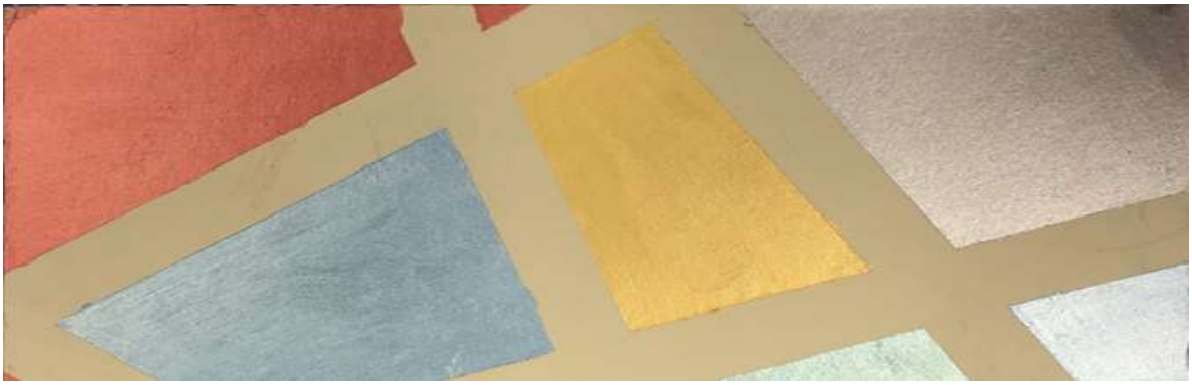
MENTAL CAPACITY REPORT: THE WIDER CONTEXT

October 2021 | Issue 116



Welcome to the October 2021 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: the 14th birthday of the MCA, an important case about the scope and limits of ADRTs, and the impact of coercive control on capacity;

(2) In the Property and Affairs Report: a deputy stand-off and new blogs from the OPG;

(3) In the Practice and Procedure Report: anticipatory declarations and medical treatment – two different scenarios;

(4) In the Wider Context Report: children, competence and capacity in different contexts, the JCHR launches an inquiry into human rights in care settings, and a Jersey perspective on deprivation of liberty;

(5) In the Scotland Report: the Supreme Court, devolution and implications for CRPD incorporation, and resisting guardianship.

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. 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 a page 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.

Contents

Eating and drinking with acknowledged risks

The Royal College of Speech and Language Therapists has published multidisciplinary guidance to help guide healthcare professionals through the complex decision-making process to support adults when eating and drinking with acknowledged risks.

As the guidance identifies, the Royal College of Physicians document 'Supporting people who have eating and drinking difficulties' (2021) is the primary guidance for care and clinical assistance towards the end of life, the RCLST document will serve as an adjunct referring to the nuances within the decision-making process for adults eating and drinking with acknowledged risks irrespective of the stage or progression of their illness.

Full disclosure: Alex was involved in the later stages of both projects.

Gillick competence and capacity: the Court of Appeal pronounces

Bell & Anor v The Tavistock and Portman NHS Foundation Trust [2021] EWCA Civ 1363 (Court of Appeal (Lord Burnett of Maldon, Sir Geoffrey Vos, MR and King LJ))

Other proceedings – family law

Summary[1]

In *Bell & Anor v The Tavistock and Portman NHS Foundation Trust* [2021] EWCA Civ 1363, the Court of Appeal roundly upheld the appeal of the Tavistock and Portman NHS Foundation Trust against the declaration made by the Divisional Court as to the relevant information that a child under the age of 16 would have to understand, retain and weigh up in order to have competence to consent to the administration of puberty blocking drugs. As is common practice now, the Court of Appeal has provided a short summary

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

of its judgment, but in headline terms, the key points of the judgment are as follows.

By way of important context, the judicial review been brought by two claimants, one of whom (Keira Bell) was a former patient of the Tavistock who was treated with puberty blockers as a 16-year old, progressed to cross-sex hormones and began surgical intervention as an adult to transition from female to male. She terminated her treatment having changed her mind and regretted having embarked upon the treatment pathway. The second claimant (Mrs A) was the mother of a child who suffered from gender dysphoria and had been referred to Tavistock, but had not yet had an appointment. The purpose of the judicial review had been to require, as a matter of law, the involvement of the court before anyone under the age of 18 was prescribed puberty blockers, thus denying the opportunity of consent to such treatment either individually or with the support of their parents or legal guardians. The argument was that those under 18 were not capable in law of giving valid consent to the treatment. The Divisional Court did not accept this proposition, but, rather than dismissing the judicial review, it (1) made the declaration above; (2) gave extensive guidance as to practice and procedure, in particular as to when the involvement of the court would be appropriate.

