HEALTH, WELFARE AND DEPRIVATION OF LIBERTY
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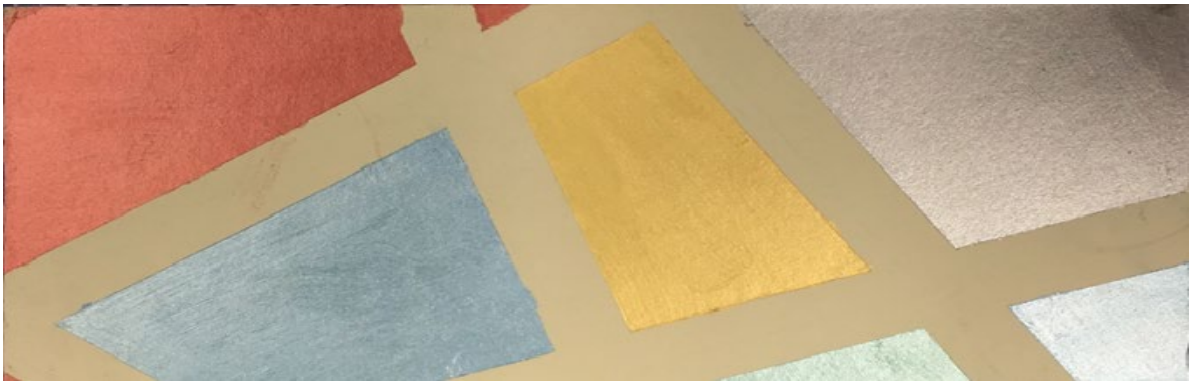

Welcome to the July 2025 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: what to do when an advance decision to refuse treatment may be in play, and the consequences of the gaps between services for those with disordered eating;

(2) In the Property and Affairs Report: capacity in the rear view mirror: how does the presumption work?;

(3) In the Practice and Procedure Report: disclosing position statements to observers; habitual residence, moving jurisdictions and 'lawful authority;' and the impact on P of being assessed;

(4) In the Mental Health Matters Report: progress of the Mental Health Bill and the tort consequences of a finding of Not Guilty by Reason of Insanity;

(5) In the Children's Capacity Report: a depressing snapshot from the national DoL court, human rights of children in the social care system and capacity and gender-affirming treatment;

(6) In the Wider Context Report: the Oliver McGowan statutory learning disability and autism training, and the pitfalls of facilitated communication

(7) In the Scotland Report: joint attorneys in dispute: appropriate remedies and; "If at first you don't succeed …": res judicata in tribunal proceedings.

The progress of the Terminally Ill Adults (End of Life) Bill can be followed on Alex's resources page here.

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.

Editors
Alex Ruck Keene KC (Hon)
Victoria Butler-Cole KC
Neil Allen
Nicola Kohn
Katie Scott
Arianna Kelly
Nyasha Weinberg

Scottish Contributors
Adrian Ward
Jill Stavert

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.

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Advance decisions to refuse treatment – what (not) to do when it appears one may be in play

Re AB (ADRT: Validity and Applicability) [2025] EWCOP 20 (T3) (Poole J)

Medical treatment – advance decisions

Summary

This is a (rare) example of a court having to grapple with advance decisions to refuse medical treatment. It is rare largely because ADRTs are rare, and also because (in our experience at least), issues relating to ADRTs are usually resolved outside court. The case has a very tangled and complex history, and important issues relating to whether the ADRT in question in fact ever existed in legal terms are still to be resolved. However, for wider and immediate purposes, the judgment is very important for the wider guidance given by Poole J at paragraph 53, in which he notes that:

