



Welcome to the September 2020 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: updated MCA/DoLS guidance, the anorexia Catch-22, and two important cases on deprivation of liberty;

(2) In the Property and Affairs Report: remote witnessing of wills, professional deputy remuneration and the OPG annual report;

(3) In the Practice and Procedure Report: CoP statistics, short notes on relevant procedural points and the UN principles on access to justice for persons with disabilities;

(4) In the Wider Context Report: the NICE quality standard on decision-making and capacity, litigation friends in different contexts, and a guest piece giving a perspective on living with a tracheostomy and a ventilator;

(5) In the Scotland Report: the human rights blind spot in thinking about discharge from hospital in the context of COVID-19.

You can find our past issues, our case summaries, and more on our dedicated sub-site [here](#), where you can also find updated versions of both our capacity and best interests guides. We have taken a deliberate decision not to cover all the host of COVID-19 related matters that might have a tangential impact upon mental capacity in the Report, not least because the picture continues to change relatively rapidly. Chambers has created a dedicated COVID-19 page with resources, seminars, and more, [here](#); Alex maintains a resources page for MCA and COVID-19 [here](#) and Neil has resources on his website [here](#).

If you want more information on the Convention on the Rights of Persons with Disabilities, which we frequently refer to in this Report, we suggest you go to the [Small Places](#) website run by Lucy Series of Cardiff University.

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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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### Living with a tracheostomy and ventilator

*[We are very grateful to Ginny Butcher, disability activist and law graduate, who we invited to share her experiences of living with a tracheostomy and ventilator, a perspective which we think may be of use for those who may be involved in decision-making in relation to such interventions where the individual in question has impaired decision-making capacity]*

Living with a neuromuscular condition is my area of expertise. I have a rare form of Muscular Dystrophy called Nemaline Myopathy. This causes a weaken of the musculoskeletal system; as a result, I am a full-time electric wheelchair user, I require two trained carers to be with me at all times, and I have a permanent ventilated tracheostomy. This is a plastic tube which sits in my trachea to create an artificial airway, it is

connected to a ventilator.

As a young child I had a severe scoliosis of the spine. At age 11, my scoliosis was so severe that my lungs were being gradually crushed. To survive, I had to have titanium spinal rods fused to the full length of my spine, and have a ventilated tracheostomy inserted.

I have now lived with this tracheostomy for half of my life. I would like to present you with a brief, first-hand account of what it is like to live with invasive ventilation and everything that comes with it.

Please keep in mind that I can only speak from my personal perspective; that of a young woman, from a privileged background, with a non-disabled and supportive immediate family, with full cognitive function, and with limited

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physical ability. I am fully *compos mentis* and can therefore control, manage, and choose my own care. I cannot speak to other circumstances.

Being attached to a ventilator for 24 hours a day is a funny thing. The sensation of being ventilated (air pushed into your lungs at a set rate and pressure) is just something that one gets used to. It may be strange at first, but ultimately it is not distressing or uncomfortable. My ventilator is small and sits neatly on the back of my wheelchair, so I can move around freely. It is somewhat noisy, so one must get used to the sound at night-time, as must any roommates.

Most people with a tracheostomy change their tube maybe once a fortnight. For a plethora of reasons, I change my tube daily. My first ever tube change was very difficult; the stoma was raw and bloody, and stitches had to be pulled out. Tube changes were painful for perhaps a number of months after the operation. But now, after so long, this process is as simple and as dull as clipping one's toenails. It takes my two carers about ten minutes to do (this includes washing my neck and other hygiene add-ons) and is completely painless. I lie there and make conversation while they work.

My tracheostomy tube can block up with secretions, so there are two main medical procedures which I can undergo in order to solve this issue.

Firstly, suctioning. I feed a catheter down into my tube and suck out any secretions. I have a suction around 10 times a day, and I also use the Yankauer sucker for my nose and mouth. I am able to control all of my suctioning as I have use of my hands and arms (to an extent), and can therefore control how deep the catheter goes.

