



Welcome to the October 2018 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: an update on the Mental Capacity (Amendment) Bill, a further appreciation of Alastair Pitblado and a report on a seminar on the new law at the end of life;

(2) In the Property and Affairs Report: deputies, costs and security bonds, and dealing with impermissible directives in powers of attorney;

(3) In the Practice and Procedure Report: two important decisions on costs and a seminar on improving participation in the Court of Protection;

(4) In the Wider Context Report: the new NICE guideline on decision-making and capacity, capacity and the Mental Health Tribunal, coverage of developments relating to learning disability and an CRPD update;

There is no Scotland report this month as our Scottish contributors are entirely tied up with projects both domestic and foreign, about which we hope to bring you news in the next Report.

You can find all our past issues, our case summaries, and more on our dedicated sub-site [here](#).

#### Editors

Alex Ruck Keene  
Victoria Butler-Cole  
Neil Allen  
Annabel Lee  
Nicola Kohn  
Katie Scott  
Simon Edwards (P&A)

#### Scottish Contributors

Adrian Ward  
Jill Stavert

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

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### **NICE guideline on decision-making and mental capacity: very good try but only two thirds of a banana.**

*[What follows is a personal view by Alex, with which his fellow editors may or may not agree!]*

To some extent, those responsible for pulling together the [NICE guideline](#) (NG108 on decision-making and mental capacity published on 3 October) were in an impossible position. They could not rewrite the Code of Practice, despite the fact that real life has caught up with and substantially overtaken the Code. To do so would lead to inevitable problems as to which practitioners were required to follow, given that the Code is statutory, but NICE guidelines provide an important part of the regulatory

framework for health bodies, in particular. They were also caught between the need to provide recommendations for organisations and recommendations for individual practitioners: the demands of both are not the same.

The guideline contains a useful summary of key points, and has some really important and helpful aspects, including, in particular, seeking to place support for decision-making in its context by including recommendations about both advance care planning and best interests decision-making. Both of these latter aspects constitute equally important parts of the framework for the support of the exercise of legal capacity mandated by Article 12 CRPD, and it is very helpful that the guideline recognises

this – although it is perhaps a telling irony that it does so without any reference to the CRPD at all.

The guideline contains the helpful encapsulation of the *Aintree* approach to best interests that:

*Carers and practitioners must, wherever possible, find out the person's wishes and feelings in order to ensure any best interests decision made reflects those wishes and feelings unless it is not possible/appropriate to do so. Where the best interests decision ultimately made does not accord with the person's wishes and feelings, the reasons for this should be clearly documented and an explanation given. The documentation of the assessment should also make clear what steps have been taken to ascertain the person's wishes and feelings and where it has not been possible to do this, the reasons for this should be explained. (paragraph 1.5.13)*

It also contains the very helpful reminder that

*Practitioners should be aware that a person may have decision-making capacity even if they are described as lacking 'insight' into their condition. Capacity and insight are 2 distinct concepts. If a practitioner believes a person's insight/lack of insight is relevant to their assessment of the person's capacity, they must clearly record what they mean by insight/lack of insight in this context and how they believe it affects/does not affect the person's capacity (paragraph 1.4.24)*

However, the guideline does not – perhaps because it could not – get into the really gritty difficulties that arise in relation to assessment of mental capacity. It is all very well, for instance, saying that

*To lack capacity within the meaning of the Mental Capacity Act 2005, a person must be unable to make a decision because of an impairment or disturbance in the functioning of the mind or brain. That is, the impairment or disturbance must be the reason why the person is unable to make the decision, for the person to lack capacity within the meaning of the Mental Capacity Act 2005. The inability to make a decision must not be due to other factors, for example because of undue influence, coercion or pressure, or feeling overwhelmed by the suddenness and seriousness of a decision (paragraph 1.4)*

That is a statement of the law. It does not provide assistance to a practitioner who is faced with a case such as Mrs G's where a person with a mild impairment and is caught in a complex social situation (or a 'spider's web' as Mrs G described herself). What are they to do?