> *There are few reported judgments concerning ADRTs and none have the unfortunate history of this case. The Trust has rightly accepted responsibility for failing to address the apparent ADRT in a proper and timely manner once it was brought to light. This case provides some important lessons for individuals who have made an ADRT or are contemplating doing so, for their families and friends, and for clinicians and NHS Trusts. They include:*
>
> *53.1 The MCA 2005 Code of Practice, paragraph 9.38 states:*
>
> > *"It is the responsibility of the person making the advance decision to make sure their decision will be drawn to the attention of healthcare professionals when it is needed. Some people will want their decision to be recorded on their healthcare records. Those who do not will need to find other ways of alerting people that they have made an advance decision and where somebody will find any written document and supporting evidence. Some people carry a card or wear a bracelet. It is also useful to share this information with family and friends, who may alert healthcare professionals to the existence of an advance decision. But it is not compulsory. Providing their GP with a copy of the written document will allow them to record the decision in the person's healthcare records."*
>
> *An ADRT will not be effective if the relevant people do not know it exists. In the present case the ADRT had not been placed in AB's medical records or provided to his GP before he sustained*

his brain injury. AB relied on friends to alert healthcare professionals of the ADRT but they did not do so for nearly four months after his brain damage was sustained. Any individual wanting to make an ADRT would be well-advised both to (i) provide a copy to their GP, and (ii) give clear instructions to anyone else to whom they provide a copy to bring it to the immediate attention of healthcare professionals in the event that the individual is unable to make decisions for themselves about their medical treatment.

53.2. Disputes about the authenticity of an ADRT may be rare but provision of the document to the individual's GP would avoid any later allegations that the document was made at a later date than appears on its face.

53.3. A signed, written ADRT that is valid and applicable to the clinical situation is legally binding on clinicians. There is no need for a best interests discussion because the patient has made their decision and it is to be treated as if it is their decision at the time when a question of treatment arises. The wishes of the family cannot override a valid and applicable ADRT nor can clinicians' views of the wisdom of the ADRT.

53.4. The RCP PDOC Gudelines 2020 state:

> *"Where there is genuine doubt about the capacity of the patient at the time to make the ADRT or about its validity or applicability, legal advice should be sought and, if necessary, an application made to the Court of Protection." (paragraph 4.5.1)."*

The Trust's previous internal guidance did not follow the RCP PDOC Guidelines 2020 in this respect. Furthermore, the Guidelines emphasise that clinical teams should request a copy of the ADRT and not rely upon a report of what it says. These documents require careful consideration as Hayden J said in NHS Cumbria CCG v Rushton (above):

> *"25. Mrs Rushton's circumstances do however provide an opportunity for this Court to emphasise the importance of compliance both with the statutory provisions and the Codes of Practice, when preparing an Advance Decision. Manifestly, these are documents of the utmost importance; the statute and the codes provide essential safeguards. They are intending to strike a balance between giving proper respect and recognition to the autonomy of a competent adult and identifying the risk that a person might find himself locked into an advance refusal which he or she might wish to resile from but can no longer do so. The balance is pivoted on the emphasis, in the case of life-sustaining treatment, given to compliance with the form specified by statute and codes. The Court has highlighted the profound consequences of non-compliance with the requirements: W v M and S and A NHS Primary Care Trust [2012] COPLR 222; Re D [2012] COPLR 493.*
>
> *26. It perhaps requires to be said, though in my view it should be regarded as axiomatic, that the medical profession must give these advanced decisions the utmost care, attention and scrutiny. I am confident the profession does but I regret to say that I do not think sufficient care and scrutiny took place here. The lesson is an obvious one and needs no amplification. Where advanced decisions have been drawn up and placed with GP*

> *records there is an onerous burden on the GP to ensure, wherever possible, that they are made available to clinicians in hospital. By this I mean a copy of the decision should be made available and placed within the hospital records with the objective that the document should follow the patient. It need hardly be said that it will rarely, if ever, be sufficient to summarise an advance decision in a telephone conversation."*

AB's apparent ADRT demanded careful scrutiny as soon as it was brought to light. That ought to have involved some immediate enquiries to ascertain its validity and consideration of its applicability. Once doubts were raised about its authenticity there was a need for an application to the Court of Protection.

