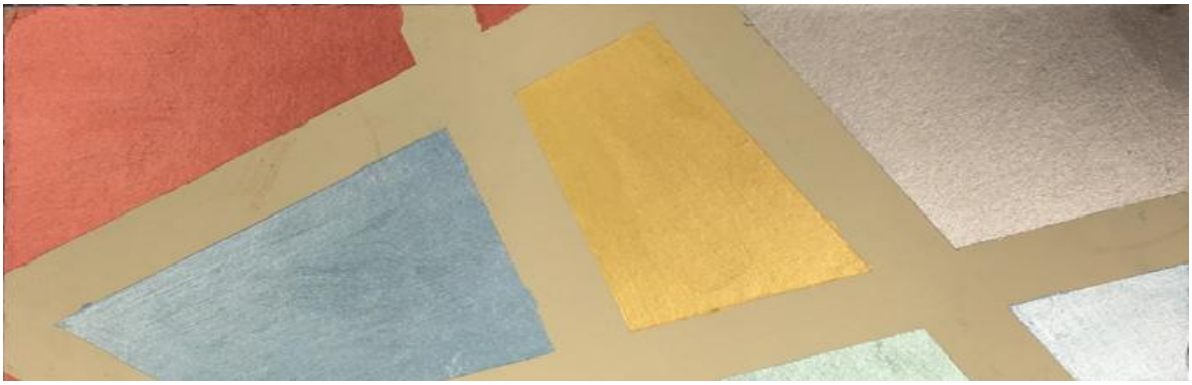

Welcome to the July 2026 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: Permission to appeal granted in *Townsend*; post-AGNI guidance; and a new Guidance Note on Capacity for Care Providers

(2) In the Property and Affairs Report: Statutory wills; charging for being an appointee; and guidance on assessing financial capacity

(3) In the Practice and Procedure Report: Court of Protection and child deprivation of liberty statistics; court fees rising; reasons challenges in the Court of Protection; medical treatment cases – whether to issue, and the consequences of waiting too long

(4) In the Mental Health Matters Report: EU Recommendation of the Committee of Ministers to member States on respect for autonomy in mental healthcare

(5) In the Children's Capacity Report: A CAMHS psychiatrist's view on child deprivation of liberty cases – and what interventions can help to break the 'vicious cycle' of restrictions and institutionalisation

(6) In the Wider Context Report: Adult social care reform; the Muckamore Abbey Inquiry Report is published; and what becomes of solicitors whose clients lacked capacity

(7) In the Scotland Report: Circumvention and undue influence

A reminder that that whilst Chambers have launched a new and zippy version of our website which may look unfamiliar, all the content that you might need – our Reports, our case-law summaries, and our guidance notes – can still be found via here.

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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

Court of Protection and child deprivation of liberty statistics

The most recent (January to March 2026) statistics have been published for the Court of Protection. They will be of historical note as representing (we anticipate) the high water mark of deprivation of liberty applications (both s.21A and 'community DoL' applications) before the *AGNI* decision. Somewhat oddly, the note in the supporting table explaining the 2,264 applications does not relate to the reporting period, but, to give an indication, the 2,199 deprivation of liberty applications for the previous quarter (the end of 2025), broke down as follows: 276 for Section 16, 608 for Section 21A and 1,315 for the Re X process.

Separately, the Family Court statistics also show that there were 393 applications for authorisation of deprivation of liberty of a child in the same period (the most in any quarter for which broken-down records are available), 99 of which related to children aged 16 and 18 (and 40 to children under 10). Again, we will watch with interest to see whether there is an *AGNI* impact going forward.

Court of Protection fees rising

Subject to parliamentary approval and effective 13 July 2026, there will be increases to Court of Protection fees:

Description	Current	New
Application to start proceedings or application for permission to start proceedings	£421	£432
Filing an appeal	£265	£272
Hearing fees	£259	£266
Copy of a document fee	£5	£8

Capacity: the court and the expert, and the 'reasons burden'[1]

[1] Note: having appeared in this matter, Arianna has not contributed to the writing of this note.

in *London Borough of Camden v BW & Anor (Capacity Decisions; Reasons)* [2026] EWCOP 26 (T3) (Lieven J)

Practice and Procedure (Court of Protection) - other

In one of what is likely to be one of her last decisions as a Tier 3 judge (having very recently been appointed a Court of Appeal judge), Lieven J considered a very complex situation in *London Borough of Camden v BW & Anor (Capacity Decisions; Reasons)* [2026] EWCOP 26 (T3). At its heart were two questions as to the capacity of the young woman, BW: (1) to make decisions about taking psychotropic medication;[2] and (2) about sharing information with her sister. Her case was, sadly, one which was not entirely untypical of cases now appearing before the court, i.e. a young woman identified as vulnerable to sexual exploitation and abuse, with a history of contacting men on the internet and then being exploited. BW had also been arrested a number of times for assault, but had been assessed as unfit to plead or stand trial on at least one occasion.

