insurance policy with the Public Guardian on appointment and will notify the Public Guardian immediately if there is any reduction in the terms or level of the insurance cover.

Some additional documents should also be filed with the application:

a. copy of the authorisation by the Lord Chancellor to act as a trust corporation; and

b. confirmation of its charitable registration.

(A copy of the insurance policy need not be filed with the application, but must be lodged with the Public Guardian on application.)

PRACTICE AND PROCEDURE

A framework for ensuring applications are made

The Royal Bournemouth and Christchurch Hospital NHS Foundation Trust and Dorset Healthcare University NHS Foundation Trust v SE [2018] EWCOP 45 (Theis J)

Best interests – medical treatment – practice and procedure – other

Summary

The issue in this case (decided in November 2018, but appearing on Bailii in August 2019) was whether it was in SE's best interests to have her right leg amputated.

SE was diagnosed with schizophrenia and had delusional beliefs which led the clinicians to assess her as lacking capacity to decide whether or not to undergo this procedure. By the time the matter came before the court, it was agreed by all parties that SE lacked capacity to make this decision herself.

The only issue for the court to determine therefore, was whether the amputation was in SE's best interests. The medical evidence was clear, that without it she would die in a short time frame. Set against this was the fact that SE did not want an amputation (albeit she had at times been ambivalent about it). A factor that the court considered to be particularly important in the balancing exercise was that while SE did not want the amputation, she was clear that she did not want to die. Unsurprisingly therefore the court made the order authorising the amputation.

Comment

The judgment in this case is notable for the criticisms the judge made of the applicant's failures to follow the correct steps to bring the application before the court in a timely manner and on proper notice to SE's family. So concerned was Theis J about the applicant's conduct that she directed that a letter be sent to Mr Justice Hayden (Vice President of the Court of Protection) setting out what the court was told were the concrete changes that had been made as a result of the case to ensure that those on the front line are not without effective legal advice in relation to applications that should be made in a timely way in the future. Those steps are set out at the conclusion of the judgment and make essential reading for all Trusts as stress-testing to ensure that they have a sufficient framework in place.

The limits of interim declarations and out of hours applications

Guy's and St Thomas' NHS Foundation Trust v X [2019] EWCOP 35 (Theis J)

Best interests – medical treatment – mental capacity – medical treatment – practice and procedure – other

Summary

This case concerned the obstetric care and delivery of X, a young woman who had a number of different mental health diagnosis including bipolar disorder, schizoaffective disorder and personality disorder. She had been in a psychiatric hospital for 6 weeks at an early stage in her pregnancy.

X attended Guys and St Thomas' Hospital where

the doctors became concerned that there was a high risk of still birth. They concluded that the safest option was to deliver by c-section. X wanted the baby to be born alive but did not consent to a c-section – she had strong views about wanting a 'natural birth'. She was assessed as lacking capacity to make decisions about her obstetric care and the delivery of her baby.

The matter came before the Court of Protection as an out of hours' telephone application in the early hours of the morning, at which hearing X represented herself. The Court was critical in the judgment of both the fact that the application was not brought earlier in the day so that the hearing could take place in Court hours, and of the fact that the Official Solicitor was unable to represent X at the out of hours hearing as the office does not offer an out of hours service.

The judge adjourned the application to the following morning, by which time the Official Solicitor was available to represent X as her litigation friend.

By the time of that adjourned hearing, X had agreed to have labour induced as soon as possible. In fact, X had her baby the following day without the need for a c-section.

The judge dealt with the issue of capacity in a somewhat striking fashion. The Official Solicitor did not consider that there was sufficient evidence before the court to rebut the presumption that X had capacity to make decisions about her obstetric care and the delivery of her baby. Accordingly, the Official Solicitor submitted that the court should not make any order, but that in the event X lost capacity in the future, the matter could be restored urgently. The high point of the Trust's case on capacity was that there was sufficient evidence to make an interim declaration on capacity pursuant to s.48 MCA 2005 (namely that there was reason to believe X lacked capacity).