53.5. A prolonged disorder of consciousness is one in which the patient is unconscious for more than four weeks (RCP PDOC Guidelines 2020, paragraph 1.1). For a patient in a PDOC, in the absence of a known ADRT, those responsible for treating P will need to follow the best interests guidance within the RCP PDOC Guidelines 2020 and within caselaw such as NW London CCG v GU [2021] EWCOP 59. The emergence of a patient from PDOC is of considerable importance and should be recorded only when the criteria for emergence are met and recorded. The importance of a finding of emergence can hardly be understated. It is relevant to decision-making about treatment and best interests, as well as to communications with the family and long-term planning. In the present case it was also crucial to the applicability of the ADRT which the Trust had at the time when it recorded emergence. Accepting Professor Wade's opinion, it is regrettable that professional rigour was not applied at the time when it was wrongly noted that AB had emerged from his PDOC when under the care of the Trust. That error has contributed significantly to delay in identifying and then resolving the issues in this case.

53.6. MCA 2005 s25(2) sets out when an ADRT is not valid. A clinician is unlikely to know simply by looking at the document whether it has been subsequently withdrawn, whether it has been rendered invalid by the making of an LPA, or whether P has done anything else clearly inconsistent with the ADRT remaining their fixed decision. The Trust's new internal guidance enjoins a clinician presented with an ADRT to assume that it is valid unless they have doubts about its validity. However, it would be wise for clinicians presented with an apparent ADRT pro-actively to make enquiries - with the family or friends of P if possible - to discover whether there is any evidence that might call into question the validity of the ADRT under MCA 2005 s25(2).

53.7. Unless the ADRT is clear, questions as to its applicability under MCA 2005 ss25(3) and (4) and, if the treatment under consideration is life sustaining treatment, s25(5), require careful consideration and may require legal advice to be sought, as the RCP PDOC Guidelines 2020 recommend. If there is unresolved doubt or an ongoing dispute about the validity, applicability and/or authenticity of an ADRT, then it is likely that an application to the Court of Protection will be required. The Trust accepts that it should have made such an application in this case. Instead, CD made the application but her primary concern at the time of the application was not the ADRT but the parts of the Living Will and Letter to Presiding Judge dealing with contact with members of AB's family. Hence the issues concerning the ADRT itself were not promptly brought to the Court's

attention until January 2025. The Trust had the resources and experience to make a prompt application for a determination of the validity and applicability of the ADRT and it should have done so. The need to make a prompt application when the validity, admissibility or authenticity of an ADRT are in doubt or dispute is clear: administering a treatment to a person who has refused it through an authentic, valid and applicable ADRT is as unlawful as is providing treatment to a person with capacity who refuses consent to it. MCA 2005 s26(5) allows treatment to be given "while a decision as respects of any relevant issue [relating to an apparent advance decision] is sought from the court" but that is not a reason to delay seeking a decision from the court.

53.8. Even if the ADRT is not valid and/or is inapplicable, it may yet be taken into account in a best interests decision. Furthermore, clinicians and P's family may agree that P's best interests coincide with their expressed wishes, even if those wishes were contained in an invalid or inapplicable ADRT. Even if there are disputes about the provision of some treatments, such as CANH, there may be agreement about others, such as CPR. Hence, ongoing consideration of best interests should not be put on hold whilst the validity and applicability (and indeed, authenticity) of an ADRT is being scrutinised. These are processes that should be followed in parallel with each other.

53.9. Any person who questions the authenticity of an ADRT which is ostensibly valid and applicable, or who is concerned that it was made under undue influence, must provide some reasonable grounds for raising those issues. The Courts will not sanction significant delays in resolving disputes about an ADRT without good cause.