The question before the court was whether the Divisional Court was right to do both of these things. As the Court of Appeal noted, the arguments that it had heard about the Divisional Court's approach to the evidence provided the background to this question.

The Court of Appeal held that the Divisional Court had erred in its approach to the evidence. Having noted that evidence adduced by the claimants appeared to have informed the Divisional Court's conclusion that the treatment was experimental, and in relation to the conclusion that it was highly unlikely that a child under 14 could give valid consent to puberty blockers and improbable that a child aged 14 or 15 could do so, the Court of Appeal identified that:

> *38. The claimants made no application for permission to rely upon the expert evidence they produced. Although some expert evidence was served with the claim the majority was served shortly before skeleton arguments were due to be lodged. None of it complied with the rules regarding expert evidence and a good deal of it is argumentative and adversarial. Tavistock sought to exclude the expert evidence on the grounds that it was inadmissible because it was not necessary to resolve the legal issue before the court; and also because it comprehensively failed to comply with the rules regarding expert evidence in any event. The issue was not resolved. Much of it was adduced to contradict the evidence given by Tavistock and the Trusts. Such evidence is rarely admitted but a particular difficulty here was that there was no way of resolving evidential disputes. The court supported the guidance it gave "in the light of the evidence as it has emerged": see para [147]. It would have been preferable for the status of the claimants' expert evidence to be resolved. It was controversial and would not, as we have said, ordinarily be preferred over that of a defendant in judicial review proceedings.*

At paragraphs 62ff, the Court of Appeal returned to this theme:

62. The correct approach was not in dispute. It was not for the court hearing a judicial review to decide disputed issues of fact or expert evidence (see paras [9], [70] and [74]). That principle is only subject to exceptions that are not relevant to this case. The question is whether, notwithstanding its acceptance of the principle, the Divisional Court placed reliance on the contested and untested expert evidence of the claimants as Tavistock and the Trusts contend. The claimants submit that the salient facts decided by the court were taken from Tavistock's own evidence so that they were effectively common ground.

63. This dispute applies most significantly to the two findings to the effect that treatment of gender dysphoria with puberty blockers was "experimental" (see paras [28], [74], [93], and [134]), and that the vast majority of patients taking puberty blockers go on to cross-sex hormones and are on a pathway to much greater medical interventions (see paras [68] and [138]). The Divisional Court recorded at para [70] that Professor Butler had "explained that it is very common for paediatric medicines to be used off-label and that this factor does not render the treatment in any sense experimental." It nonetheless concluded at para [134] that the treatment was experimental in the sense it explained in that paragraph (real uncertainty over the short and long-term consequences of the treatment with very limited evidence as to its efficacy). The argument may, in one sense, be semantic, but, respectfully, we think that it would have been better to avoid controversial factual findings.

64. The same points apply to the finding that the vast majority of patients taking puberty blockers go on to cross-sex hormones and are on a pathway to much greater medical interventions. The evidence filed by Tavistock indicated that more than half of those who embark upon a course of puberty blockers go on to cross-sex hormones. For the Divisional Court to have reached with confidence the conclusion set out at [138] that the "vast majority of patients taking [puberty blockers] go on to [cross-sex hormones] and therefore that s/he is on a pathway to much greater medical interventions", it would, we think, have been necessary not only to look at the limited data provided by Dr de Vries and Dr Carmichael, but also to evaluate evidence as to how patients were chosen for puberty blockers, the progression of the treatment, and multiple issues affecting progression between treatment pathways, including the consent processes for subsequent treatment stages. Tavistock and the Trusts argue that the Divisional Court failed to appreciate the difference between a causal connection and an association, whatever the proportion of those who move from one treatment to another. The correlation may be the result of effective selection of those for puberty blockers and information sharing at the consent stage. The point, however, is that these judicial review proceedings did not provide a forum for the resolution of contested issues of fact, causation and clinical judgement.