Tracheal suctioning for me is completely painless, and it is such a part of my daily life that I hardly think about it. However, if I make a mistake and push the catheter in too deep, it can touch my lung tissue. This stings a little and may cause a small amount of bleeding, but there are no long-term effects.

Secondly, a cough assist. My carers connect my tracheostomy tube to a machine and it forces a high volume of air into my lungs and sucks it out again. This moves any secretions up my lungs so that I can suction them out. I use this machine daily, it takes only 10 minutes and actually makes me feel lovely afterwards as my lungs are hopefully clear and expanded. The sensation of using the machine is strange, perhaps a little uncomfortable, as my lungs are being stretched and vacuumed, but it is short lived.

There are some stresses which come with this form of invasive ventilation. The ventilator pipe can pop off at any moment, so I must have a carer nearby at all times in order to re-attach it. I can experience drowning if any water enters my tracheostomy tube, so my carers are careful when bathing me and I try not to enter any water fights. I must be extremely hot on charging ventilator batteries and carrying spares wherever I go. Ventilator batteries are not my only piece of baggage; I take four bags of equipment whenever I leave the house. This is bothersome, but it can mostly be left in the car, so it is manageable.

I would say, overall, the tracheostomy and ventilator have greatly improved my life. Prior to my operation I was ventilated via a face mask. This meant that I struggled with eating (I was forced to have a gastrostomy inserted) and speaking. With the tracheostomy, I can eat and

talk 'normally'. Having completed a LLB, LLM, and LPC, this has come in very handy. There was a concern that I would be unable to talk after having the tracheostomy inserted, but I am lucky in the sense that I retained my ability to verbalise.

This form of invasive ventilation definitely comes with an array of burdens and struggles. But I know for me, I have learnt over time how to manage and accept these things. I absolutely have days where I feel uncomfortable, breathless, tired, or even self-conscious, but not to an extreme level. I live a full and energetic life; I have been rock climbing, abseiling, canoeing, and zip wiring all with my ventilator strapped to my body. I have flown a plane and completed a half marathon and acted in a professional play.

My tracheostomy and I have a complicated relationship, but we live in precarious harmony. Personally, I would much rather be alive and living with a tracheostomy and ventilator, than be dead.

### NICE Quality Standard: Decision-Making and Mental Capacity

In August 2020, NICE published [QS194](#), a quality standard covering decision making in people aged 16 and over, using health and social care services who may lack capacity to make their own decisions (now or in the future). It aims to support implementation of the aims and principles of the Mental Capacity Act 2005 and relevant Codes of Practice. It is not a substitute for these. As NICE rather ruefully notes, it was *"developed before the coronavirus pandemic and is intended to support quality improvement as services return to normal. Please tell us if there are any particular issues relating to COVID-19 affecting its use that should be highlighted."*

The quality standard is based around four 'quality statements':

- [Statement 1](#) People aged 16 and over who may lack capacity to make decisions are supported with decision making in a way that reflects their individual circumstances and meets their particular needs.
- [Statement 2](#) People aged 16 and over at risk of losing capacity to make decisions, and those with fluctuating capacity, are given the opportunity to discuss advance care planning at each health and social care review.
- [Statement 3](#) People aged 16 and over who are assessed as lacking capacity to make a particular decision at the time that decision needs to be made, have a clear record of the reasons why they lack capacity and the practicable steps taken to support them.
- [Statement 4](#) People aged 16 and over who lack capacity to make a particular decision at the time that decision needs to be made have their wishes, feelings, values and beliefs accounted for in best interests decisions.

Against each quality statement are a set of quality measures which are designed to enable measurement of whether the statements are being met, as well as an indication of what the statement means for different audiences, including the relevant individuals themselves.

### Learning disability and contraception – survey

Jodie Rawles is part of a team, based at the University of Cambridge, conducting research

around the contraception decisions of people with learning (also known as intellectual) disabilities. Research tells us that lots of people with learning disabilities use contraception, but very little is known about how these decisions are made.