In addition, it is worth noting that Poole J, in considering whether the ADRT in question was svalid and applicable, returned to his analysis in *PW (Jehovah's Witness: Validity of Advance Decision)* [2021] EWCOP 52, and noted that:

> *42. No party has taken any issue with that analysis. In particular, no party suggested that, as a matter of principle, for the purposes of s25(2)(c) the Court should disregard what AB has done after he lost capacity to make decisions about his treatment. Whilst the Courts have to make binary decisions about whether P has or has not lost capacity to make decisions about their treatment, it does not follow that everything P says and does after losing capacity should be disregarded. In a different case a person might lose capacity but still be able to vocalise a desire not to be bound by the ADRT they had previously made. It would be troubling if that was to be wholly disregarded.*

Comment

Even advance decisions that clearly exist (i.e. where there is no doubt that the person had the relevant decision-making capacity, and was not under coercion) pose ethical dilemmas, as identified in *PW* (and see further here). However, even more problematic is the situation where those involved do not know what questions to ask, or actions to take, in the face of knowledge of a potential ADRT being in play. Poole J's guidance is therefore particularly useful for setting out so clearly what needs to happen.

Disordered eating and the gaps between services – the consequences for the Court of Protection

Cwm Taf Morgannwg Health Board v AB & Anor [2025] EWCOP 24 (T3) (McKendrick J)

Mental capacity – assessing capacity

Summary[1]

This is a judgment about case management in a very difficult case involving a 17 year old with profoundly disordered eating. As the child, AB's mother put it:

> *She is beautiful (inside and out), she is highly intelligent and extremely articulate, with her whole future ahead of her. She is brilliant at art, studies hard at school, and dreams of one day being a paediatric nurse. She is a 17 year old CHILD currently fighting the most horrendous battle of her life that no child should have to face.*

It is of note for two reasons. The first is the intense concern of the judge, McKendrick J, to get to the bottom of whether or not AB had capacity to make the decisions in question. As he noted (in a footnote to the first paragraph of his judgment):

> *The application was issued within the Court of Protection's jurisdiction. Given AB is a child, I have been alive to the possibility of providing clinicians with consent to treat under the High Court's Inherent Jurisdiction in the absence of consent from AB herself. See the succinct expression of the court's protective power at paragraph 2 of Sir James Munby's magisterial judgment in A NHS Trust v X [2021] EWHC 65 (Fam); [2021] WLR 4 WLR 11: "It is conventional wisdom that no child (that is, someone who has not reached the age of 18) has such an absolute right, and that even if the child is Gillick competent (see Gillick v West Norfolk and Wisbech Area Health Authority [1986] AC 112) or, having reached the age of 16, comes within the ambit of section 8 of the Family Law Reform Act 1969, the court, in the exercise of its inherent parens patriae or wardship jurisdiction, can in an appropriate case – typically thought of as being a case where the consequence of the child's decision is likely to be serious risk to health or death – overrule the child's decision, either, as the case may be, vetoing some procedure to which the child has consented or directing that the child should undergo some procedure to which the child is objecting." The fact that this powerful, residual, protective power is available to me, has added to the anxiety that has clouded these proceedings.*

The second was the judge's intense concern as to the gaps that AB appeared to be falling through – and the court was being confronted with – given the intersecting powers, obligations and stances of the multiple public bodies involved, leading to these observations:

> 33. *This application was issued urgently on 27 June 2025. It was heard by the court within hours, out of hours. Orders were made. Further orders were made by Henke J over the weekend. It took up considerable court time in the urgent applications list on 30 June 2025. Further orders were made. It required two further hearings on 9 July 2025. All this judicial time recognised the gravity of AB's condition and the need to have in place a lawful framework to treat her.*
>
> 34. *One can understand the reasoning behind each public bodies' position, to some extent. Wye Valley's role largely ended when AB was discharged from its acute ward. Herefordshire and Worcestershire*

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

Health and Care NHS Trust made a good faith attempt to file a witness statement of events rather than a capacity assessment. One can understand there may be a limited role for a community psychiatric team if AB is sectioned and therefore Powys may have a limited role. I accept Powys County Council's limited role until discharge from section. I can also understand the logic of Cwm Taf's position that whilst under 1983 Act detention, the role of this court may be limited.