The court agreed with the Trust that it was appropriate to make an interim declaration that X lacked capacity to make decisions about her obstetric care and the delivery of her baby and authorised the treatment plan on this basis.

Comment

It is difficult to see the justification for relying on s.48 MCA 2005 in the way that Theis J did in this case. At the point that the court is being asked to authorise serious medical treatment against a person's wishes, the court is being asked to make a final order. If the evidence was not sufficient at this final hearing, to rebut the presumption that X had the capacity to make the decisions herself applying the test on capacity set down in s.15 MCA 2005, then we suggest that the court should have acceded to the Official Solicitor's submission to make no order.

See by contrast the comments Francis J made in *United Lincolnshire Hospital NHS Trust v CD* [2019] EWCOP 24 when he agreed with the Official Solicitor that to authorise the treatment pursuant to section 4B of the MCA (section 4B authorises the deprivation of liberty "*while a decision as respect any relevant issue is sought from the court")* would not be appropriate as it would involve adjourning the s16 order until after the birth, "*which was entirely artificial since it is in relation to treatment during labour that the issue arises*" (emphasis in original).

Separately, Theis J was – we suggest – entirely

correct to flag the problem (which is at root a resourcing problem) that the Official Solicitor is unable to offer an out of hours service. As Theis J noted, "[w]*hy should the timing of an application have an impact on X's ability to be properly represented, which she would have been if the application had been made a few hours earlier?*" We will see whether the Official Solicitor is, indeed, able "*urgently* [to] *review this position and consider putting in place arrangements that will ensure appropriate representation out of normal court hours for those individuals who are the subject of urgent applications that potentially involve serious medical treatment*."

Disclosure from proceedings to the police

Re M (Children) (Disclosure to the Police) [2019] EWCA Civ 1364 (Court of Appeal (Sir Andrew McFarlane P, Simon and Nicola Davies LJJ))

Other proceedings – criminal – practice and procedure – other

Summary

This was an appeal to the Court of Appeal by parents against a decision of Keehan J's in care proceedings, acceding to an application brought by the police for disclosure to the police of the witness statements and position statements filed by the parents.

It is of interest to Court of Protection practitioners as it is concerned with the power of the court to permit access to documents filed within proceedings to a non-party where those documents interfere with a litigant's right in civil proceedings not to be put in the position of making an admission of criminal conduct i.e. the privilege against crimination or self-incrimination (now on a statutory footing – see s.14 Civil Evidence Act 1968).

The parents were British citizens who met in Syria and had two children there. On their return to the UK the parents were arrested under s.41 Terrorism Act 2000 but later released on police bail. The children were taken into foster care and the local authority brought care proceedings arguing that the threshold criteria were met on the basis that Syria '*is currently characterised by violent conflict and the children have either been exposed to this or were at risk of exposure, and as such have suffered emotional harm or been at risk of suffering significant emotional and physical harm*'.

The appeal was concerned with the rule against self-incrimination which does not apply in care proceedings as a result of s.98 Children Act 1989, with the important proviso that evidence or answers given in those proceedings are not admissible in any criminal proceedings other than perjury. The leading case on the approach to be adopted by a court when considering disclosure to the police is *Re C (A Minor) (Care Proceedings: Disclosure)* [1997] Fam 76. This case identifies 10 factors which are likely to be relevant to any such application.

Keehan J granted the police's application primarily on the basis that the investigation of alleged offences contrary to the Terrorism Act 2000 established "*particularly substantial weight to the public interest in such offences being investigated*." Of particular relevance to the Judge was the fact that the there was nothing in the parents' witness statements, that might be termed an admission of wrongdoing or guilt of any offence. The Court of Appeal upheld the judgment on this basis, adding that even "*where, in another case, the material that is subject to a*

disclosure application might contain potentially incriminating evidence, that factor would not establish a complete bar to disclosure. In such circumstances, the court would evaluate the application by giving careful consideration to the Re C factors before determining whether disclosure was necessary and proportionate."