To find out more, the team have produced an anonymous, online survey for people who are, or have been, involved in the lives of adults with learning disabilities. The survey takes approximately 15 – 45 minutes to complete. They would really like to hear from you if you have been involved in the lives of people with learning disabilities in some way, whether that be as a family member, support worker, legal professional, or in some other capacity.

You are eligible to take part if:

- You are above the age of 16
- You have been involved in the lives of adults (aged 16+) with learning disabilities within the last five years
- The time that you have spent with adults with learning disabilities has been in England or Wales

While the survey questions are focused on *contraception* decisions, you do not need to have been involved in the contraception decisions of adults with learning disabilities before to take part.

To find out more or take part, please see [here](#).

### Hospital discharges and Continuing Health Care

On 21 August 2020 the NHS COVID-19 [guidance](#) on hospital discharge was comprehensively

updated. This document makes clear that the usual obligations under the MCA 2005 continue to apply. As such, if there is reason to believe that an individual lacks capacity to make decisions about ongoing care and treatment then a capacity assessment should be carried out followed by, where relevant, the making of a best interests decision (see p.13).

The guidance also indicates that testing is required prior to discharge to a care home:

*DHSC/PHE policy is that people being discharged from hospital to care homes are tested for COVID-19 in a timely manner ahead of being discharged (as set out in the Coronavirus: adult social care action plan), regardless of whether they were residents of the care home previously or not. Where a test result is still awaited, the person will be discharged if the care home states that it is able to safely isolate the patient as outlined in Admission and Care of Residents in a Care Home guidance. If this is not possible then alternative accommodation and care for the remainder of the Hospital Discharge Service Policy and Operating Model required isolation period needs to be provided by the local authority, funded by the discharge funding. (p.7 para 3.13)*

From 1 September 2020, CHC assessments and Care Act 2014 assessments will recommence in England (the NHS having paid for care packages from 19 March to 31 August 2020 for patients discharged from hospital or who would otherwise have been admitted to hospital). Specific [guidance](#) on the reintroduction of CHC was published on 21 August 2020.

In summary, NHS funding will be provided (in

addition to existing local authority and CCG funding) to help cover the cost of post-discharge recovery and support services for up to a maximum of six weeks following discharge from hospital. During that period, an assessment of the individual's longer-term needs (including a CHC assessment and an assessment under the Care Act 2014 if relevant) should be undertaken. The expectation is that these assessment processes will be completed within the six week period, and CCGs will not be able to rely on the additional NHS discharge support funding at the end of this time.

### Who Pays?

Updated "Who Pays?" guidance has been [published](#) on NHS England's website, and came into effect from 1 September 2020. The guidance sets out the framework for establishing which NHS body in England is responsible for paying a provider of healthcare services for an individual's NHS care and treatment. It is to be used as the basis for resolving any relevant funding disagreement in relation to historic or ongoing cases.

The core principle remains unchanged that the commissioner responsible for payment will be the CCG of which the patient's GP practice is a member, although the guidance does outline some exceptions to this (see section D, paragraphs 12-19).

The main changes concern stays in hospital (paragraph 13), discharge from hospital and continuing care (paragraph 14) and s.117 aftercare under the MHA 1983 (paragraph 18). There are also new, compulsory arrangements for dispute resolution (Appendix 1 and Appendix 4). It remains the case that uncertainty about

which commissioner is responsible for funding should not lead to the refusal or delay in providing treatment.

### Article 2 in the community

Those following the Melissa Lee inquest will be aware that it concerns the death of a 26 year old woman, with a complex history of mental health problems and substance abuse, who is understood to have died from a drug overdose in 2016. At the time of her death, Ms Lee was an outpatient whose mental health difficulties were being treated through a care plan which provided for care and treatment in the community.