The guideline is also silent on the 'translation' gap that is increasingly obvious as between the words of the MCA and realities on the ground. What, for instance, do the words 'use and weigh' actually mean? And do you need to ask different questions to assess whether a person is able to 'understand' information depending upon whether they have dementia, schizophrenia or learning disability (spoiler alert, the answer must be 'yes.'). In fairness, the authors recognise that a key area for further research is in relation to using mental capacity assessment tools to assess capacity. They also do touch on the really gritty stuff relation to one area, acquired brain injury, where they note that:

*Practitioners should be aware that it may be more difficult to assess capacity in people with executive dysfunction– for*

*example people with traumatic brain injury. Structured assessments of capacity for individuals in this group (for example, by way of interview) may therefore need to be supplemented by real world observation of the person's functioning and decision-making ability in order to provide the assessor with a complete picture of an individual's decision-making ability. In all cases, it is necessary for the legal test for capacity as set out in section 2 and section 3 of the Mental Capacity Act 2005 to be applied.*

However, the concept of 'executive dysfunction' is not one that appears in the MCA, nor has it been the subject of detailed judicial scrutiny. Precisely how does it fit with the time-specific nature of capacity? Is what is being said here that the person should be said currently (for instance) to be unable to use and weigh the information that they are unable to turn decisions into actions (in lay parlance, to walk the walk even if they can talk the talk)? For what it's worth, I would suggest that this is entirely legitimate, but it would have been helpful had the guideline actually said this.

More broadly, the guideline is also silent as to how fluctuating capacity is to be approached (save by reference to the – obvious – desirability of seeking to undertake advance care planning). The thorniness of these issues and the real practical difficulties they cause on the ground are exemplified in the CDM case, and the fact that – too late for the drafters to take into account – permission has been granted by the Court of Appeal in the case so that the approach can be considered.

I am acutely aware that the guideline reflects a lot of very hard work by many very committed

people, and that the criticisms above might be said to be designed to show off the hobby-horses that I want to ride. But to me, the guideline can only stand as a partial substitute for what is really needed:

- (1) An updated Code of Practice (which should, we understand, be a lot closer than it had been before given the introduction of the Mental Capacity Amendment Bill); and
- (2) Grainy, multi-disciplinary, guidance as to how, actually, to assess capacity in difficult cases (with, as a crucial pre-requisite, consideration as to what constitutes a satisfactory assessment of capacity). By way of trailer, this is precisely what the Mental Health and Justice project on contested capacity assessment is seeking to achieve.

### **New guidance for anaesthetists (and others) about Jehovah's Witnesses and patients who refuse blood**

The Association of Anaesthetists of Great Britain and Ireland have published guidance on anaesthesia and peri-operative care for Jehovah's Witnesses and patients who refuse blood. Although some of the technical and clinical, relating to the specific consequences for anaesthetists of a refusal to accept blood, its principles are of broader application. Importantly, the guidance was drafted in conjunction with Witnesses so sets the relevant decision-making in its necessary context.

### **Deprivation of liberty: when is consent irrelevant?**

*Re T (A Child)* [2018] EWCA Civ 2136 (Court of Appeal (Sir Andrew McFarlane P, Moylan and

Jackson LJ))

*Article 5 ECHR – deprivation of liberty – children and young persons*

### Summary

The issue in this appeal was whether a lack of valid consent was a pre-requisite to the exercise of the inherent jurisdiction authorising the restriction of the liberty of a young person in the equivalent of secure accommodation. The inherent jurisdiction is being increasingly used because of a lack of secure placements approved by the Secretary of State. As a result, there are two parallel processes for authorisation: one being s.25 of the Children Act 1989 ('CA'); the other the inherent jurisdiction. In that regard, the Court of Appeal expressed its real concern that so many applications under the latter are having to be made outside the statutory scheme and safeguards laid down by Parliament under the former (paras 5, 88-90).

The young person (aged 15 at the time of the first instance decision; now 16) was considered to be both *Gillick* competent to and actually consenting to the proposed care regime. The degree of restrictions on her liberty were such that, if the placement was in a unit registered as a secure children's home, it would have required authorisation under CA 1989 s.25. At first instance Mostyn J accepted that a lack of valid consent had to be established for the purposes of the subjective element of *Storck*. And that such consent had to be authentic and enduring which, on the facts, it was not.