35. *However there are a number of concerning features of this litigation which are individually and collectively caused by the public bodies (although I recognise the very limited role played by Powys County Council). These are:*

    a. *A failure to appreciate these proceedings began as an urgent out of hours application and the hearings and orders made without hearings have all had to be fitted into already very busy court lists. It is especially disappointing to note that orders made have been routinely ignored. Nor have the Court of Protection rules been followed.*

    b. *Whilst AB is currently detained under section 2 of the 1983 Act, she requires an urgent capacity assessment. The chronology seems clear: her capacity appears to have fluctuated and there have been questions over capacity and liability to be detained. There is repeated reference to voluntary admission. She has a complex presentation. Thought needs to be given now, as to whether she lacks capacity in circumstances where her section 2 1983 Act liability to be detained and treated is discharged. Will there be the framework to keep her safe or will there be a further urgent out of hours application?*

    c. *It is surprising that two orders from this court to two different public bodies which were made to ascertain this court's jurisdiction, have not been followed. It is concerning that Powys felt the appropriate response was to email the parties letting them know the order would not be complied with, without considering a formal COP 9 to vary the order, as the original section 49 order provided for.*

    d. *It is a matter of concern that Cwm Taf are detaining and treating AB and knew of this hearing and had sufficient understanding of the issues involved, yet they did not write to the court to update it or instruct representatives to attend. Nor does it appear to me they adopted a constructive approach to Wye Valley's legitimate attempt to be discharged as applicant and replaced by another public body.*

    e. *All in all, the failure of these public bodies to work together is perplexing. They each appear to operate in silos having only regard to their own duties, without any common sense approach to the life of a child, who requires them to work together to protect her.*

f. *Overall, the approach taken by the public bodies has failed to properly respect Mrs CD* [AB's mother] *and AB herself. The lack of common sense thinking appears to have permitted a disregard for the humanity of those involved. Mrs CD's powerful, maternal plea (above) should be re-read by those treating AB and those advising and representing the public bodies.*

36. *The court had anticipated that the Court of Protection proceedings might end. This is clear from orders set out above. However, I unhesitatingly agree with the submissions of the Official Solicitor that AB's capacity is complex. It needs to be assessed. It may provide a life sustaining framework to enable her treatment, should she lack capacity. Aside from post 1983 Act detention issues, it seems to me that whether AB has capacity to consent or not to forced treatment is a fundamental issue which should be properly taken into account when considering her regime under detention and any treatment without her consent pursuant to section 63 of the 1983 Act. Likewise it is also relevant should the court exercise its parens patriae jurisdiction.*

37. *The communication between the relevant public bodies has been sufficiently poor that in the exercise of my quasi-inquisitorial jurisdiction, I cannot accede to Cwm Taf's submission that I stay or conclude these proceedings at the hearing. I do not have the necessary confidence to do so. Furthermore, such an approach would be unfair to Mrs CD. I shall adjourn the matter for the limited evidence as set out above. I add that experience suggests Court of Protection practitioners generally adopt a collaborative approach and the missteps in this matter may have been caused by the urgent nature of the application for variety of very busy professionals.*

Comment

The problem of silos is one that causes impossible problems and heartache outside the courtroom (one of the reasons why the interface between health and social care has troubled the Law Commission greatly in its disabled children's social care project, and also why the work of the SPROCKET project is potentially so important). It is deeply depressing that resolution – even if only partial resolution so far in this case – sometimes then has to involve the time and resources of a judge being deployed not to resolve questions of capacity and best interests, but rather to act, in effect, as an armed care coordinator.

Short note: medical treatment, medical advice and capacity (and the inherent jurisdiction)

At points in the very detailed judgment of Theis J in *Blackpool Teaching Hospitals NHS Foundation Trust v GWS & Ors (Capacity)* [2025] EWCOP 23 (T3), the prospect that the court might be invited to make declarations about medical treatment under the inherent jurisdiction loomed. Ultimately, however, the Vice-President found that the 18 year old in question lacked capacity to make the medical treatment decisions in question, leaving tantalisingly open (as other judgments have done) the question of whether and under what circumstances it could ever be appropriate for a court to find a person to have capacity to make the decision, but nonetheless to override that decision by deploying the

inherent jurisdiction.[2]