In 2017 the coroner decided that the inquest did not engage Article 2 ECHR because there was no arguable case that the state had breached the operational duty under Article 2 or the systemic duty under Article 2 in the context of a mental health service user receiving services in the community. Ms Lee's mother successfully challenged this decision by way of judicial review ([\[2019\] EWHC 3227 \(Admin\)](#)), with the court finding that the reasons given for the finding that the Article 2 operational duty was not engaged were inadequate. As such, this matter was remitted back to the coroner for fresh consideration; the coroner's [decision](#) in this regard (given in December 2019) has recently become available via the Mental Health Law Online website. In short, the coroner has found that the Article 2 operational duty was not engaged and also that it was not arguably breached on the facts of Ms Lee's case.

In deciding whether the Article 2 operational duty was engaged the coroner applied the three "indicia" identified by the Supreme Court in *Rabone v Pennine Care NHS Trust* [2012] 2 AC 72

said to assist in assessing whether the Article 2 duty applied in a new situation not previously considered by the courts: (i) assumption of responsibility and exercise of control; (ii) the vulnerability of the person concerned; and (iii) the nature and degree of the risk involved. The key aspects of the coroner's reasoning in this regard were as follows:

*The first of the three "indicia" is assumption of responsibility. Melissa was a young woman who at the relevant time apparently had mental capacity to make decisions as to her own care. She was living independently in the community, in her own home. She was receiving social care assistance and clinical care for personality disorder in the community. The Trust had produced a care plan in conjunction with Melissa herself, and the objective of that plan was to promote her personal autonomy. Its guiding principles and provisions were intended to underpin her care and support her in living independently, rather than to place her under supervision. Accordingly, and as explained by Dr Mitchell, the plan sought to avoid unjustified hospital admissions in the best clinical interests of the patient.*

*In my view, the situation in Melissa's case did not involve assumption of the level of responsibility by the state which has been found in the cases where the Article 2 duty is owed. The state did not exercise close supervision or control, as in the cases involving detention or a situation closely comparable to that of detention. It did not take responsibility for overseeing Melissa's daily life. It did not assume responsibility by creating a danger for her, as has been the case in some of the authorities.*

[...]

*The second of the three "indicia" is vulnerability. It is true that, in one sense, Melissa was more vulnerable than most people in the community, in that she had mental health problems which presented an established propensity for self-harm (with the risk of serious harm). However, she did not demonstrate the kind of helpless or acute vulnerability which Lord Dyson instances at para. 23 of the Rabone case (there, a child known to be at risk of abuse). Melissa had mental capacity at the relevant times, and was involved in the care plans which were made for her. She exercised self-will and had the means and ability to request help. To the extent that she was vulnerable, it was an inherent vulnerability to her own condition.*

[...]

*The third of the three "indicia" is the nature and degree of risk. Again, it is true that Melissa presented a particular kind of risk. However, it was a long-term, chronic risk of self-harming which fluctuated and at over a long period entailed the possibility of inadvertent, serious harm. This nature and degree of risk can be seen from her previous episodes of self-harm and from the sequence of events in the months and weeks leading up to her death which I have summarised above. Although there were signs of dangerous behaviour in the period leading up to Melissa's death, the records indicate that similar signs could have been identified at many times in the past. In Rabone at para. 24, when referring to this feature, Lord Dyson suggested that the question was whether or not the risk was "ordinary" for*

*individuals of the kind in question (his example being that of soldiers in a combat zone). The risk of self-harm and suicide in Melissa's case was chronic and was sadly consistent with her condition. The best available guidance, and the advice of clinicians, supported her living independently despite that chronic risk.*

The coroner went on to find that even if the Article 2 operational duty was engaged, there was no arguable breach. In particular, it was said that there was no point at which clinicians ought to have appreciated that Ms Lee presented a real and immediate risk of death in circumstances where there was a history of self-harming behaviour that was part of Ms Lee's chronic clinical presentation, and where Ms Lee was under a regime of care whereby she was only to be admitted to hospital where that was necessary to deal with immediate management of a crisis and for clear and specific therapeutic purposes.