Perhaps unsurprisingly in light of this history, the woman had been the subject of innumerable assessments. In 2023, she had been assessed for purposes of Court of Protection proceedings by Dr Ince, who held (in views accepted by the court, and not subsequently challenged) that BW lacked capacity to litigate; make decisions regarding her care, accommodation and support needs; contact with others; access to the internet and social media; and to manage her property and affairs. He subsequently also identified that she had capacity to engage in sexual relations. The court made orders as to her residence and care arrangements. In 2025, she had a series of mental health crises with delusional beliefs, and decreased functioning. Her behaviour was described as being extremely challenging, including assaulting staff and attempting to abscond. She refused to take her oral medication, save on one occasion. In August 2025, in the context of her sister and the Official Solicitor raising whether she should be put on psychotropic medication, her community psychiatrist expressed the view that BW had capacity to decide whether or not to take it. Between October and December 2025, BW was admitted to mental hospital, initially under s.2 MHA 1983, and then as a voluntary patient.[3]

A further expert, Dr Sheehan, identified that there was a "*a general acceptance that antipsychotic medication has been effective in reducing* [BW]*'s aggression and irritability*," but reached the conclusion that BW had capacity to decide whether or not to take it. He also concluded that she had capacity to decide whether or not to share information with her sister.

At first instance, at a hearing convened to consider BW's capacity, Senior Judge Hilder concluded that, contrary to the view of Dr Sheehan, BW lacked capacity in both regards. She also held that it was in BW's best interests for her to take psychotropic medication. The hearing was held in circumstances of some urgency, because the

[2] Note, the framing of the question at both first instance and on appeal was on the basis of 'consenting' to such medication, which likely reflects the realities of the situation, but is at interesting odds to conventional medical treatment cases, in which the decision is not about consent / refusal, but whether to have the specific procedure.

[3] Parenthetically, it would be extremely interesting to know the basis on which this was considered to be lawful in circumstances where it is difficult to see how this could not have been a confinement, and (on the face of the judgment) it is not obvious how she could have capacity to consent to that confinement. Pre-*AGNI* it is very difficult to see how this could not have been seen to have been a deprivation of liberty requiring formal authority (the information in the judgment does not give enough material upon which to assess whether post-*AGNI* she would still be seen as deprived of her liberty)

clinicians thought that BW needed her depot injection imminently.

Senior Judge Hilder's conclusions had been as follows (paragraph numbers being those in the underlying judgment, which had not been published, but extracts from which appear in the judgment of Lieven J):

21. Firstly, it is part of the information relevant to making a decision about depot medication that not having it and the consequential prospect for deterioration on BW's ability to avoid incidents of aggressive behaviour are likely to bring about the end of BW's current placement at [Address A]. That information was just wholly missing from Dr Sheehan's assessment. As the depot time approaches, incidents of aggression have increased. Insofar as Dr Sheehan said he was 'not sure' about the change of active level and medication as the depot time approaches, in my judgment his hesitant view must be considered in the light of the prescribing clinician's view that another dose is required.

22. Secondly, it is part of the information relevant to making decisions about information sharing with AW that, without full information, her ability to support BW by input into the planning and delivery of the care arrangements which necessarily have to be made by others is likely to be adversely affected. It is relevant to the question of information sharing that BW's care arrangements have to be determined by others in her best interest. So when Dr Sheehan acknowledges, as he did orally, that he did not explore with BW her much-expressed view that she does not need anything like her current restrictive care arrangements to keep her safe, that amounts to a significant deficit in the process of assessment.