The Vice-President's reasoning in relation to her conclusion that the man, in fact, lacked capacity merits setting out in full as a worked example of the resolution of a complex case:

> *125. I recognise that failure to take on board medical advice per se cannot be sufficient to establish an inability to use and weigh that information but here the decision to ignore medical advice carries clear and high risk of long term disability or death. This needs to be considered in the context of GWS's clear wish to survive and improve his situation in life. The inconsistency between his words and actions also support the conclusion that he is unable to use and weigh the risks he is told about. This is not GWS choosing not to give weight to the harsh realities of his situation, namely acute kidney failure and the risks of discharge when he has nowhere to go. I agree with Ms Roper this is an inability to use and weigh the most critical pieces of information in reaching a decision about treatment and a decision on discharge.*
>
> *126. In reaching this conclusion I am acutely aware of the presumption of capacity, to consider whether any further support can be made available to GWS, the need to avoid the protection imperative or for any conclusion to be outcome led. The evidence demonstrates GWS has continued to be given support with his advocate and there being more consistency in those who speak to him. I do not consider at this stage any further support can be provided. In my judgment, taking the evidence as a whole, I have reached the conclusion, on the balance of probabilities, that GWS is unable to use and weigh the relevant information in relation to the decisions set out above. Even making allowance for the fact that it is not necessary for him to understand all the detail of the information there are salient factors here which involve serious and long-term implications for GWS that he is not using and weighing in reaching his decision.*
>
> *127. Turning to consider the reason for this inability there is, in my judgment, considerable evidence that GWS is suffering from multiple impairments of his mind or brain within the meaning of s2(1) MCA 2005. He has a confirmed diagnosis of ADHD, clear evidence of PTSD, an ongoing dependency syndrome in relation to ketamine and, possibly, elements of autism although there has been no formal diagnosis in relation to the latter. I agree with Ms Roper that it is the combination of those matters taken together with his current circumstances that creates what she calls the 'perfect storm'. Dr Glover's addendum report made clear he considered there was stronger evidence of PTSD, that the symptoms of that are likely to influence GWS towards misuse of drugs and his relentless determination to access ketamine despite understanding the harm it causes. His conclusion that GWS retained capacity on a fine balance was based on his assessment that he detected little impact of those conditions on his pattern of thinking. However, Dr Glover accepted he did not discuss in any detail the decision about whether or not to have the stent procedure so was not fully able to consider that in the context of the particular decision in question. In the*

[2] Spoiler alert – we think that it is highly doubtful: see paragraphs 27 and 28 of our guidance note on the inherent jurisdiction.

light of what MacDonald J set out in North Bristol NHS Trust v R Ms Roper submits, and I agree, there is not a requirement for a formal diagnosis. The MCA does not require the 'impairment of, or disturbance in' to be tied to a specific diagnosis. The court is not precluded from reaching a conclusion on the question in the absence of a formal diagnosis or the court being able to formulate precisely the underlying condition or conditions. As MacDonald J stated in North Bristol NHS Trust at [48] 'the question for the court remains whether, on the evidence available to it, the inability to make a decision in relation to the matter is because of an impairment of, or a disturbance in the functioning of, the mind or brain.'

128. I agree with Ms Roper that on a day to day basis there is much force in Dr Glover's conclusions. The Trust has carried out multiple assessments of GWS's capacity and has reached the same conclusion, that he has capacity. However, having considered all the evidence that position has changed and the evidence supports a conclusion, on a fine balance, that GWS's underlying impairments compounded by his current circumstances are currently preventing GWS from using and weighing the information relevant to decisions about his treatment and discharge. It is acknowledged that a capacitous individual may make a decision in the face of advice even where the outcome is catastrophic. Here there is evidence that GWS is not using and weighing relevant information about the outcome of his decision, such as any stent blockage being symptomless and the life changing consequences of that in circumstances where he expresses a clear wish to live and improve his life. This conclusion is also supported by GWS's approach to the question of surgery, imposing conditions that do not properly use and weigh the medical evidence about the consequences of that. If GWS has such a compulsion to exert control despite those significant risks that, on a balance of probabilities, can only be explicable in the context of and because of his impairments.

