39 Essex
CHAMBERS

MENTAL CAPACITY REPORT: THE WIDER CONTEXT

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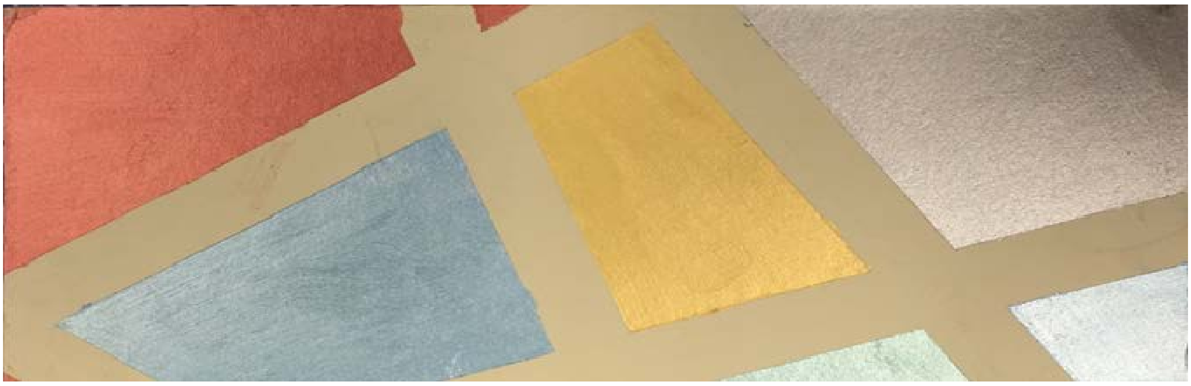

Welcome to the February 2023 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: is depriving a person of their phone depriving them of their liberty, a reminder that the court is the ultimate arbiter of best interests and an Ombudsman comes belatedly to the rescue;

(2) In the Property and Affairs Report: a reminder of the new process for applying for deputyship and how the Powers of Attorney Bill would amend the MCA 2005;

(3) In the Practice and Procedure Report: the Vice-President intervenes on s.49 reports and new contempt rules;

(4) In the Wider Context Report: Parliamentary consideration of the draft Mental Health Bill, a toolkit for supporting decision-making, and confidentiality and common sense;

(5) In the Scotland Report: the Supreme Court dismisses an appeal against assessment for services and an opposed application for guardianship.

You can find our past issues, our case summaries, and more on our dedicated sub-site here, where you can also sign up to the Mental Capacity Report.

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

Contents

CQC 'Covert administration of medicines' guidance

The CQC has produced guidance for adult social care services for situations when medicines are administered in a disguised format. It can be seen as building upon the case law relating to covert medication, most notably *AG v BMBC* [2016] EWCOP 37, *A Local Authority v P* [2018] EWCOP 10, and *Re A* [2022] EWCOP 44. Those cases recognise that deliberately disguising the administration of medicine where a person refuses it requires a legally thoughtful approach to ensure Article 8 and MCA 2005 compliance.

The CQC's guidance emphasises the right to refuse medicines [1] and suggests that covert administration is *"only likely to be necessary or appropriate where:*

- *a person actively refuses their medicine and*
- *that person is assessed not to have the capacity to understand the consequences of their refusal. Such capacity is determined by the Mental Capacity Act 2005 and*
- *the medicine is deemed essential to the person's health and wellbeing."*

In terms of the best interests process, the guidance states it *"must be a multi-disciplinary team decision:*

- *you can hold a 'best interest' meeting remotely but you should keep clear records of who was involved and what was agreed*
- *involve care staff, the health professional prescribing the medicines, and a family member or advocate, to agree whether administering medicines covertly is in the person's best interests*

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[1] Self-evidently, outside the context of the Mental Health Act 1983.