23. Ms Kelly asked the question: "What is it about BW's relationship with [AW] which gives rise to a distinction between her or others who have responsibility towards the care arrangements?" (I am conscious that that is a paraphrase of a whole line of questions, but I think that it captures the gist.) Dr Sheehan identified that relationships with family members may be different to relationships with professionals, but he did not identify how BW's wishes about the flow of information to AW are different from consideration of her capacity at the time

24. This is a very difficult case. BW's unique profile of abilities and capacities makes it very difficult for her to navigate life and also for others to assist her. Again, I am acutely conscious of the statutory assumption of capacity, of the need to avoid a protective imperative, of the need not to set a threshold unfairly high, but I am not satisfied that Dr Sheehan's conclusions adequately reflect the position. I agree with BW's own representatives that the assessment process is fatally undermined by superficiality in key respects.

25. Taking into account the full range of capacity assessments over time and the evidence presently of BW's carers as set out in the social worker's statement and indeed by AW, it is my judgment that BW does not understand the relevant information for either of the decisions currently under consideration, and is not able to use or weigh those relevant factors; and that both of those factors are due to the impairment attributable to her current diagnosis of autism.

26. Accordingly, today, I make a declaration that BW lacks capacity in each of the domains which I have been considering.

Senior Judge Hilder went on to hold that it was in BW's best interests to have the medication (it is unclear what her determination was as regards the sharing of information). As can be seen, Senior Judge Hilder's reasons were relatively short form. A central plank of the appeal brought against her decision by the local authority was on the basis that those reasons were inadequate. The appeal was also brought on the

basis that it had been procedurally unfair to reach a conclusion about best interests when the hearing had been listed for determination of capacity; that ground was, however, abandoned at the hearing before Lieven J, and it was acceptable on BW's behalf that, if she lacked capacity to take psychotropic medication, it was in her best interests to have it.

Dealing with the reasons challenge first, Lieven J noted that:

60. […] *The standard of reasons is that encapsulated by Lord Brown at [36] in South Bucks v Porter (no 2). The reasons must explain to a reasonably informed reader why the Judge considered BW did not have capacity. In doing so they must cover the principal issues, here the statutory requirements of the MCA, and they must show why the Judge departed from the view of the expert, Dr Sheehan. However, they are addressed to the parties who are familiar with the case; they do not have to be lengthy; and they do not have to recite all or even large parts of the evidence.*

61. Mr Hadden in effect submits that there was an enhanced duty in respect of reasons because of the presumption in favour of capacity. His argument is that if the Judge was going to find that BW did not have capacity, then given the statutory presumption she had to explain her reasons particularly clearly. In my view, this argument is not correct. The Judge obviously has to apply the law correctly, but there is no suggestion that she did not do so, and no such argument was advanced by Mr Hadden.

62. I note that the Skeleton Argument says: "the Judge displaced the presumption of capacity…" However, Mr Hadden did not pursue this argument, and it is in my view hopeless, particularly given that at J24 the Judge expressly referred to the statutory assumption of capacity. Plainly the Judge was well aware of the statutory presumption and applied it to the case.

63. The standard of reasons remains the same whatever the issue, or where the burden lies, it remains to provide clear and intelligible reasons for the conclusions reached.

Lieven J considered that:

64. The reasons here achieved those requirements. At the heart of the issue in the case was whether BW understood and could weigh up the information which was relevant to the decisions about medication and sharing information, see s.3(1)(a) and (c) of the MCA. Central to the Judge's decision was the requirement in s.3(4) that a person needs to be able to understand the "reasonably foreseeable consequences" of making the decision. A reasonably foreseeable consequence of BW not taking the medication was, in the Judge's view, that she would lose her current placement, see J21. The Judge was correct to take this into account and give it considerable weight. The placement had expressly stated that if there was another incident of aggression to staff BW would be asked to leave.

65. I do not accept that this consequence was too remote for it to be relevant to the conclusion that BW did not have capacity. Firstly, that was a decision for the Judge, who heard the evidence, subject only to appeal if her judgement was wrong. Secondly, in my view, the likely loss of the placement was an obvious, direct and reasonably foreseeable consequence of BW stopping the medication, becoming aggressive and being required to leave her current placement. Further, such a consequence was likely to have disastrous consequences for BW given her history of homelessness, periods in prison and periods of compulsory detention under the MHA. The words of Lord Stephens in JB at [74] are particularly pertinent here because the loss of accommodation was a serious and grave consequence that it was important that BW could understand. The same was true of the potential

loss of support/advocacy by AW if she did not have all the relevant information.