After reviewing the Strasbourg and domestic authorities, the President (giving the sole reasoned judgment of the court) held that a lack of valid consent was not a jurisdictional pre-

requisite either for making a statutory secure accommodation order or for the High Court to exercise its inherent jurisdiction to authorise a local authority to restrict a young person's liberty. This was because:

- (i) The consent, or otherwise, of the young person is not a relevant factor in the statutory scheme. Section 25 and Article 5 ECHR involves different processes. The former *authorises* the local authority to keep the child in secure accommodation. It means the person in charge of that accommodation *may* restrict the child's liberty.
- (ii) There is no domestic authority to the effect that it is necessary to find an absence of valid consent before the court may authorise a local authority to restrict the liberty of a young person. The inherent jurisdiction order does not *itself* deprive liberty; it *merely authorises* the same.
- (iii) To hold otherwise would be to confuse the distinct temporal perspectives of Art 5 and an application for authorisation. Whether a person is deprived in breach of Article 5 is often a *retrospective* evaluation of their current and past circumstances. Consent in that contest is therefore likely to be an important element: "*one cannot normally be said to be deprived of liberty when one has freely agreed to the relevant regime*" (para 78). Whereas the court's role under the statutory and inherent jurisdiction processes is normally *prospective*.
- (iv) It would mistake the purpose of an order under the inherent jurisdiction authorising

the placement of a child in the equivalent of secure accommodation. Neither the local authority nor a child/young person can authorise what Parliament has decided only the court can authorise.

So, in summary:

*81. Drawing these matters together, once it is seen that the court's power under s 25 / s 119 is not dependent upon any question of consent, the difficulties that arose in this case, as it was presented to the judge and, initially, to this court, disappear. The fact that any consent may or may not be 'valid' or 'enduring' on the day the order is sought, or at any subsequent point, or that a 'valid' consent is later withdrawn, is irrelevant to the scope of the court's powers, whether they are exercised under statute or under the inherent jurisdiction of the High Court. The existence or absence of consent may be relevant to whether the circumstances will or will not amount to a deprivation of liberty under Art 5. But that assessment is independent of the decision that the court must make when faced with an application for an order authorising placement in secure accommodation, registered or otherwise.*

## Comment

This decision is a significant one for children services. And it will be relevant to *In the matter of D (A Child)* which was heard in the Supreme Court on 3-4 October 2018. The issue there was whether the confinement of D, a young person aged 16, who lacked capacity or competence to make decisions about his residence and care, amounted to a deprivation of his liberty in circumstances where his parents were consenting to the confinement. The role of

consent also lies at the core of the appeal in conditional discharge case of *MM v Secretary of State for Justice*, heard on 26 July 2018. Judgments in both cases are awaited.

It is no doubt true that a person can be deprived of liberty even where they are consenting to their confinement. An obvious example is the Mental Health Act 1983 where risk may warrant detention even where the person agrees to be confined. To that end, the "lack of valid consent" requirement of *Storck* could be characterised as a sufficient, but not a conclusive, element of the deprivation of liberty equation, at least within a framework which expressly provides for the exercise of coercive state power.

The judgment raises many interesting issues. For example, the emphasis on the permissive nature of court orders in the present context does resonate with DoLS authorisations and Court of Protection orders in the sense that they permit – but do not demand – a deprivation of liberty. And that must be right; there must be room to adjust the intensity of the care arrangements on the ground.

The court's distinction between prospective and retrospective approaches to deprivations of liberty is also of interest. There may however be an important jurisdictional distinction here. The powers of the court under the Children Act and inherent jurisdiction are not dependent upon the child or young person's consent. Whereas the Court of Protection's jurisdiction only exists if the person lacks the capacity to make the relevant decisions: in other words, is unable to give any relevant consent.

Even though there is reference in case law to the prospective or "forward looking focus of the

Court of Protection”, consent – and therefore the capacity to consent – is time specific. Authorisations to deprive liberty in this jurisdiction must be contingent upon a lack of capacity to consent as it is important that the permissive nature of DoLS and judicial authorisations are not used inappropriately where people are able to make their own decisions.