Comment

There is no equivalent to s.98 Children Act in the Mental Capacity Act. Thus, witnesses in Court of Protection proceedings are able to invoke the privilege against self-incrimination as codified in section 14 of the Civil Evidence Act 1968. If incriminating evidence is given in the proceedings, and an application is made for disclosure of it to a third party, the court will consider it against the following legal background:

(i) If the proceedings are in private, rules 4.2 and 5.9 of the Court of Protection Rules 2017 give the court the power to determine what material related to the proceedings can be communicated or published to non-parties.

(ii) If the hearing is in public, third parties can obtain from the court records a copy of any judgment or order given or made in public. If any other documents are sought, an application must be made to the court. The court can only make an order in respect of documents in the court records (rule 5.9). This is not defined in the rules. However, the Supreme Court recently had cause to consider this phrase in the case of *Cape Intermediate Holdings Ltd v Dring (for and on behalf of Asbestos Victims Support Groups Forum* UK [2019] UKSC 38, in which it held that:

> *The "records of the court" must therefore refer to those documents and records which the court itself keeps for its own purposes. It cannot refer to every single document generated in connection with a case and filed, lodged or kept for the time being at court. It cannot depend upon how much of the material lodged at court happens still to be there when the request is made.*

(iii) In both public and private hearings, the court has an inherent jurisdiction to uphold the constitutional principle of open justice. As the Supreme Court held: '*It follows that, unless inconsistent with statute or the rules of court, all courts and tribunals have an inherent jurisdiction to determine what that principle requires in terms of access to documents or other information placed before the court or tribunal in question.*'Thus, if the disclosure is required in pursuit of this principle, the court can order disclosure beyond that provided for in the rules.

Associations update

The East Midlands Group of the Court of Protection Practitioners' Association has now

been established; and is being officially launched with a practitioners' knowledge day conference on 7 November. For more details, see here.

The Court of Protection Bar Association now has a website, here, on which the autumn series of events (including the inaugural annual dinner, with guest speaker Sir Alan Ward) can be found.

THE WIDER CONTEXT

Advance Decisions: Uncovering what GPs need

Compassion in Dying undertook a 10-week research project with 10 practising GPs across England to better understand the knowledge and experience of GPs have of advance decisions to refuse treatment ('ADRT'). The headline finding from their report was that none of the 10 felt comfortable helping someone to create an ADRT. And most had not received formal training on it since medical school. Five themes emerged from the research:

1. GPs had significant gaps in knowledge about ADRTs and how they can benefit people

This included a lack of awareness that a valid and applicable advance decision is legally binding and must be followed.[4] There was a common belief that ADRTs were only for those unwell, older or near end of life and some GPs could not see their benefits by way of personalised treatment and peace of mind. They saw it as a 'legal process' rather than a medical one, wrongly assuming it required a solicitor. But, rather than paying around £500 in legal fees, charities such as Compassion in Dying offer free support to make an ADRT, thereby avoiding unnecessary time and financial barriers being raised to people recording their decisions for future care.

2. GPs imposed a financial barrier by charging for appointments to discuss ADRTs

Some GPs classified supporting a person to make an advance decision as chargeable private work which fell outside their General Medical Services. But, the charity says, it is unacceptable that anyone should face a financial barrier to making treatment decisions as a result of GPs charging to discuss a person's future health in this way.

3. GPs felt that conversations about death, dying and planning for the end of life would be too upsetting or difficult

This resulted in some GPs failing to initiate conversations about people's wishes for end-of-life care and treatment and opportunities to support people to express and documenting their wishes being missed. As a result, instead of such conversations happening well ahead of time when people have space to reflect on the information presented to them, they often happen in stressful situations which can leave people feeling anxious. Some GPs did not feel in a position to properly advise on ADRTs, one stating for example, "*I don't know all of the treatments someone is given after a stroke*".