With particular reference to the report of Dr Sheehan, Lieven J considered that:

66. The Judge was correct to say that Dr Sheehan had not considered the potential consequence of the loss of the placement in his report and had not asked BW about it. He had therefore failed to weigh up a highly material matter when reaching his conclusion on capacity. For the matter to be relevant, for it to be open to the Judge to rely on it, it was not necessary that it be referred to in the letter of instruction. Dr Sheehan was instructed to assess capacity, and he needed to consider what were the reasonably foreseeable consequences of the decision in question.

67. Although the Judge's reasons are short, she dealt with the important critical issue, whether BW could weigh up the information relevant to the decision about her medication, including the likely consequence of her deciding not to take it.

68. The same analysis applies to the decision about sharing information with AW. Dr Sheehan did not explore with BW the likely consequences of AW not being able to advocate on her behalf, and what the Judge plainly viewed as the lack of realism around BW's view that she did not need the current care arrangements. This was an entirely valid concern given that BW had been found not to have capacity in respect of assessing her care needs. Again, this amounts to failing to consider and weigh up the likely consequences of the decision not to share information with AW, and the impact on the provision of the care she undoubtedly needed.

69. There was a lack of assessment in Dr Sheehan's report, as the Judge states at J23, as to how BW's lack of capacity in relation to decisions about her care, which was not disputed, related to a finding that she had capacity to decide AW should not have information shared with her. With all respect to Dr Sheehan, the statement that relationships with family members may be different to those with professionals, misses the point that the history strongly suggested that BW's family, and AW in particular, had been critical in ensuring that BW received the care support she needed and was entitled to. BW was adamant that she did not want AW to be given information about her care, but the Judge was entitled to conclude that BW was unable to weigh up the consequences of that decision.

Perhaps ambitiously, it was submitted by the local authority that Senior Judge Hilder had acted pursuant to the 'protective imperative,' rather than considering BW's capacity to make decisions, even if unwise. Lieven J had little truck with this:

70. The Judge is the Senior Court of Protection judge, and extremely experienced in this jurisdiction. There is nothing in the judgment to suggest that she has confused an unwise decision with a finding of lack of capacity. It is clear from the judgment that she found BW not to have capacity because she concluded that BW did not understand the reasonably foreseeable consequences of her decisions.

Lieven J was also underwhelmed by the suggestion that Senior Judge Hilder was wrong to place reliance on the earlier capacity evidence of Dr Ince, and also as regards the challenge that she had not given adequate reasons for departing from the report of Dr Sheehan:

74. Ground 4 focuses on the Judge's alleged lack of reasons for departing from Dr Sheehan's recommendation. Mr Hadden submits where the Judge was disagreeing with the expert on capacity, she had to give further and more detailed reasons. The Skeleton says that if the Judge was to depart from the expert "this required the clearest of bases and explanations". I note that

there is no authority given for this proposition and Mr Hadden could not point me to one. Mr Hadden relies on Hemachandran where the Court of Appeal overturned a first instance decision where the Judge had determined capacity contrary to the consensus view of all the experts. It is relevant in that case that there was such a consensus view, whereas here there was one expert, who as the Judge explained, had not taken into account some of the key considerations that were relevant under the tests in the MCA.

75. There is no doubt that the decision as to capacity is one for the Judge, and the Judge is fully entitled to depart from the capacity assessment, whoever it is undertaken by.

76. As Ms Kelly submits it was not the Judge's job to critique Dr Sheehan's report. She had to reach a decision on capacity taking into account all the relevant evidence, including her own knowledge of BW. A fair reading of the judgment makes it perfectly clear why the Judge departed from Dr Sheehan's views and what factors she took into account.

Comment

This case is a useful reminder that judges are entitled to depart from the reports of experts instructed to assist on capacity, and also that there is no difference in the 'reasons burden' by virtue of the presumption of capacity. The judge needs to have before them sufficient evidence to establish (on the balance of probabilities) that the person lacks capacity to make the relevant decision. However, that is a different question to the question of the nature and extent of the reasons that they have to give. Given that the consequences for a person of being found to have capacity can be just as serious as being found to lack it (here, potentially, not taking medication recognised as being of assistance), it can readily be seen why there is an equivalent duty on a judge to explain their conclusions either way.

The discussion of the capacity issue in relation to the sharing of information is also relevant and important in a context where the conclusion can sometimes too readily be reached that a person has capacity to make such a decision on the basis (1) of desires to uphold patient confidentiality; and (2) failures to probe the extent to which the person recognises and is able to process that they may have others in their life who provide a support network.