### Short note: capacity and the Mental Health Tribunal

On 23 July 2018 the Upper Tribunal (Administrative Appeals Chamber) handed down its judgment in *VS v St Andrew's Healthcare* [2018] UKUT 250 (AAC) in which the nature of the capacity required by a patient to bring proceedings before the First-tier Tribunal in its mental health jurisdiction was determined on the papers.

Upper Tribunal Judge Jacobs rehearsed the relevant legal background, making it clear that he accepted that the test for capacity in the Mental Capacity Act 2005 codified or confirmed the pre-existing common law principles and the FTT should now apply the principles and approach set out in the MCA and its Code of Practice. On the test required by a patient to bring proceedings before the FTT, Judge Jacobs held that the:

*patient must understand that they are being detained against their wishes and that the First-tier Tribunal is a body that will be able to decide whether they should be released.'*

As noted by Judge Jacobs, this test means that *“the capacity required to bring proceedings is less demanding than the capacity required to conduct*

*them.”* The reasons for this stem largely from the wording of rule 11 of the Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008 (SI No 2699) which provides that a FTT may appoint a legal representative for a patient where the patient lacks the capacity to appoint a representative but the Tribunal believes that it is in the patient's best interests for the patient to be represented. If *“the same test of capacity were applied to bringing proceedings as applies to conducting proceedings, any decision by the First-tier Tribunal to appoint a representative under rule 11(7) for a patient whose capacity was not fluctuating would have the inevitable result that the proceedings had not been properly brought. Given that the existence of an application is the foundation of the tribunal's jurisdiction, that case would then have to be struck out.”* The Judge noted that this approach is consistent with Barker J's decision in *Re RD* [2016] EWCOP 49 in which Baker J held that the capacity to bring proceedings in the Court of Protection required *‘P to understand that the court has the power to decide that he/she should not be subject to his/her current care arrangements.’* This is of course a lower threshold than the capacity to conduct proceedings.

### Learning from suicide: a thematic review

NHS Resolution has published its report, *“Learning from suicide related claims: A thematic review,”* written by Dr Alice Oates. As is noted in the foreword to this 148 page report, *“NHS Resolution is in a unique position in that it holds information about every personal injury claim made against NHS trusts in England over the past 23 years. This information, when correctly distilled, can be used to identify national themes about potential problems associated with NHS care. These themes*

*can then be used to focus improvement work to reduce the likelihood of similar problems in the future. The learning generated from reviewing claims could then be used to improve care, improve safety, reduce avoidable harm and decrease future litigation costs."*

The review analysed claims made to the NHS between 2015 and 2017 after an individual has attempted to take their life, (where member organisations received funding to provide legal representation at inquest via NHS Resolution's inquest scheme) with the aim of:

- Identifying the clinical and non-clinical themes in care from both completed suicide and assisted suicide that resulted in a claim for compensation.
- Disseminating the shared learning and using this as a driver for change and quality improvement.
- Highlighting evidence of good practice that could address areas for improvement, signpost potential solutions and make recommendations for change.

The review forms part of the ambition of the former Secretary of State for Health and Social Care, Jeremy Hunt, to "*aim for nothing less than zero inpatient suicides.*" The review comes against against the background of 4,575 suicides registered in 2016 in England (continuing a year-on-year decreasing trend) with approximately 25% of people who go on to take their lives having been in contact with mental health services in the year before their death.

101 claims between 2015 and 2017 that were reviewed. Admissions of liability were made in 46% of the claims reviewed.

There were some examples of good practice in relation to a number of trusts that had a proactive approach to engaging families, staff and patients in improvement work. However:

- Those with an active diagnosis of substance misuse were referred to specialist services less than 10% of the time.
- Risk assessments were often inaccurate, poorly documented and not updated regularly enough. There was little account taken of historical risk.
- Observation processes were inconsistent.
- Communication with families was poor.
- Support offered to families and staff was variable.
- There was evidence of poor quality serious incident investigations at a local level:
  - The family were involved in only 20% of investigations
  - Only 2% of investigations had an external investigator and 32% of incidents were investigated by a single investigator
  - The recommendations were unlikely to stop similar events happening in the future

The review makes 9 recommendations:

- A referral to specialist substance misuse services should be considered for all