As such, while every individual case will turn on its facts, this particular case demonstrates the difficulties in attempting to extend the Article 2 operational duty to mental health service users being treated in the community, as opposed to those who are being detained or whose hospitalisation amounts to a high degree of control being exercised by agents of the State.

### Article 2 – systemic vs individual failures in the context of DNACPR

The Divisional Court has recently handed down judgment in *R (Iroko) v HM Senior Coroner for Inner South London* [2020] EWHC 1753 (Admin), a

challenge to the relevant coroner's ruling that there was no requirement to hold an Article 2 compliant inquest in that particular case. In circumstances where the Hospital Trust had made a "do not resuscitate" ("DNR") decision<sup>1</sup> without having consulted with the deceased's family, the Claimant argued that Article 2 required an examination of whether there were systemic failings underlying Trust's failure in this regard.

The challenge was dismissed, with the court finding that there was no systemic failure which would trigger the need for an Article 2 compliant inquest. That was because the Trust's DNR Policy was clear that, in taking a DNR decision, clinicians were required to consult with family members. In so far as the clinicians here failed to comply with the DNR Policy, that was an individual error in the face of systemic requirements (see paragraph [40]).

### Short Note: the EAT and litigation capacity

*Stott v Leaded* [2020] UKEAT 0263\_19\_2002 is an interesting case which considers when the court should properly consider that a party before it lacks capacity to conduct proceedings.

The Appellant in the case brought a claim for unfair dismissal having been sacked from his job as a sequence picker for twice having breached rules preventing him from leaving his "work cell" during a shift. The Appellant was agreed to be disabled by reason of mental impairment, namely anxiety. His claim for unfair dismissal was not successful however, the Employment

<sup>1</sup> In fact, it was not a Do Not Attempt Resuscitation decision, but a Do Not Attempt CPR decision.



Tribunal determining that it was neither substantively nor procedurally unfair.

He appealed to the Employment Appeal Tribunal, representing himself and settling his own notice of appeal and skeleton argument. At the Preliminary Hearing, however, he advised the court that he had problems with both mobility and Autistic Spectrum Disorder. At the hearing before the EAT, he was represented by an Employment Law Appeal Advice Scheme (“ELAAS”) representative: a barrister acting in a pro bono capacity on his behalf<sup>2</sup>.

At the commencement of the EAT hearing, the Claimant’s ELAAS representative addressed the Court, taking on the role of friend of the Court (“amicus curiae” as formerly known) rather than on the Claimant’s behalf, to raise concerns she had regarding his litigation capacity. She noted that he had previously been determined to lack litigation capacity in unconnected possession and committal proceedings and was in position of a certificate as to capacity from a psychiatrist. With reference to the *Assessment of Mental Capacity: A Practical Guide for Doctors and Lawyers* – edited by Alex – the ELAAS representative submitted that if the court were to proceed with the appeal without considering further the question of the Appellant’s capacity, it would be acting unlawfully.

Naomi Ellenbogen QC, sitting as a Deputy High Court Judge, acknowledged that she had not been referred to any authority directly concerning the EAT’s power to appoint a litigation friend. Nonetheless, she determined that following the judgment in *Jhuti v Royal Mail*

*Group Ltd* [2018] ICR 1077, once invited to investigate a party’s mental capacity, the ETA should only accede to such an approach where there is clear evidence to support it (para 8.i). Noting the lack of any clear Rules or Guidance to be followed in the EAT in such circumstances, she recorded the Court’s hope that “urgent consideration” would now be given to implementation of powers regarding proceedings involving protected parties. She adjourned the appeal in order that up to date evidence as to the Appellant’s litigation capacity could be sourced.

As Naomi Ellenbogen QC remarks in her judgment, it is significant and concerning that some 2.5 years after the “urgent” need for rules regarding the treatment by tribunals of those lacking capacity had been identified by the Court of Appeal in *AM (Afghanistan)* [2017] EWCA Civ 1123 no obvious progress has been made in this area. It is equally troubling that, but for the pro bono representation with which the Appellant was fortunate enough to have been provided, the matter might never have been raised.