4. GPs had negative preconceptions about refusing treatment

They were concerned about repercussions if an advance decision they supported a person to make was followed at a later date. One worried that "*some long lost son is going to turn up and say you got mum to sign this*". Some GPs also felt an ADRT could be in conflict with their duty to

[4] Eg see *NHS Cumbria CCG v Rushton* [2018] EWCOP 41 where the GP failed to ensure the ADRT was known about and respected by the medical team.

provide medical care and with medical culture.

5. GPs had practical concerns about the ease and process of supporting a person to make an advance decision

They felt a standard appointment slot did not provide enough time to support someone to create an ADRT and that it was often too difficult to translate a person's vague wishes into a robust care plan. There was also a lack of familiarity with template ADRT forms.

Recommendations

On the back of this research, the charity put forward the following recommendations:

1. Signpost people to free support to make an ADRT

Third sector organisations are ready to help. GPs, community link workers and social prescribers should also know who they are and to signpost to them.

2. Primary care needs to continue to work towards a change in medical culture where end-of-life care is personalised and based on what matters to each person

GPs should support people to consider and document their wishes and preferences, embrace people's right to make decisions about their treatment and care, and be more prepared to talk about death and dying. CCGs and GP practices need to ensure their GPs have protected learning time available to support them to develop their knowledge, skills and confidence around supporting people to plan ahead. Primary Care Networks offer a new opportunity to foster multi-disciplinary team leadership.

3. GP practices should sign up to The Daffodil Standards

Developed by the Royal College of General Practitioners and Marie Curie, these (2019) standards provide a free, evidence-based approach to improving end-of-life care.

4. GP practices should not charge for appointments to discuss an advance decision and the British Medical Association (BMA) should review its guidance on this

National guidance should make it clear to GPs that discussing, reviewing, signing and keeping a copy of Advance Decisions are core services which should not be charged for.

Covert medication guidance

SCIE and NICE have produced a quick guide to giving medicines covertly, aimed primarily at care home managers and home care managers providing medicine support sets out the essentials, namely:

(1) Person with capacity

If declining medication, care staff to record this and the reason if given. If this happens regularly or may present a risk to the person's health, ask the prescriber to review the person's treatment. It may be possible to stop the medicine or prescribe an alternative.

(2) Person proven to lack capacity

A medicines policy, including a process for giving medicines covertly, should be in place which covers:

- Mental incapacity: an appropriate person (e.g. the prescriber) should carry out a mental capacity assessment;

- Best interests: the prescriber, in discussion with care staff, a pharmacist, and someone who can communicate the views and interests of the person, such as a family member or advocate, should decide whether the medicines can be stopped or given in a different form, or whether it is in the person's best interests to be given the medicines without their knowledge. Check whether the person has made an advance decision. Medicines should not be given covertly unless agreed at this meeting.
- Keeping records: record capacity assessment and best interests decision and update care plan, to provide clear authorisation to care staff to give medicines covertly if that is in the person's best interests.
- Making a plan: seek advice from pharmacist for how to administer the medication.
- Regular reviews: the appropriate people (e.g. including the prescriber) should regularly review the decision to give medicines covertly to check whether it is still needed.

For urgent decisions, the guide says these can be made in discussion between the care staff, prescriber and family or advocate, as long as a formal best interests meeting is arranged as soon as possible.

(3) Involving others:

The guide says care staff should be aware of the role of other professionals in any decision to give medicines covertly:

- Prescriber (the person prescribing a medicine e.g. a doctor, pharmacist or nurse) to complete a medication review, which may help avoid the need for covert administration if the medicine can be stopped or given in a different form; to undertake a mental capacity assessment; and to lead on the best interests decision.
- Pharmacist to help make the best interests decision and to give advice as to how the medicines can safely be given without the person's knowledge. They can also undertake medicines reviews.
- Attorney appointed for health and welfare decisions to represent the person and their preferences (lasting power of attorney).
- Independent mental capacity advocate (IMCA) to give an independent view of what is in the person's best interests, where the person lacks capacity and doesn't have friends or family or an attorney to support them.