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- individuals presenting to either mental health or acute services with an active diagnosis of substance misuse. If referral is decided against, reasons for this should be documented clearly.
- There needs to be a systemic and systematic approach to communication, which ensures that important information regarding an individual is shared with appropriate parties, in order to best support that individual.
  - Risk assessment should not occur in isolation – it should always occur as part of a wider needs assessment of individual wellbeing. Risk assessment training should enable high quality clinical assessments, which include input from the individual being assessed, the wider multi-disciplinary team and any involved families or carers.
  - The head of nursing in every mental health trust should ensure that all staff including: (1) mental health nursing staff (including bank staff and student nurses who may be attached to the ward); (2) health care assistants who may be required to complete observations; and (3) medical staff who may 'prescribe' observation levels undergo specific training in therapeutic observation when they are inducted into a trust or changing wards. Staff should not be assigned the job of conducting observations on a ward or as an escort until they have been assessed on that ward as being competent in this skill. Agency staff should not be expected to complete observations unless they have completed this training.
  - NHS Resolution should continue to support both local and national strategies for learning from deaths in custody.
  - The Department of Health and Social Care should discuss work with the Healthcare Safety Investigation Branch (HSIB), NHS Improvement, Health Education England and others to consider creating a standardised and accredited training programme for all staff conducting SI investigations.
  - Family members and carers offer invaluable insight into the care their loved ones have received. Commissioners should take responsibility for ensuring that this is included in all SI investigations by not 'closing' any SI investigations unless the family or carers have been actively involved throughout the investigation process.
  - Trust boards should ensure that those involved in arranging inquests for staff have an awareness of the impact inquests and investigations can have on individuals and teams. Every trust should provide written information to staff at the outset of an investigation following a death, including information about the inquest process.
  - NHS Resolution supports the stated wish of the Chief Coroner to address the inconsistencies of the PFD process nationally. NHS Resolution recommends that this should include training for all coroners around the PFD process.

**Short note: Advocacy Toolkit for those with learning difficulties**

The [Justice for LB Toolkit](#) produced by Advocacy Focus is a valuable resource kit aimed at giving

professionals the tools to help those with learning difficulties become more involved with their care assessments. It also provides important information and guidelines about working with people who have learning disabilities, community or cognitive issues. The Toolkit links to various Easy Read documents produced by Advocacy Focus to support assessments and to enable people who may have trouble communicating become more involved in decisions around their care. There is a dedicated Easy Read document for Mental Capacity Assessments which gives information around why an assessment is happening and how a decision is made.

### Learning disabilities and autism – troubling BBC reports

In a disturbing [report](#) by the BBC on 2 October 2018, it was reported that the use of restraint on adults with learning disabilities in hospital units in England rose by 50% between 2016 and 2017. According to information obtained by the BBC, patient on patient assaults rose from 3,600 to more than 9,000 over the same period and figures from this year suggest that assaults are continuing to rise, and that instances of face-down or prone restraint (which should no longer be used) also increased from more than 2,200 to 3,100 incidents.

The number of people who still remain in inpatient hospital units because of a shortage of community services is also alarming. According to figures obtained by the BBC, the number of adults in inpatient units has reduced slightly from about 2,600 to 2,400 but the number of children in such units has almost doubled. The case of Bethany – a 17 year old girl with autism – being detained in a Treatment and

Assessment Unit is discussed in the BBC Radio 4 programme “Transforming Care – Is it Working?” which is available [here](#).

### Care home registration refusal

In an unusual case reported on the CQC [website](#), the FTT tribunal has upheld the refusal by CQC of registration of a provider of services to those with learning disabilities on the basis that it did not demonstrate it would comply with CQC’s policy ‘Registering the Right Support’ – as well as the underpinning national guidance – that states new services and variations to registrations within a campus and congregate setting should not be developed due to this model of care not being in the best interests of people with a learning disability.