- *the decision must not be taken alone.*

The decision is medicine-specific, so the necessity for covert administration must be identified for each medicine prescribed. Moreover, "[e]*ach time new medicines are added or the dose changes of an existing medicine, you must:*

- *identify the need again*
- *make and record further 'best interest' decisions."*

It goes on to caution:

> *Some medicines can become ineffective when mixed with certain foods or drink. Crushing a tablet or opening a capsule before administration may make its use 'off-licence'. You must tell the prescriber if medicines are being administered in this way. Altering the characteristics may change a person's response to the medicine.*
>
> *For example, crushing a tablet designed to release slowly over 24 hours might result in overdose. Or it could increase any adverse effects due to the whole dose being released too quickly.*
>
> *Always take pharmaceutical advice from an appropriate healthcare professional. You must make sure medicines remain safe and effective when prescribed for administration covertly.*

With regards to the difficult situation where a person's decision-making ability fluctuates, the guidance suggests *"the service should have a covert plan in place. You must only use the plan when the person lacks capacity*".

The following should be included in any covert medicine care plan:

- *actions taken to give medicines in the normal manner*
- *how medicines will be administered covertly*
- *specialist input to show suitability of the method chosen, for example crushed or mixed with certain food or drinks*
- *whether the medicine is unpalatable*
- *adverse effects (actual or perceived)*
- *swallowing difficulties*
- *lack of understanding about what the medicine is for*
- *lack of understanding of the consequences of refusing to take a medicine*
- *ethical, religious or personal beliefs about treatment*
- *what to do if the person refuses food or drinks.*

Moreover, "[m]*edicines administration records should clearly record which medicines you administer covertly and when. This is particularly important for people with fluctuating capacity."*

Revised certificate as to capacity to conduct proceedings published

A revised version of the form used to address (and where the person lacks the capacity, to explain in detail why that is the case) capacity to conduct proceedings has now been published. Although it says on gov.uk that it is dated 1 September 2007, it is in fact current as to the law in 2023 (including, importantly, the proper ordering of the capacity test: starting with the functional limb). It is relevant where there is a concern in relation to the capacity to conduct proceedings in relation to an adult who is a party or intended party to proceedings in the Family Court, the High Court, a county court, the Court of Protection or the Court of Appeal. Note, however, that it does not apply in relation to 'P,' i.e. the subject of proceedings before the Court of Protection: analysis of their capacity to conduct proceedings (and make relevant decisions) is to be carried out on the COP3 form (itself being revised at the moment).

The National DoL Court in action

The Nuffield Family Justice Observatory have published their report "An analysis of the first two months of applications at the national deprivation of liberty court." This is an analysis of first two month of applications listed in the national deprivation of liberty (DoL) court at the Royal Courts of Justice, which is running for a pilot period of 12 months. The DOL court deals with all applications issued in England and Wales for authorisation to deprive children of their liberty under the inherent jurisdiction of the High Court. The report[2] makes for sobering reading. It found that:

> *children who are subject to DoL applications are extremely vulnerable. They typically have multiple and complex needs that are evident in behaviours that can make them a risk to themselves or others. Some have severe physical or learning disabilities, some have been subject to criminal or sexual exploitation. Most have experienced significant adversities such as rejection, bereavement, abuse and neglect during their childhoods.*

The report goes on to note that

> *Although their needs may have recently escalated, the vast majority of children who are subject to DoL applications are well known to statutory services. For many children, their emotional and behavioural difficulties are evident from late childhood. It is clear that they need far better support at an earlier stage.*

For those of us who practice in this area, the finding that "[t]*oo few placements were available that could meet the complex needs of children*" is sadly unsurprising. The report goes on to note that in just under half of applications, children were going to be placed in unregistered settings (45.6%) – this included the use of semi-independent (unregulated) placements, hospitals, residential homes that were Care Quality Commission (CQC) but not Ofsted-registered, and rented flats or holiday lets staffed with agency workers. The report found that