65. As will appear from what we say in the next section of this judgment, we have concluded that the declaration implied factual findings that the Divisional Court was not equipped to make.

Turning to the question of whether the Divisional Court was right to make the declaration, the

Court of Appeal identified that no example of a declaration being granted in judicial review proceeding in which a clear legal challenge had failed was drawn to their attention. It then noted that

> *70. The declaration is in terms which not only states the law but also identifies an exhaustive list of the factual circumstances that must be evaluated in seeking consent from a child and specifies some matters as conclusive facts. It comes close to providing a checklist or script that clinicians are required to adopt for the indefinite future in language which is not capable of clear and uniform interpretation and in respect of which there were evidential conflicts. Some of the factors identified in the declaration are simple statements of fact. Others beg questions to which different clinicians would give different answers.*

The Court of Appeal was particularly struck by the fact that:

> *75.* […] *The declaration would require the clinicians to suspend or at least to temper their clinical judgement and defer to what amounts to the clinical judgement of the court on which key features should inform an assessment of Gillick competence, influenced by the views of other clinicians who take a different view and in circumstances where Mr Hyam accepts that the service specification, which sets out criteria for referring a child for puberty blockers, is not unlawful.*
>
> *76. The* ratio decidendi *of* Gillick *was that it was for doctors and not judges to decide on the capacity of a person under 16 to consent to medical treatment. Nothing about the nature or implications of the treatment with puberty blockers allows for a real distinction to be made between the consideration of contraception in* Gillick *and of puberty blockers in this case bearing in mind that, when Gillick was decided 35 years ago, the issues it raised in respect of contraception for the under 16s were highly controversial in a way that is now hard to imagine. A similar conclusion was reached by Silber J in connection with abortion in* R (Axon) v. Secretary of State for Health *[2006] QB 539 at para [86].*

The Court of Appeal identified that

> *78. The legal issue before the Divisional Court was not a general inquiry into the content of information and understanding needed to secure the informed consent of a child, although we have great sympathy with the Divisional Court given the large volumes of materials which informed that clinical issue. The declaration which the Divisional Court made does not sit happily with the observations of Lord Phillips* [in *Burke*, as to the dangers of a court being used as a "*general advice centre*," and also declarations which did not resolve issues between the parties but *"appeared intended to lay down propositions of law binding upon the world*"]

It continued:

> *80. A formal declaration states the law. In so far as it specifies facts as part of the law (itself a difficult concept) they remain the law. There is a great deal of difference between the declaration originally sought*

in these proceedings ("no prescription of puberty blockers without court approval") or in Gillick ("no contraceptives without parental consent") and the declaration made here. It turns expressions of judicial opinion into a statement of law itself. In addition, it states facts as law which are both controversial and capable of change. Both Lords Fraser and Scarman in Gillick expressed views about the matters which a clinician would have to explore with a patient, without being prescriptive and recognising that it was for the clinicians to satisfy themselves, in their own way. No declaration was contemplated to capture the essence of that thinking. It would have been inconsistent with the ratio of the case that clinicians must be trusted to make the decisions for the court effectively to give them a manual about how to do so. It is instructive to consider the language of Lord Scarman on the main issue in Gillick at pages 188H to 189A:

> *"I would hold that as a matter of law the parental right to determine whether or not their minor child below the age of 16 will have medical treatment terminates if and when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed. It will be a question of fact whether a child seeking advice has sufficient understanding of what is involved to give consent valid in law."*

81. His conclusion on the law is found in the first sentence but the second recognises that the question whether valid consent is given in any case is a question of fact. That depends upon the individual circumstances of any child and the surrounding circumstances of the clinical issues. Both he and Lord Fraser identified at a high level what they could expect a clinician to take into account in making a clinical decision. Turning their observations into formal declarations (all the more so if they included immutable facts) would have been inappropriate. It is a matter of clinical judgement, tailored to the patient in question, how to explain matters to ensure that the giving or refusal of consent is properly informed. As Lord Fraser observed at page 174F, medical professionals who do not discharge their responsibilities properly would be liable to disciplinary sanction. The law of informed consent culminating in Montgomery also exposes the vulnerability of clinicians to civil action from someone they have treated who shows that they did so without first obtaining informed consent.