Timing and procedure in Serious Medical Treatment applications

University Hospitals Birmingham NHS Foundation Trust v EN [2025] EWCOP 59 (T3) (McKendrick J)

Practice and Procedure (Court of Protection) – other

In a cri de coeur from McKendrick J (which was heard in 2025, but only recently reported), practitioners are reminded that those making urgent medical treatment applications must reflect on the practical realities of the court and Official Solicitor to deal with those applications on short notice. In *University Hospitals Birmingham NHS Foundation Trust v EN* [2025] EWCOP 59 (T3), the applicant had made an application for orders to compulsorily treat 'EN' by way of a caesarean section under a general anaesthetic and with the use of restraint if necessary. At the time of judgment, EN was detained under s.3 MHA with a diagnosis of schizophrenia, and was 40 weeks + 3 days pregnant. The child was her third child, and her previous child had required delivery by emergency caesarean section. The background to the application is set out at [7]: *'While she was initially compliant with her care, her mental health and her presentation have deteriorated. Essentially the background is that she has been*

refusing to co-operate with staff, is often dysregulated in mood and behaviour and there is significant concern that she will not co-operate with the necessary obstetric care required to be delivered of her baby. She could give birth imminently.' EN was expressing wishes to both hospital staff and her representative via the Official Solicitor that she wished to have a vaginal delivery, and the matter was listed for a hearing the day after it was filed, hearing evidence from EN's consultant obstetrician and gynaecologist. After identifying that further evidence was required from an anaesthetist on the risk of a general anaesthetic and obtaining the evidence, neither the Official Solicitor nor the court appeared to have great difficulty in agreeing that EN lacked capacity and the Trust's plan to proceed with a caesarean section was in her best interests.

We highlight this case in the Practice and Procedure section due to McKendrick J's setting out his concerns about the manner in which the application was brought:

> 4. *I am giving this judgment ex tempore under challenging circumstances. The application was purportedly issued around 10 past 4 yesterday afternoon. I say purportedly as it was issued by way of an email with 12 separate attachments, each of which was password protected. I was supposed to be dealing with other matters today but it was the applicant trust's position that the matter had to be dealt with today…*
>
> 60. *…I have considered this matter as carefully as I possibly can in the rushed, unsatisfactory circumstances that have led up to this hearing. I repeat, there has been no question of the Official Solicitor or this court acting as some form of rubber stamp. There has been questioning, and testing of the evidence. For those reasons, I will make the orders…*
> 61. *I will add a postscript to the judgment as follows. The circumstances of how this application was brought to court are unacceptable. It was clear to the applicant trust that Ms EN was a woman with psychiatric challenges. It was clear from 29 June 2025 that she was detained pursuant to Section 3 of the Mental Health Act. As I understand the chronology, she was assessed on Monday of this week and whilst in the morning it was considered she was engaging and had capacity, it was clear by the middle of Monday that she was not. The application was issued at 10 past 4 yesterday afternoon, seeking a four-hour hearing the next day.*
> 62. *I have received an email from a highly experienced solicitor explaining the delay. It has been approved by the applicant trust's team. They say on the various occasions when the obstetricians and Ms EN met they felt Ms EN was able to understand and agree to the birth plan as discussed. They accept she was seen as high risk because of her mental health and a plan was drawn up at 34 weeks gestation. They say that when she was seen in clinic on 1 July she was still capable of making decisions and an MDT meeting took place on 3 July and it considered the question of fluctuating capacity. Legal advice was sought by the obstetrician from the legal department of the trust on 3 July 2025 and was informed there was a substantial risk of a patient becoming so unwell as to lose capacity which means that the treatment might have to be forced on her. The Court of*

Protection was in a position to make a declaration.