> *children with learning and physical disabilities were less likely to be placed in an unregistered setting. In contrast, where the DoL application was primarily related to concerns around self-harm, risk to others and/or criminal exploitation, children were more likely to be placed in an unregistered setting. This may indicate a particular lack of sufficient and suitable placements for children with these needs.*

The report concludes by underlining:

> *the urgent need to develop new provision, at a local level, with joint input from children's social care, mental health services and schools. It is not something that can be left to chance. It will require a nationwide strategy, with significant commitment at local and national level, including national government.*

Safety and wellbeing reviews: lessons learned

NHS England has published the results of their review of the safety and wellbeing of every person with a learning disability and all autistic people who are being cared for in an inpatient

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[2] Which only looks at the applications themselves, rather than the outcomes, which will be the subject of a further report.

setting in England as at 31 October 2021. The findings included that 3% of people required a safeguarding referral to address significant concerns that were identified, and that only 59% of them had care and treatment needs that could only reasonably be delivered in hospital. 57% were placed out of area. The report noted that '*there were examples of individuals being placed in psychiatric intensive care units on a long-term basis because 'there was nowhere else to go'*" and suggested that the current approach to commissioner oversight of care might not be working. Yet again, people were experiencing high levels of restraint, seclusion and segregation, and the MCA was not being consistently applied. People were being harmed by admission as a result of inactivity and weight gain, which increased the likelihood of health problems and premature mortality. The review notes that these findings are neither unexpected nor new.

EHRC inquiry into challenging adult social care decisions

The Equality and Human Rights Commission has published the result of its inquiry into Challenging Adult Social Care Decisions in England and Wales. The EHRC found that the system was failing those who need it, and made a number of recommendations including that local authorities need to review whether they are providing properly accessible information, and whether their advocacy services are effective.

Mediation of Medical Treatment Disputes: A Therapeutic Justice Model – help wanted

Dr Jaime Lindsey, of the University of Essex, would like your help if either:

1. You have been involved in a medical treatment mediation in England & Wales over the past 10 years (involving either an adult or a child), and want to take part in an interview about it; or
2. You are a mediator who might be involved in a medical treatment mediation over the next 13 months, and might be able to assist in enabling observation of the mediation.

Please all rush at once to help Jaime, as this is very important work (to learn more about it, see here).

Suffer not the (soon to be born) little child

Kettering General Hospital NHS Foundation Trust v C and North Northamptonshire Council [2023] EWHC 239 (Fam) (Hayden J)

Other proceedings – family (public law)

Summary

This application was made by Kettering General Hospital NHS Foundation Trust for anticipatory declarations relating to the unborn child of 'C.' C was 37 weeks pregnant, and was HIV-positive. It appears that she contracted HIV in the course of receiving childhood vaccinations in Romania. C had taken one dose of anti-retroviral treatment in 1999, but had since declined it. She felt that she would avoid the ill effects of AIDS by diet and vitamins, despite apparently many efforts by doctors to persuade her to take the treatment over the years in both Romania and the UK.

C had continued to decline anti-retroviral treatment during pregnancy and objected to her baby being given the treatment after birth. C's objection to the medication was that it made her feel unwell, with vomiting and dizziness. It is noted in the judgment that she had agreed to take the medication on several occasions and attend the hospital to do so, but on arriving at the hospital had declined (it also appears that she was given drugs to take at home, but it is not clear whether she had taken those).

C was due to give birth by elective caesarean section the day after the case was heard. The Trust sought an order to commence the administration of anti-retroviral treatment for the baby immediately after birth, for a period of four weeks; Hayden J noted that "[c]*ritical to the prospects of success for this treatment is that it should commence within 4 hours of the birth*" (paragraph 2).