### Short note: litigation friends and liability for costs

*Glover v Barker, Confiance & Barker* [2020] EWCA Civ 1112 concerns the vexed subject of when litigation friends in civil proceedings should be liable for costs.

It is a fiendishly long and complex judgment arising out of the fiendishly long and complex litigation regarding negligent tax advice given to the Claimant, Mr Barker, regarding the creation

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<sup>2</sup> Katherine Apps of 39 Essex Chambers, who has not contributed to this note.

of an employee benefit trust ("EBT"). The EBT created a sub-trust of which it was intended that Mr Barker's five children from three different relationships would become beneficiaries. Due to the negligent advice, however, it was necessary for Mr Barker to seek to wind up the sub-trust. He launched proceedings in order to do so; a compromise was agreed which provided for £1 million to be settled on discretionary trusts for the benefit of one of Mr Barker's children, Euan, and the principal beneficiaries of the sub-trust. The compromise was reached on the basis that Euan was acting as representative for all of Mr Barker's Principal Beneficiaries. In fact however, two of his minor children – his eldest children, twins, and their mother, were unaware of the settlement, or indeed the claim.

A claim was then made on behalf of the twins with their mother acting as litigation friend, seeking to set aside the order authorising the compromise. It was not successful and a costs award was made against the company said to be the children's assignee. The costs were not paid and the company representing the twins was wound up.

In further litigation brought by the twins by their litigation friend and mother that followed, the court held that, had it been asked to approve the order compromising the original proceedings, it would have had "no hesitation" in approving the settlement; further, that even if it had been aware that the twins were not aware of the proceedings and that their brother was not representing them, the settlement would, in all probability, still have been approved. The parties sought the costs of the application as against the children's litigation friend. The judge refused to make a costs order against the twins directly but did

order their mother and litigation friend to pay the costs of all the other parties.

This costs order was the subject of the Court of Appeal judgment. The judge at first instance had determined that "[w]hen considering whether to make an order for costs against a litigation friend, who has acted for an unsuccessful child party, the court should apply the general approach that, as regards costs, the litigation friend is expected to be liable for such costs as the relevant party (if they had been an adult) would normally be required to pay. The governing rule is that the court has regard to all the circumstances of the case and it is open to the litigation friend to point to any circumstance as to their involvement in the litigation which might justify making a different order for costs from that which would normally be made against an adult party."

Allowing the litigation friend's appeal, Newey LJ giving a judgment, with which LJJ Patten and Moylan agreed, held that while it remained the case that liability for costs should typically be imposed on a claimant's litigation friend, this was with the important caveat that, "when deciding whether to make such an order, the Court is exercising a discretion and entitled to have regard to the particular circumstances of the case" (paragraph 62). Holding further that there was not a "general principle to the effect that a defendant's litigation friend should be liable for such costs as the child or protected party would normally be required to pay", Newey LJ set down this helpful precis of the law at paragraph 64:

*i) ....where a litigation friend has not previously given an undertaking to pay the costs at issue, the power to make an order for costs against a litigation friend derives exclusively from section 51 of the*

1981 Act;

*ii) When deciding whether an order should be made against a litigation friend under section 51, the "ultimate question" is "whether in all the circumstances it is just to make the order";*

*iii) It will typically be just to order a claimant's litigation friend to pay costs if such an order would have been made against the claimant himself had he not been a child or protected party, but it remains the case that the Court is exercising a discretion and entitled have regard to the particular circumstances;*

*iv) There is no presumption that a defendant's litigation friend should bear costs which the defendant would have been ordered to pay if not a child or protected party. That the litigation friend controlled the defence of a claim which succeeded will not of itself generally make it just to make an adverse costs order against the litigation friend. Factors that might, depending on the specific facts, be thought to justify such an order include bad faith, improper or unreasonable behaviour and prospect of personal benefit. If a director causes his company to litigate "solely or substantially for his own benefit" (to quote Lord Brown in Dymocks), that may point towards a costs order against him. The fact that a litigation friend stands to gain a substantial personal benefit must also, I think, be capable of weighing in favour of a costs order against him.*

Following this analysis, the Court of Appeal allowed the litigation friend's appeal and set aside the costs order made at first instance.