129. I agree with the Trust that the evidence rebuts the presumption of capacity and GWS does not currently have the capacity to make decisions about his treatment, particularly the treatment to replace his stents, and does not have capacity to decide to discharge himself from hospital prior to that surgery being undertaken. I agree this decision is time specific and should be kept under active and close review.

Short note: capacity, best interests and birth arrangements

Oxford University & Ors v AX [2025] EWCOP 21 (T3) [3] breaks no new legal ground, but is a decision which is notable for its careful *JB*-compliant analysis of the capacity of the woman in question to make decisions about her birth arrangements, and (it being found that she lacked that capacity) of her best interests, taking into account all of the factors required by s.4 MCA 2025.

Calling medico-legally curious intensivists

An opportunity has arisen for new clinical members to join the Legal and Ethical Policy Unit of the Faculty of Intensive Care Medicine. LEPU (on which Alex has sat since the outset) was founded as an expert panel to advise the FICM on legal and ethical matters. It is comprised of

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

legal professionals from all four UK home nations and ICM clinicians with medicolegal expertise. The Unit falls under the remit of the FICM Professional Affairs and Safety Committee (FICMPAS) but acts autonomously. Its main aims are to identify, review, analyse and act upon legal and ethical matters relevant to the specialty.

The positions are open to any medical professional who has an affiliation with FICM, provided they have relevant medicolegal expertise.

For more details, and to apply (closing date 11 August) see here.

Editors and Contributors

Alex Ruck Keene KC (Hon): alex.ruckkeene@39essex.com
Alex has been in cases involving the MCA 2005 at all levels up to and including the Supreme Court. He also writes extensively, has numerous academic affiliations, including as Visiting Professor at King's College London, and created the website www.mentalcapacitylawandpolicy.org.uk. To view full CV click here.

Victoria Butler-Cole KC: 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. She is Vice-Chair of the Court of Protection Bar Association and a member of the Nuffield Council on Bioethics. To view full CV click here.

Neil Allen: neil.allen@39essex.com
Neil has particular interests in ECHR/CRPD human rights, mental health and incapacity law and mainly practises in the Court of Protection and Upper Tribunal. Also a Senior Lecturer at Manchester University and Clinical Lead of its Legal Advice Centre, he teaches students in these fields, and trains health, social care and legal professionals. When time permits, Neil publishes in academic books and journals and created the website www.lpslaw.co.uk. To view full CV click here.

Arianna Kelly: Arianna.kelly@39essex.com
Arianna practices 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 inherent jurisdiction matters. Arianna works extensively in the field of community care. She is a contributor to Court of Protection Practice (LexisNexis). To view a full CV, click here.

Nicola Kohn: nicola.kohn@39essex.com

Nicola appears regularly in the Court of Protection in health and welfare matters. She is frequently instructed by the Official Solicitor as well as by local authorities, CCGs and care homes. She is a contributor to the 5th edition of the *Assessment of Mental Capacity: A Practical Guide for Doctors and Lawyers* (BMA/Law Society 2022). To view full CV click here.

Katie Scott: katie.scott@39essex.com

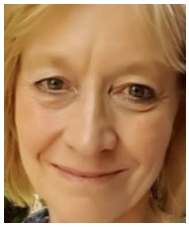
Katie advises and represents clients in all things health related, from personal injury and clinical negligence, to community care, mental health and healthcare regulation. The main focus of her practice however is in the Court of Protection where she has a particular interest in the health and welfare of incapacitated adults. She is also a qualified mediator, mediating legal and community disputes. To view full CV click here.

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

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 regularly present at seminars and webinars arranged both by Chambers and by others.

Alex also does 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 September. Please email us with any judgments or other news items which you think should be included. If you do not wish to receive this Report in the future please contact: marketing@39essex.com.

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

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

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

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

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

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

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

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

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