63. *It then appears that there was discussion between that Trust and the psychiatric Trust. There was another MDT meeting on 7 July and it was felt that she lacked capacity to make the decisions about her care. As I say, on 8 July she seemed to accept induction of labour but again deteriorated quickly thereafter and I am told the obstetric team were not aware of the guidance set out by Keehan J in NHS Trust v FG and it was not appreciated, as it should have been last week, that an application to court was likely.*
64. *The reference to NHS Trust v FG is a reference to Keehan J's decision called NHS Trust 1 v G Practice Note [2014] EWCOP 30. In an annex to that judgment, Mr Justice Keehan set out clearly what should happen in these types of cases. He emphasised in particular that early identification of an individual in respect to whom an application might have to be made is essential. He set out that late applications must be avoided absent genuine emergencies and set out the very undesirable consequences.*
65. *I have had to deal with matters at a pace this morning, but it seems to me on a summary analysis of what I have been told that this application should have been made easily last week because there was a risk that this vulnerable woman who is detained may have significant challenges. It does not seem to me that the aggressive, guarded, difficult behaviours blew out of nowhere yesterday. Indeed on the obstetric Trust's own evidence, that was the position at the start of this week.*
66. *To compound matters, it is unacceptable that this very urgent application was sent into court by way of an email with 12 separate attachments, each of which were password protected. I do not understand why solicitors are sending into the court password protected documents. To further compound matters the application was sent to the wrong email address. This urgent application was sent to the wrong email address. This created unnecessary delay. It is further unacceptable that no bundle was sent to me until 23 minutes past 10 this morning.*
67. *This is not simply a judge venting spleen regarding procedures and rules. This is because the application I have been required to deal with this morning is of the utmost gravity for Ms EN. Whilst I am satisfied I have received the assistance and evidence necessary to make decisions on capacity and best interests, that may not be the case in every scenario. It was not acceptable at the outset of this hearing there was no proper evidence on anaesthesia. That further delayed determination of matters.*
68. *There may come a time when a mistake is made and grave harm or death befalls a patient before the Court of Protection, because of the unacceptable procedural steps that lead up to hearings.*
69. *It is also unacceptable that the matter I should have been dealing with today has had to be put off. Other litigants who need determination of their litigation now have to wait. I do not see that there are any good reasons for any of this.*

70. *The Official Solicitor has not sought an application for her costs. If she had made an application I would have granted a costs order against the Trust in full. In the exercise of my discretion, applying Court of Protection rule 19.5, I would not have accepted any resistance from the Trust that I should not depart from the general rule in personal welfare proceedings. I would have accepted, applying 19.5(1), that the conduct of the party has merited a cost order against the Trust in the full amount. I would have been prepared to have heard submissions as to whether that costs order should have been paid pursuant to the Civil Procedure Rules on an indemnity basis, applying the general principles of CPR 44.3.*
71. *However, I am not asked to make any costs order and therefore I simply make those obiter observations so that if other Trusts bring these urgent applications in respect of caesarean sections they understand the time has come that cost orders will have to be more routinely made to ensure applications are brought in a timely fashion to ensure that vulnerable women like Ms EN's care is not jeopardised by late applications being brought to court.*

Comment

McKendrick J's points on the impacts of late applications on the court and other court users are clear and require no interpretation (though the query of why password-protected documents would be filed with the court is worthy of amplification). We would, however, note this case in concert with the next piece on making robust attempts to resolve healthcare disputes without the personal and financial costs inherent in having recourse to the Court of Protection. We consider that while in this case, it appears that the need for an application was well-established, there are many other healthcare disputes in which the approach of trying to work with the patient is a successful one and avoids unnecessary applications being made to court.

Resolving health disputes out of court: a policy paper

In Resolving Health Disputes Out of Court: A Policy Paper by Jamie Lindsay and Margaret Doyle, the authors focus on 'on out-of-court resolution of disputes between healthcare professionals, patients, and family members in the context of medical care and treatment for adults and children.' It draws on discussions from a symposium held in March 2026 at the University of Oxford to consider how policy and practice in this area might be developed. The paper notes the personal and financial costs for people and healthcare professionals who end up in court, and 'sets out a series of recommendations aimed at supporting earlier and more effective management of disputes before cases reach the Family Court (for children) or Court of Protection (for adults). The recommendations include:

- The development of online resources around dispute resolution and signposting;
- Protocols for access to medical records;
- Access to independent advocacy by families to challenge medical decisions;
- 'Family members should have a right to obtain an independent second opinion where there is a best interests disagreement, funded by the relevant

NHS body. This right could be implemented based on a similar principle to Martha's Rule and DHSC should investigate this option.' It is also recommended that a standard commissioning process should be developed for second opinions, and a standard expert declaration for them;

- Further funding and development of protocols for Clinical Ethics Committees should be developed, and families and healthcare professionals should be supported to engage with them;

- *NHS Trusts and families should consider use of independent mediation before proceeding to litigation, except in emergencies. There should be no requirement on family members or HCPs to mediate, only the requirement to consider mediation…Commissioners should fund independent mediation and should include funded legal and advocacy advice for families taking part in mediation….Independent mediation should generally be attempted before proceedings are issued.'*

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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.

Neil's training dates are available 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.

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