Comment

This is a helpful guide and the role of the prescriber is of particular interest. But it is important to note that: (i) if there is an attorney for health and welfare decisions, it is the attorney that will be responsible for making the best interests decision, in consultation with relevant others; (ii) it is not the role of an IMCA to give a view on the person's best interests; and (iii) whilst the prescriber has a key role to play, those needing to rely upon the defence to liability in MCA s.5 will be those administering the covert medication.

Alcohol, capacity and vulnerability

Alcohol Change UK has published a report

highlighting the role of alcohol being "missed or poorly managed" in the care of vulnerable adults, contributing to their death.

The report analyses all 11 Safeguarding Adult Reviews from England in which alcohol was identified as a significant factor in the person's life and/or death. The findings of the report are stark indeed. In 2017, 5,507 deaths in England were directly attributable to alcohol. Vulnerable adults were found to be particularly at risk. The overarching finding was that, perhaps unsurprisingly, most of the adults featured in the reviews had multiple complex needs in addition to alcohol misuse, including mental health problems, chronic physical health conditions, neurological conditions caused by alcohol, self-neglect, exploitation by others, unfit living conditions, and experiences of a past traumatic event such as bereavement and physical or sexual abuse. In almost all cases, support services failed to cope with that complexity. Although many of these people had dozens or even hundreds of interactions with social workers, paramedics, GPs, police, A&E departments and others, the professional working with them had not received adequate training to identify and address the alcohol elements of the situation. This meant that risks posed by alcohol were missed, under-estimated or poorly managed. In some circumstances, alcohol-dependency and self-neglect were treated as a 'lifestyle choice'. This led to further barriers in the care of these people – or even the withdrawal of care; and their untimely deaths.

Two key themes emerge from the reviews. First, a significant number of reviews (6 of 11) indicated that vulnerable adults were being exploited and abused. Their vulnerability stemmed from a range of circumstances, from severe mental health problems to disability. The cause of death in three of these cases was murder or injury from physical abuse. Second, four of the reviews involved men who had become unemployed, lived alone and lost contact with their families. The cause of death in these cases was related to self-neglect and refusal of care from services. Despite the Care Act 2014 identifying people with alcohol problems as possibly needing care and support, there is little guidance in applying this legislation, or the Mental Capacity Act 2005, to this group of people.

The report describes "*a significant gap in frontline workers' knowledge about applying the Mental Capacity Act (2005) and the Care Act (2014) to this group, linked to a lack of national guidance on this*." The report states, worryingly:

> *Eight of the reviews highlight the lack of understanding of mental capacity by frontline practitioners: both as a concept that could be applied in these cases and in terms of how to apply and assess it in practice. Mrs A's review observes that "some practitioners […] have a broad understanding of mental capacity principles […] but not detailed knowledge (p. 21). Adult A's review recommends strengthening knowledge with respect to the Mental Capacity Act (2005) and how to conduct referrals to the Office of the Public Guardian and the Court of Protection (p. 47). Carol's review comments that, "Among professionals, the understanding of mental capacity and how to assess it is not robust, which impacts upon professionals responding effectively to cases which are complex, limiting the risk assessment and professional response"* (p. 23)

Going forward, the report advises that:

> *At the national level, work is required to clarify how the Mental Capacity Act and the Care Act should be intelligently applied to vulnerable adults who are misusing alcohol. In particular, the challenges of applying the concept of self-neglect to substance misusers and applying the Mental Capacity framework to people with fluctuating capacity need to be urgently addressed if more unnecessary deaths are to be avoided.*

The report makes 10 recommendations, including the following two which are relevant to the Mental Capacity Act 2005:

- The Mental Capacity Act 2005 Code of Practice should be amended to include specific guidance for working with individuals with alcohol misuse or dependence, especially when they are likely to have complex needs.
- National guidance should be produced on applying the Mental Capacity Act 2005 to people with fluctuating capacity due to alcohol misuse.

This report makes for troubling reading. We agree that the revision of the Code of the Practice provides a golden opportunity to revisit the issues arising in alcohol-related cases, and that these issues deserve specific attention in the revised Code of Practice.