### Learning Disabilities Mortality Review Programme Second Annual Report: Government Response

The deaths reviewed by the Learning Disabilities Mortality Review (LeDeR) showed that, compared with the general population, the median age of death is 23 years younger for men with a learning disability and 29 years young for women, often for entirely avoidable reasons. The second annual LeDeR report was published in May 2018 and made nine key recommendations, all of which have been accepted by the Government. In the [Government response](#) to the Learning Disabilities Mortality Review (LeDeR) Programme Second Annual Report (available [here](#), the Department of Health and Social Care (DHSC) and NHS England jointly set out their formal response to each of the recommendations. The recommendations are:

- (1) Strengthen collaboration and information sharing, and effective communication,

between different care providers or agencies.

- (2) Put forward the electronic integration (with appropriate security controls) of health and social care records to ensure that agencies can communicate effectively, and share relevant information in a timely way.
- (3) Health Action Plans developed as part of the Learning Disabilities Annual Health Check should be shared with relevant health and social care agencies involved in supporting the person (either with consent or following the appropriate Mental Capacity Act decision-making process).
- (4) All people with learning disabilities with two or more long-term conditions (related to either physical or mental health) should have a local, named health care coordinator.
- (5) Providers should early identify people requiring the provision of reasonable adjustments, record the adjustments that are required, and regularly audit their provision.
- (6) Mandatory learning disability awareness training should be provided to all staff, delivered in conjunction with people with learning disabilities and their families.
- (7) There should be a national focus on pneumonia and sepsis in people with learning disabilities, to raise awareness about their prevention, identification and early treatment.
- (8) Local services strengthen their governance in relation to adherence to the MCA, and provide training and audit of compliance 'on

the ground' so that professionals fully appreciate the requirements of the Act in relation to their own role.

- (9) A strategic approach be taken nationally for training of those conducting mortality reviews or investigations, with a core module about the principles of undertaking reviews or investigations, and additional tailored modules for the different mortality review or investigation methodologies.

DHSC and NHS England have set out a number of actions in response to the recommendations which are to be implemented at various stages over the next few years. A LeDeR oversight group will be established and meet regularly to monitor progress against the recommendations. We will keep readers updated with any major developments.

### Rightfullives exhibition

The wonderful Rightfullives online exhibition (<http://www.rightfullives.net/>) is an extraordinary exhibition, curated by Julie Newcombe, Mark Neary and Mark Brown, that explores the theme of Human Rights and people with autism and/or learning disabilities. It started in May 2018 when a call to arms was put out for contributions from anyone interested in human rights for learning disabled people. The resulting exhibition contains a range of powerful and moving exhibits from learning disabled people and their supporters which are rich in diversity. We would encourage all our readers to take a look online.

### SCIE supported decision-making film

The often neglected principle of not treating a person as incapable of making a decision unless

all practicable steps have been tried to help them is the focus of a [short film](#) that has been published on the Social Care Institute for Excellence (SCIE) website. In it, Lorraine Currie (MCA and DoLS Manager at Shropshire Council) explains that “taking all practicable steps” is much more than just facilitating communication with the person, but crucially, taking the steps to help the person make the decision. It is only if there are no practicable steps left (because they’ve all been unsuccessful) that practitioners should then move to carry out the capacity assessment.

As Lorraine points out, this places a real responsibility on practitioners to help people make the decision and will require practitioners to “front-load” the work. Not only could this actually save time for professionals in the long run (as there would be no need for best interests meetings) but this is fundamentally part of the cultural shift towards empowerment of individuals encapsulated by the MCA.

### CRPD update

The Committee has [published](#) an important General Comment, 7, on the participation of persons with disabilities, including children with disabilities, through their representative organisations, in the implementation and monitoring of the Convention. A very useful blog post by Neil Crowther as to what it says, and does not say (in particular in relation to organisations representing, rather than being led by disabled persons) can be found [here](#).

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## Editors and Contributors



**Alex Ruck Keene:** [alex.ruckkeene@39essex.com](mailto:alex.ruckkeene@39essex.com)

Alex is recommended as a 'star junior' in Chambers & Partners for his Court of Protection work. He has been in cases involving the MCA 2005 at all levels up to and including the Supreme Court. He also writes extensively, has numerous academic affiliations, including as Wellcome Research Fellow at King's College London, and created the website [www.mentalcapacitylawandpolicy.org.uk](http://www.mentalcapacitylawandpolicy.org.uk). To view full CV click [here](#).