While this judgment is useful for the

encyclopaedic review of the law it sets out on the subject, its main takeaway, as is increasingly the case it seems in the Court of Appeal, is that the award of costs is a matter for the discretion of the court to be determined by the facts of the particular case.

### The 'frozen' attorney

Whilst we await – we hope – further guidance on the position in relation in the next iteration of the MCA Code of Practice/from the OPG, Alex has given some thoughts on his website as to the – not uncommon – situation where an attorney is empowered to make a decision but cannot bring themselves to make it.

#### RESEARCH CORNER

We highlight here recent research articles of interest to practitioners. If you want your article highlighted in a future edition, do please let us know – the only criterion is that it must be open access, both because many readers will not have access to material hidden behind paywalls, and on principle.

This month, we highlight the special issue of the International Journal of Law and Psychiatry drawing on the work of the Mental Health and Justice Project. Amongst other articles, it includes an article co-written by Alex on Taking capacity seriously? Ten years of mental capacity disputes before England's Court of Protection.

#### BOOK REVIEW

[A Practical Guide to the Law of Medical Treatment Decisions](#) (Ben Troke, Law Brief Publishing, 2020, c£39.99)

Ben Troke, a solicitor and partner at Hill Dickinson, expresses the hope in the introduction in this new book that in it, he can "*set out a practical overview that might be helpful not only to lawyers in the field, but also to clinicians and to any individuals who have an interest in how crucial medical treatment decisions will be made for ourselves and our families.*" He succeeds triumphantly in his goal, in a book which is accessible, accurate, timely (including discussion of COVID-19), personal (in the right way), and even in places surprisingly funny. In a (relatively) short compass, he manages to cover a huge amount of ground, covering both the position in England & Wales both in respect of children and in respect of adults; importantly, he also never loses sight of the fact that – more here than anywhere else – the law and ethics are in constant conversation.

Many who buy this book may well be doing to get an overview of the key issues, and I suspect that many of those who do so will indeed be clinicians as Ben anticipates. They will gain a huge amount from it, and, in many cases, it will provide them all that they need to be able to think through matters from themselves (and/or – which is just as important – stop and ask themselves whether now is the time to go and consult a lawyer). However, even for the real enthusiasts who already have on their bookshelves works such as the monumental [Principles of Medical Law](#) or the slimmer, but still very dense (in the right

way) [Medical Treatment: Decisions and the Law](#), the book will make a stimulating read.

*Alex Ruck Keene*

[Full disclosure, I had sight of this book, and made comments upon it, in draft form, and was also provided with a copy by the publishers.

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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 Visiting Professor at King's College London, and created the website [www.mentalcapacitylawandpolicy.org.uk](http://www.mentalcapacitylawandpolicy.org.uk). To view full CV click [here](#).

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Victoria regularly appears in the Court of Protection, instructed by the Official Solicitor, family members, and statutory bodies, in welfare, financial and medical cases. 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), and a contributor to Heywood and Massey Court of Protection Practice (Sweet and Maxwell). To view full CV click [here](#).

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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](http://www.lpslaw.co.uk). To view full CV click [here](#).

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

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Katherine has a broad public law and human rights practice, with a particular interest in the fields of community care and health law, including mental capacity law. She appears regularly in the Court of Protection and has acted for the Official Solicitor, individuals, local authorities and NHS bodies. 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: [adrian@adward.co.uk](mailto: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.

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

## Conferences

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

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

### **Advertising conferences and training events**

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

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

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