The FCA and vulnerable customers

The Financial Conduct Authority (FCA) is publicly consulting on guidance for firms on the fair treatment of vulnerable customers. It will proceed in two stages. The first stage sets out the draft Guidance in three main sections:

1. Understanding the needs of vulnerable consumers.
2. Ensuring staff have the skills and capabilities needed.
3. Translating that understanding into taking practical action.

The second stage is to consult on revised draft Guidance, publishing a cost-benefit analysis alongside it. The consultation is currently at the first stage.

The consultation document defines a vulnerable consumer as "*someone who, due to their personal circumstances, is especially susceptible to detriment, particularly when a firm is not acting with appropriate levels of care.*" This definition is deliberately broad and the Guidance applies to persons who either are, or may be, in vulnerable circumstances, which is to be welcomed.

The draft Guidance relies on a number of Principles requiring firms to treat all customers fairy, including those who are, or are potentially, vulnerable. The principles include the requirement to pay due regard to the interests of its customers and treat them fairly. The draft Guidance does not itself provide a checklist of required actions but provides options for ways in which firms can comply with the Principles, such as:

- Understanding the needs of vulnerable customers: Firms should understand the needs arising from different vulnerabilities.
- Skills and capability of staff: Firms should ensure that staff have the appropriate skills and capability to understand the needs of

individual vulnerable customers and respond appropriately to the needs of vulnerable customers.

- Product and service design: Firms should consider the positive or negative impacts of a product or service on vulnerable customers and should consider the needs of vulnerable customers at all stages of product and service design.
- Customer services: Firms should ensure their customer service provision meets the needs of vulnerable customers, delivering good flexible customer service that responds to the needs and situations of the customer, and provide specialist services where appropriate.
- Communications: Firms should take steps to ensure vulnerable customers are not disadvantaged in understanding products and services, and should take into account vulnerable customers' information needs.
- Monitoring and evaluation: Firms should regularly monitor the extent to which they are doing what they should under the Principles in terms of treating vulnerable customers fairly.

Whilst this draft Guidance is undoubtedly to be welcomed for focusing the spotlight on vulnerable customers, particularly those who may be at risk of financial abuse, it remains to be seen whether it really has enough "teeth" to protect vulnerable consumers. The aspirations are laudable but the Guidance itself is just that: guidance. It is not legally binding and does not create any additional obligations on firms. Nonetheless, we hope that it concentrates minds on the specific interests of vulnerable, or potentially vulnerable, customers and leads to positive changes in best practice across the financial sector.

Readers who would like to comment on the first stage of the FCA's consultation are encouraged to respond by 4 October 2019 by email to: ApproachtoConsumers@fca.org.uk or by post to: Consumer Strategy Team, Financial Conduct Authority, 12 Endeavour Square, London, E20 1JN.

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:

1. The fascinating and important article collection in Frontiers Compulsory Interventions in Psychiatry: an Overview on the Current Situation and Recommendations for Prevention and Adequate Use.
2. The papers/presentations by Professor Anselm Eldergill to the Academy of European Law on the ECHR, the UNCRPD and the legal rights of citizens suffering mental ill-health; the rights of persons with disabilities in criminal proceedings; and the ECHR and mental health.

SCOTLAND

Scott Review Terms of Reference

In the April Report we welcomed the announcement by the Minister for Mental Health, Claire Haughey, of an extended independent review to cover mental health, adults with incapacity, and adult support and protection legislation, into which current work on adults with incapacity legislation is to be subsumed. In the June Report we welcomed the appointment of John Scott QC to chair the review. Following extensive consultation and discussion, the terms of reference for the review have now been finalised and publicised, and are available here.

The focus on "mental disorder" in the first sentence of the terms of reference reflects the particular concerns forming the starting-point for the Minister's initiative in establishing the review, which we continue to commend and support. The full terms of reference nevertheless reflect a wider review, and indeed set no explicit limiting boundaries. John Scott has confirmed that it is his intention that the review should take account of the needs of everyone within the scope of the existing three Acts, and of people making provision for possible future circumstances within that broad ambit. John has also confirmed that the review team will be consulting further on how to get lived experience at the heart of the review. In doing this they will take account of the Wessely Review (of mental health legislation in England & Wales).