The medical evidence in support of this treatment for the infant was overwhelming. Because C appeared not to have taken retroviral therapy in pregnancy, the baby would need a course of three separate drugs for four weeks after birth to offer the best chance of preventing HIV positive status. It was also recommended that C take certain drugs immediately before and during delivery, which she said she would take, but previous agreements to take medication had not been seen through. The Trust considered that even if C stated that she would consent to the baby's treatment after birth, she was likely to rescind this consent. It was also noted that C and her partner had gone to a number of different hospitals, it appeared to avoid pressure to take retroviral medication.

Hayden J considered the scope of his powers under the inherent jurisdiction as it applied to a child who had not yet been born. He noted that he was <u>not</u> exercising the powers of the Court of Protection in respect of C, and made no findings that she lacked capacity:

> *16 […] It is also important to state that no jurisdiction arises under the Mental Capacity Act 2005, in the Court of Protection. The fact that C's views in relation to the proposed treatment may be entirely out of step with received medical opinion, does not challenge and certainly does not rebut, the presumption that she is capacitious to take the decision herself. Very recently in NHS Surrey Heartlands Integrated Care Board v JH [2023] EWCOP 2, I made the following observation which strikes me as having resonance here:*
>
> > *"[22] JH has long been of the belief that his stomach pains are in some way related to his Asperger's Syndrome. He has held this view for most of his adult life. It is misconceived. But many people hold irrational, inaccurate or even superstitious views in relation to their own health. In the context of Covid-19 vaccinations, a significant cohort of people do not accept or trust the accuracy of orthodox, peer-reviewed medical opinion and guidance. None of this is to be equated with lack of capacity. It is simply a facet of human nature."*

At the time the application was heard, C was in hospital, preparing for the caesarean section. It appears that the application was made without notice to C, though for reasons that are not clear, C was also listed as a party to the proceedings. Hayden J considered that:

> *17. […] the Court is required to consider an application made in the absence of C. It is elementary that C has rights, pursuant to Articles 6 and 8 of the European Convention of Human Rights (ECHR), to be fully involved in the planning both for the birth of her baby and the baby's postnatal care. These principles are reflected in the ECHR case law e.g., W v United Kingdom (1988) 10 EHRR 29 at paras [63]–[64], McMichael v United Kingdom (1995) 20 EHRR 205 at para [87] and Re G (Care: Challenge to Local Authority's Decision) [2003] EWHC 551 (Fam), [2003] 2 FLR 42, at paras [30]-[31], [35]-[36]. However, the Article 8 and*

> *6 rights engaged are not absolute rights and require to be balanced against other competing rights and interests. The ECHR has recognised that there will be, circumstances where parental involvement must yield to alternative rights, particularly where the interests of children are engaged. Without notice applications, in this sphere, have been endorsed as compatible with the Convention in a number of cases, see: Haase v Germany [2004] 2 FLR 39; Venema v The Netherlands [2003] 1 FLR 552. Many of the cases arise in the context of emergency protection orders where the ECHR has emphasised that it is for the state to establish that a careful assessment of the impact of the proposed measure on the parents and child was carried out, prior to the implementation of the plan, as well as careful consideration of the possible alternatives. These principles of proportionality resonate throughout the whole of the European jurisprudence…*
>
> 20. […] *when considering whether this case can proceed in the absence of C, it must be justified as both necessary and proportionate. There must be compelling reasons for justifying what must be regarded as an exceptional procedure. Munby J described it as "at the extremity of what is permissible under the Convention" and "a highly exceptional course of conduct", echoing the language of the ECHR in P, C and S v United Kingdom (2002) 35 ERR 31, [2002] 2 FLR 631.*

Hayden J made clear that the application of this principle would be fact-specific.