**Victoria Butler-Cole:** [vb@39essex.com](mailto:vb@39essex.com)

Victoria regularly appears in the Court of Protection, instructed by the Official Solicitor, family members, and statutory bodies, in welfare, financial and medical cases. Together with Alex, she co-edits the Court of Protection Law Reports for Jordans. She is a contributing editor to Clayton and Tomlinson 'The Law of Human Rights', a contributor to 'Assessment of Mental Capacity' (Law Society/BMA 2009), and a contributor to Heywood and Massey Court of Protection Practice (Sweet and Maxwell). To view full CV click [here](#).



**Neil Allen:** [neil.allen@39essex.com](mailto:neil.allen@39essex.com)

Neil has particular interests in human rights, mental health and incapacity law and mainly practises in the Court of Protection. Also a lecturer at Manchester University, he teaches students in these fields, trains health, social care and legal professionals, and regularly publishes in academic books and journals. Neil is the Deputy Director of the University's Legal Advice Centre and a Trustee for a mental health charity. To view full CV click [here](#).



**Annabel Lee:** [annabel.lee@39essex.com](mailto:annabel.lee@39essex.com)

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



**Nicola Kohn:** [nicola.kohn@39essex.com](mailto: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 4<sup>th</sup> edition of the *Assessment of Mental Capacity: A Practical Guide for Doctors and Lawyers* (BMA/Law Society 2015). To view full CV click [here](#).

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## Editors and Contributors



**Katie Scott:** [katie.scott@39essex.com](mailto: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, and is chair of the London Group of the Court of Protection Practitioners Association. To view full CV click [here](#).



**Simon Edwards:** [simon.edwards@39essex.com](mailto:simon.edwards@39essex.com)

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



**Adrian Ward:** [adw@tcyoung.co.uk](mailto:adw@tcyoung.co.uk)

Adrian is a recognised national and international expert in adult incapacity law. While still practising he acted in or instructed many leading cases in the field. He has been continuously involved in law reform processes. His books include the current standard Scottish texts on the subject. His awards include an MBE for services to the mentally handicapped in Scotland; national awards for legal journalism, legal charitable work and legal scholarship; and the lifetime achievement award at the 2014 Scottish Legal Awards.



**Jill Stavert:** [j.stavert@napier.ac.uk](mailto: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, Alzheimer Scotland's Human Rights and Public Policy Committee, the South East Scotland Research Ethics Committee 1, and the Scottish Human Rights Commission Research Advisory Group. 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

### Conferences at which editors/contributors are speaking

#### Centre for Mental Health and Capacity Law CRPD events

Jill Stavert's Centre at Edinburgh Napier is holding three events around the CRPD in October and November: a workshop on CRPD, mental health and capacity: overcoming obstacles to implementation; a seminar by Dr Shih-Ning Then: *An Antipodean Perspective: Supported Decision-making in Law and Practice* and a lecture by Professor Penelope Weller on *Advance decision-making and the Convention on the Rights of Persons with Disabilities: a cross-jurisdictional discussion*. For details and to book, see [here](#).

#### Taking Stock

Neil and Alex are speaking at the annual Approved Mental Health Professionals Association/University of Manchester taking stock conference on 16 November. For more details, and to book, see [here](#).

### Other events of interest

The London branch of the Court of Protection Practitioners Association is holding a seminar on care home fees on 8 November. For details, and to book, see [here](#).

### Advertising conferences and training events

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

Our next edition will be out in early October. Please email us with any judgments or other news items which you think should be included. If you do not wish to receive this Report in the future please contact: [marketing@39essex.com](mailto:marketing@39essex.com).

**Michael Kaplan**  
Senior Clerk  
[michael.kaplan@39essex.com](mailto:michael.kaplan@39essex.com)

**Sheraton Doyle**  
Senior Practice Manager  
[sheraton.doyle@39essex.com](mailto:sheraton.doyle@39essex.com)

**Peter Campbell**  
Senior Practice Manager  
[peter.campbell@39essex.com](mailto:peter.campbell@39essex.com)



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[clerks@39essex.com](mailto:clerks@39essex.com) • **DX: London/Chancery Lane 298** • [39essex.com](http://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

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[For all our mental capacity resources, click here](#)