We also welcome the news that Jill Stavert and Colin McKay will be joining John Scott as part of the review team. As readers of the Report know, Jill is a contributor to this Scotland section and her details appear at the end of the Report. Colin is Chief Executive of the Mental Welfare Commission for Scotland. Together they were primarily responsible for "Scotland's Mental Health and Capacity Law: The Case for Reform", published jointly by Jill's Centre for Mental Health and Capacity Law, Edinburgh Napier University, and the Mental Welfare Commission in May 2017. They will bring huge knowledge and experience to the review team, and their involvement emphasises the prime placement of "the Case for Reform" in the list of previous and ongoing work in the terms of reference.

Adrian D Ward

Independent Review of Learning Disability and Autism in the Mental Health Act : Stage 3 Consultation

The Independent Review of Learning Disability and Autism in the Mental Health Act has now reached its Stage 3 and is now consulting on possible changes to the Mental Health (Care and Treatment)(Scotland) Act 2003 and for persons with learning disability and autism. Full, and once again very accessible, details about the consultation and guidance on how to respond can be found here.

The consultation ends on 1st November 2019.

Jill Stavert

Guardianship ordered despite adult's opposition; failure to ensure legal representation of adult's position

The case of *West Lothian Council, Applicant* was decided in Livingston Sheriff Court by Sheriff S A Craig on 27th January 2017, and has now been

noted at 2019 GWD 25-412. The Council sought appointment as welfare guardian to an adult who opposed the application. It was accepted that the adult met the criteria in section 58 of the Adults with Incapacity (Scotland) Act 2000. Evidence was led by the applicant that in relation to ability to consent to sex and related matters, the adult lacked capacity to make informed decisions and lacked a functioning memory. She had had sex several times, and was highly vulnerable to exploitation. She lived in accommodation that was said to be unsuitable. She required to live somewhere that provided 24-hour care. The local authority sought powers *inter alia* regarding with whom the adult had contact and her place of residence. The adult opposed the proposed orders on the grounds that they were not necessary to safeguard her personal welfare. The sheriff accepted the evidence led by the applicant. She concluded that the adult was likely to seek out relationships which might place her at risk. She also held that the adult was secretive and lacked candour when dealing with professionals. The sheriff confirmed that the adult's views had been taken into account, but in all the circumstances the powers sought were required. They met the statutory requirements. They were the least intervention required. They were proportionate in all the circumstances. They were necessary to protect her.

The order was granted as craved, for a period of three years.

Two points are worthy of comment. Firstly, the adult participated in the hearing, accompanied by her support worker, but not represented by a lawyer. A solicitor represented the applicant authority. Another solicitor had been appointed curator ad litem, but agreed that granting the order was appropriate. There was thus no representation by a lawyer of the adult's position, raising significant doubts as to whether procedural fairness was achieved, and specifically whether there was compliance with article 6 of the European Convention on Human Rights. It is not explained why a curator ad litem, rather than a safeguarder, was appointed.

Secondly, it is not clear that the adult's wishes and feelings as to the importance that she attached to sexual experiences had been properly taken into account (as required by s1(4)(a) of the Adults with Incapacity (Scotland) Act 2000), or that the requirement for the minimum necessary restriction upon the freedom of the adult (in terms of s1(3)) had been complied with, or that her will and preferences in that regard had been respected and proportionality achieved (in accordance with article 12 of the UN Convention on the Rights of Persons with Disabilities). The cause for concern appeared not to be that the adult wanted to engage in sexual activity, but that the ways in which she did so exposed her to risk of harm. For compliance with the foregoing provisions, one would have expected to see at least careful consideration of appropriate ways to ensure that the adult might be supported towards achieving a non-exploitative relationship that did not place her at risk.

These two points are linked to the extent that compliance with the first might have ensured that the second be addressed.