The Official Solicitor acted as amicus in C's absence in the circumstances set out in paragraph 18 of the judgment:

> *This application was made on 23rd January 2023. I was informed of it at 11:30am. Fortunately, I was able to accommodate it quickly. I signalled that I could hear it by 12pm. In the event, due to difficulties in instructing Counsel, the case was heard at 2pm. Cafcass, understandably, were unable to assist, given the child is not yet born. Nonetheless, I was concerned about the proportionality of proceeding in circumstances where C had purposely not been informed of the hearing. For this reason, I asked counsel for the applicant Trust, Mr Patel KC, to ask his team to make enquiries as to whether the Official Solicitor might be prepared to act as amicus. Ms Castle, the Official Solicitor, readily agreed and I am extremely grateful to her for doing so. Counsel, Miss Gollop KC was instructed.*

In considering the substance of the case, Hayden J noted that C was stating that she was taking retroviral medication, and that she would agree to the baby having it after birth. However, it was also clear that C was very anxious about the treatment, and C had told one of her treating doctors that *'if her baby vomited, she would most likely stop the baby from receiving further medication as she "knows how bad it was for her".'* [24] The court was clear in its findings that C was motivated to do what was best for her baby, but she remained very hesitant in respect of the treatment. Hayden J summarised the risks thus:

> *27. Thus, the identifiable risks here are stark and, to some degree, complex:*
> *i. Based on the history, it is possible that C may simply not co-operate with the birth plan at all;*
> *ii. It seems unlikely that C has been taking the retroviral medication in the period leading up to her birth, thus increasing the risk of infection in labour;*
> *iii. C has a heavy viral load, a poor immune system and has not really ever taken anti-retroviral medication, at any stage since her initial infection. Accordingly, there is risk that her baby*

> *will already have been infected i.e., during the course of the pregnancy. This, in conjunction with (ii) above, renders it necessary for the baby to have retroviral medicine almost immediately on birth in order to have the best chance of becoming HIV negative. Thus, time is of the essence!*
> *iv. There is a later risk that C's initial co-operation with the baby's medication may be withdrawn if she considers the baby to be sick.*

Hayden J considered that only an anticipatory declaration could ensure that the baby was treated in the timeframe which was considered to be crucial for success. The court accepted that C might carry through with her statements that she would give consent to the treatment, *"but it is certainly not possible to be confident that it will. On the baby's birth, it is, to my mind, redundant of contrary argument that it will be the baby's best interest to receive the medication offering the best chance of avoiding infection"* (paragraph 28).

The Official Solicitor tested in the evidence in the matter, and initially submitted that "the exceptional' circumstances required to justify a declaration of this kind being made, in the absence of C, were not met in this case." However, the Official Solicitor ultimately argued that, if Hayden J *"considered that the "exceptional" criteria identified in the case law were met, they would not press against it. I am entirely satisfied that the circumstances in this case, do meet those criteria. The fact that the baby may be able to live with HIV does not mean that he should. It is wholly contrary to his best interests. The doctors and medical team are entirely right to identify the immediate medical treatment as an imperative which establishes a secure basis for what remains an exceptional declaration"* (paragraph 30).

The judgment included a postscript which set out that the matters had proceeded well after the baby's birth:

> *31. In the paragraph above, I have referred to the baby by the male pronoun. As I was concluding this judgment, I was notified that the birth went well. C complied with the anti-retroviral medication immediately prior to the caesarean. Her baby boy is doing well. I have been told that both parents are expressing clear consent to the 28-day treatment regime. I hope that when they read this judgment, they will understand why the Court has taken the course it has. I should also like to extend my congratulations to them on the birth of their son.*

Comment

This matter before the court was one of the utmost urgency, with the happy outcome being that the child's family and treating team worked together to offer treatment to C's child which would dramatically reduce his risk of becoming HIV-positive.

The procedural history is perhaps less apparent on the face of the judgment. C was joined as a party to proceedings, but apparently not notified of the application while it was being considered. It is not clear from the face of the judgment precisely why C was not notified, as no specific findings were made on this point; however, in the context of the judgment, it appears that doctors were concerned that she might attempt to give birth at a centre where she was not known and retroviral treatment would not be insisted upon.

As regards the involvement of the Official Solicitor, it is clear from the face of the judgment that this was on not the basis that C lacked capacity to participate in the proceedings. On the face of it, the Official Solicitor's appointment as amicus was not in line with the position conventionally adopted (and recorded in the near contemporaneous Practice Note about urgent hearings issued jointly with Cafcass) that the Official Solicitor does not act in medical treatment cases in the Family Court/Family Division on behalf of the child. However, paragraph 18 gives the clue, namely that Cafcass considered that it could not act in a case where the child was not yet born (it would, perhaps, have been interesting to note what Cafcass' position would have been had it attended as regards the court's jurisdiction to make any order in respect of the child).

Andrew Wakefield's malign influence lingers on

In the Matter of B [2023] JRC 008 (Sir William Bailhache, Commissioner, sitting with Jurats Christensen and Hughes)

Mental capacity – assessing capacity

Summary

This was an application brought by the Jersey Minister for Health and Community Services for authorisation 'to procure that' that a man identified as B had vaccinations and boosters in respect of the Covid virus and against influenza. This application was necessary because B's father had previously been appointed by the Royal Court as health and welfare delegate for his son and objected to the vaccinations being given. Under the scheme of the Capacity and Self-Determination (Jersey) Law 2016, the Royal Court retained ultimate decision-making authority, notwithstanding the father's appointment.

This was the latest application in long running proceedings concerned with the medical treatment and care and living arrangements of a young man with profound physical and mental disabilities. Following an earlier hearing, B had moved to a care home to live with four other adults with profound disabilities, all of whom had been vaccinated against Covid and influenza.

Commissioner Bailhache made it plain that the Capacity and Self-Determination (Jersey) Law 2016 "*follows closely the provisions of the Mental Capacity Act 2005, and accordingly that decisions of the English Courts under that Act may have particular relevance to us in Jersey.*"

The court heard from Dr Ivan Muscat, a consultant microbiologist, who was the Deputy Medical Officer of Health and acted as one of the island's liaison clinicians with the Joint Committee for Vaccination and Immunisation (which advises United Kingdom health departments on immunisation). It also heard from Dr Adrian Noon, the medical director for primary care. The parents did not place any medical evidence before the court, but the Commissioner recorded this about their reasons for objecting to the vaccinations being given:

> *They believe strongly that it was the result of an MMR vaccine delivered in October 1991 when the First Respondent was approximately 16 months old that his health suffered leading to the chronic neurological disease which he now has. They were advised by Dr Andrew Wakefield that this was so – that the MMR vaccine might lead to behavioural regression and pervasive developmental disorder in children. Indeed, the First Respondent was one of The Lancet Twelve, so named after the article in The Lancet which made those various claims in relation to the safety of the MMR vaccine in or about 1997.*

The Commissioner went on to analyse the accuracy of the parents' account of the impact of the MMR vaccine and found that it was not borne out by the contemporaneous medical records.

The court therefore found that it was in B's medical best interests to have the vaccinations.

The Commissioner further went on to consider the wider non-medical issues that arose in this case – namely that because B was unvaccinated he was being shielded so as to reduce his exposure to Covid. This meant that not only were staff required to wear masks when working with him, but his social interactions had to be restricted. This regime was having a serious impact on B – not only was he socially isolated but he could not participate in hydrotherapy or speech and language therapy (because the person delivering the therapy had to wear a mask).

Unsurprisingly, the Commissioner acceded to the application.

Comment

The Commissioner engaged in a careful weighing of the evidence before the court before coming to a decision on best interests, and the outcome is not surprising. What does not appear to have been considered, though, was the impact on ability of B's father to discharge his ongoing function as decision maker for health and welfare on behalf of his son, in circumstances where the father's beliefs about his son's health were rejected as being inaccurate by the court.

Assisted Decision-Making (Capacity) Act 2015 to be commenced

After a very protracted journey, including amendments introduced even before it had been implemented, it was announced on 24 February that today that Ireland's Assisted Decision-Making (Capacity) Act 2015 would finally be fully commenced on 26 April 2023.