Adrian D Ward

Downgrading of Mental Health Tribunal for Scotland

It has come to the attention of the Report that advertisements for a new President of the Mental Health Tribunal for Scotland, to be appointed upon retiral of the current President Joe Morrow, show a significant reduction in status of the role, which inevitably means a reduction in status of the Tribunal itself. In April 2017 the daily rate for the post was £677.27. We understand that the current daily rate is £696, and that the post currently attracts a pension. These terms reflect the significant responsibility and status of the post, with the major human rights issues and responsibilities attaching to a jurisdiction in which, uniquely, people can be subjected to treatment and deprived of their liberty without their consent. The post also includes responsibility for shrieval cases concerning compulsion orders and restriction orders. Without apparent consultation or even public announcement, the advertisement indicates a daily rate of £550, with travel and subsistence expenses, but with no pension contribution.

It is not easy to understand how this downgrading of the presidency and of the Tribunal can be reconciled with the current policies of Scottish Government, and in particular of the Minister for Mental Health. See for example the terms of reference for the Scott review, recently announced, as set out in the first item.

Adrian D Ward

Retired Sheriff Brian Kearney

We have noted with great pleasure the award of honorary membership of the Law Society of Scotland to retired Sheriff Brian Kearney, at the Society's Special General Meeting on 6th September 2019. Sheriff Kearney was a well-known practising solicitor before he became a sheriff. While he could not be said to have been a specialist in what became adult incapacity practice, he has always had a keen interest in training. As a sheriff, his role with Judicial Studies Committee (which subsequently became Judicial Institute) included promoting training for sheriffs upon the Adults with Incapacity (Scotland) Act 2000 as soon as it was passed and before any of its provisions came into force, then setting a pattern for regular training on the Act which has continued ever since. Following his retiral from the Bench he became Education Convener for the Royal Faculty of Procurators in Glasgow, and again frequently included adult incapacity and related topics in the Faculty's training events. He is noted mainly for his contribution to child and family law, including as an author, and particularly in relation to the children's hearings system. His judicial career can best be characterised by his passion for making the law accessible and understandable, and by the example that he was one of the first sheriffs who wrote to children to explain his Judgments. He has made a major contribution to the development of Scots law and the humanising of practice of it. His authorship activities continue, even although for health reasons his award was accepted on his behalf by his son Paul, who is an advocate.

Adrian D Ward

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. 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.

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 contributing editor to Clayton and Tomlinson 'The Law of Human Rights', a contributor to 'Assessment of Mental Capacity' (Law Society/BMA 2009), and a contributor to Heywood and Massey Court of Protection Practice (Sweet and Maxwell). To view full CV click here.

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. To view full CV click here.

Annabel Lee: annabel.lee@39essex.com

Annabel has experience in a wide range of issues before the Court of Protection, including medical treatment, deprivation of liberty, residence, care contact, welfare, property and financial affairs, and has particular expertise in complex cross-border jurisdiction matters. She is a contributing editor to 'Court of Protection Practice' and an editor of the Court of Protection Law Reports. She sits on the London Committee of the Court of Protection Practitioners Association. To view full CV click here.

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 4th edition of the *Assessment of Mental Capacity: A Practical Guide for Doctors and Lawyers* (BMA/Law Society 2015). To view full CV click here.

Editors and Contributors

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.

Katherine Barnes: katherine.barnes@39essex.com

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.

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.

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; 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

Conferences

Conferences at which editors/contributors are speaking

Liberty Protection Safeguards: Implementation of the Mental Capacity (Amendment) Act 2019

Alex is chairing and speaking at a conference about the LPS on Monday 23 September in London, alongside speakers including Tim Spencer-Lane. The conference is also be held on 5 December in Manchester. For more information and to book, see here.

Clinically Assisted Nutrition and Hydration Supporting Decision Making: Ensuring Best Practice

Alex is speaking at a conference about this, focusing on the application of the BMA/RCP guidance, in London on 14 October. For more information and to book, see here.

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.

.

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 October. 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.

Michael Kaplan
Senior Clerk
michael.kaplan@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