This means, amongst other things, that from 27 April 2023:

- The Decision Support Service will be able to process applications for new decision support arrangements
- The Circuit Court will be able to process applications for Decision Making Representative Orders
- There will be statutory provision for the making and recognition of Advance Healthcare Directives
- Wardship will be abolished and the over 2000 wards of court which currently exist in the State will have a review of their circumstances undertaken by the wardship court and will exit wardship on a phased basis over the next three years.

For reflections on the journey to the Act, we strongly suggest (albeit with a bit of bias as there is a bit from Alex in it), the collection of essays edited by Mary Donnelly and Caoimhe Gleeson called *The Assisted Decision-Making (Capacity) Act 2015: Personal and Professional Reflections*, available for free here. This collection of essays, written from both personal and professional perspectives, highlights both the context for and different aspects of this ground-breaking piece of legislation. You can also watch a video of the launch of the book in November 2021 here. Contributors at the launch included Ms Aine Flynn, Director of the Decision Support Service, Professor Mary Donnelly, School of Law, UCC, Ms Caoimhe Gleeson, Programme Manager, National Office for Human Rights and Equality Policy, and some of the essay authors including Adam Harris, Claire Hendrick, Helen Rochford Brennan, Fiona Anderson and Suzie Byrne.

It is interesting to note that, even before the Act comes into force, it appears to be influencing at least some practitioners in Ireland. In *In the Matter of BW* [2022] IEHC 738, concerning the capacity and best interests of a young woman in respect of treatment for anorexia, Hyland J observed (at paragraph 12) that:

> *Dr. Cullivan goes through the various requirements of capacity that are now identified in the Assisted Decision-Making (Capacity) Act 2015, which is not yet in force but, nonetheless, these tests are being used frequently by medical practitioners when assessing capacity.*

Dr Cullivan concluded that BW did not have the functional ability to understand or weigh the relevant information, such that she lacked capacity to do so. Hyland J endorsed this conclusion, and therefore took steps on a best interests basis to provide for BW's transfer to a facility in England and Wales, there being no appropriate facility in Ireland.

From an English perspective, the conclusion as to BW's capacity is noteworthy because there was no express identification of a causative nexus between BW's anorexia and her functional inability to make the relevant decisions. This is required in England and Wales (see, authoritatively, paragraph 78 of *A Local Authority v JB* [2021] UKSC 52). Conversely, there is no such requirement in the Assisted Decision-Making (Capacity) Act 2015 which contains (in s.3) a purely functional test, with no 'diagnostic' element.

Narrowly, on the facts of BW's case, an interesting question arises – to which no reported decision appears to relate – as to whether and how the Court of Protection addressed in the proceedings for recognition and enforcement of Hyland J's order the fact that, on the basis of the judgment accompanying that order, BW would not be someone over whom the Court of Protection would have jurisdiction if considered through Anglo-Welsh eyes.

More broadly, many people, Alex included, will be looking with interest to see whether the test contained in the 2015 Act leads to a considerably broader approach to the identification of those lacking capacity to make material decisions in Ireland. Or will, in practice, a 'gatekeeping' function evolve by practitioners and courts identifying a need for an explanation of why the person cannot functionally make the decision, not simply that they cannot?[3]

Diversity, dignity, equity and best practice: a framework for supported decision-making

As part of ongoing work related to the Australian Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, the Living with Disability Research Centre at La Trobe University has published a huge (and hugely interesting) report seeking to set out a framework for supported decision-making. The authors (not all of whom are based at La Trobe) are Christine Bigby, Terry Carney, Shih-Ning Then, Ilan Wiesel, Craig Sinclair, Jacinta Douglas & Julia Duffy. They describe their aim in the opening of the report thus:

> *This research aimed to understand the significance of supported decision-making to the lives of people with cognitive disabilities, identify its essential elements common to anyone with cognitive disabilities in any context, and locate key implementation issues. For this Report, we understand people with cognitive disabilities to include people with intellectual disabilities, acquired brain injury, dementia and mental health conditions. Synthesising the research findings, this Report articulates the benefits of supported*

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[3] Real enthusiasts might want to look at section V of this paper co-written by Alex.

> *decision-making, sets out nine principles and eight essential elements of a 'Diversity, Dignity, Equity and Best Practice Framework for Supported Decision-making' and recommends implementation strategies.*

The report may not, perhaps, be quite the last word in this area (it leaves unaddressed, for instance, the question of whether there are some limits to support based not upon risk, but upon the nature of the decision – e.g. very personal decisions such as sex or marriage). However, it makes essential reading for anyone who wants to understand the point of supported decision-making, why it is a confusing phrase[4] (but how to navigate what it really means), and how to think about it in a practical fashion both within current legal frameworks and for purposes of developing those frameworks.

This also gives us the opportunity to flag the work that has already been done under the auspices of La Trobe University which should be much better known in the UK than it is: the La Trobe Supported Decision-Making Framework, the website and e-learning materials for which can be found here, and whose principles are applicable no matter the legal framework under consideration.

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[4] Alex would much prefer that the language of Article 12 CRPD was used in this context – i.e. support for the exercise of legal capacity – because that is what is required for compliance with the Convention; because it recognises that it is not just a matter of making decisions, but about acting upon decisions and implementing prior decisions; and because it avoids the sometimes bizarre linguistic tangles which arise in explaining that a decision which is (in fact) being constructed by someone else on the person's behalf may nonetheless represent a supported, rather than a substitute decision.

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Victoria regularly appears in the Court of Protection, instructed by the Official Solicitor, family members, and statutory bodies, in welfare, financial and medical cases. She is a contributing editor to Clayton and Tomlinson 'The Law of Human Rights', a contributor to 'Assessment of Mental Capacity' (Law Society/BMA), and a contributor to Heywood and Massey Court of Protection Practice (Sweet and Maxwell). To view full CV click here.

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

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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.

Rachel Sullivan: rachel.sullivan@39essex.com
Rachel has a broad public law and Court of Protection practice, with a particular interest in the fields of health and human rights law. She appears regularly in the Court of Protection and is instructed by the Official Solicitor, NHS bodies, local authorities and families. To view full CV click here.

Stephanie David: stephanie.david@39essex.com

Steph regularly appears in the Court of Protection in health and welfare matters. She has acted for individual family members, the Official Solicitor, ICBs 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.

Nyasha Weinberg: Nyasha.Weinberg@39essex.com
Nyasha has a practice across public and private law, has appeared in the Court of Protection and has a particular interest in health and human rights issues. To view a full CV, click here

Simon Edwards: simon.edwards@39essex.com

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

Adrian Ward: adrian@adward.co.uk
Adrian is a recognised national and international expert in adult incapacity law. He has been continuously involved in law reform processes. His books include the current standard Scottish texts on the subject. His awards include an MBE for services to the mentally handicapped in Scotland; honorary membership of the Law Society of Scotland; national awards for legal journalism, legal charitable work and legal scholarship; and the lifetime achievement award at the 2014 Scottish Legal Awards.

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

Jill Stavert is Professor of Law, Director of the Centre for Mental Health and Capacity Law and Director of Research, The Business School, Edinburgh Napier University. Jill is also a member of the Law Society for Scotland's Mental Health and Disability Sub-Committee. She has undertaken work for the Mental Welfare Commission for Scotland (including its 2015 updated guidance on Deprivation of Liberty). To view full CV click here.

Conferences

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

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

Advertising conferences and training events

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

Our next edition will be out in April. 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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Chambers UK Bar
Court of Protection:
Health & Welfare
Leading Set

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

For all our mental capacity resources, click here