The Court of Appeal was therefore clear that that the Divisional Court was wrong to make the declaration. It was equally clear that it was wrong to have given guidance, although it recognised that it "*stemmed from the understandable concern of the Divisional Court for the welfare of children suffering from gender dysphoria who, it is common ground, are deeply distressed and highly vulnerable*." Critically, however, the Court of Appeal found that the Divisional Court was "*was not in a position to generalise about the capability of persons of different ages to understand what is necessary for them to be competent to consent to the administration of puberty blockers*" (paragraph 85). The Court of Appeal also noted that:

86. […] *the effect of the guidance was to require applications to the court in circumstances where the Divisional Court itself had recognised that there was no legal obligation to do so. It placed patients, parents and clinicians in a very difficult position. In practice the guidance would have the effect of denying treatment in many circumstances for want of resources to make such an application coupled with inevitable delay through court involvement. Furthermore, the guidance that there should be an application to the court in circumstances where child, parents and clinicians all consider the treatment to be in the best interests of the child would be inconsistent with the conclusion of the Supreme Court in An NHS Trust (discussed at [49] above).*

[…]

89. We conclude that it was inappropriate for the Divisional Court to give the guidance concerning when a court application will be appropriate and to reach general age-related conclusions about the likelihood or probability of different cohorts of children being capable of giving consent. That is not to say that such an application will never be appropriate. There may be circumstances where there are disputes between one or more of clinicians, patients and parents where an application will be necessary, even if they are difficult to envisage under the service specification and SOP with which this case is concerned.

The conclusions of the Court of Appeal merit reproduction in full:

92. We should not finish this judgment without recognising the difficulties and complexities associated with the question of whether children are competent to consent to the prescription of puberty blockers and cross-sex hormones. They raise all the deep issues identified in Gillick, and more. Clinicians will inevitably take great care before recommending treatment to a child and be astute to ensure that the consent obtained from both child and parents is properly informed by the advantages and disadvantages of the proposed course of treatment and in the light of evolving research and understanding of the implications and long-term consequences of such treatment. Great care is needed to ensure that the necessary consents are properly obtained. As Gillick itself made clear, clinicians will be alive to the possibility of regulatory or civil action where, in individual cases, the issue can be tested.

93. The service specification and SOP provide much guidance to the multi-disciplinary teams of clinicians. Those clinicians must satisfy themselves that the child and parents appreciate the short and long-term implications of the treatment upon which the child is embarking. So much is uncontroversial. But it is for the clinicians to exercise their judgement knowing how important it is that consent is properly obtained according to the particular individual circumstances, as envisaged by Gillick itself, and by reference to developing understanding in this difficult and controversial area. The clinicians are subject to professional regulation and oversight. The parties showed us an example of a Care Quality Commission report in January 2021 critical of GIDS, including in relation to aspects of

> *obtaining consent before referral by Tavistock, which illustrate that. The fact that the report concluded that Tavistock had, in certain respects, fallen short of the standard expected in its application of the service specification does not affect the lawfulness of that specification; and it would not entitle a court to take on the task of the clinician in determining whether a child is or is not Gillick competent to be referred on to the Trusts or prescribed puberty blockers by the Trusts.*
>
> *94. Once it was conceded by the claimants that the Divisional Court had made no findings of illegality, the focus of this appeal was squarely on Gillick and whether, by making the declaration accompanied by guidance requiring (probably frequent) court intervention, the Divisional Court had placed an improper restriction on the Gillick test of competence. In our judgment, whilst driven by the very best of intentions, the Divisional Court imposed such a restriction through the terms of the declaration itself, by the utilisation of age criteria and by the requirement to make applications to the court. As we have said, applications to the court may well be appropriate in specific difficult cases, but it was not appropriate to give guidance as to when such circumstances might arise.*

Comment

The Court of Appeal were at interesting pains to make clear what they were not considering:

(1) The situation where a court is asked to approve life-sustaining treatment for under-18s to which they or their parents are unable or unwilling to consent (recently considered by Sir James Munby in *Re X (A child)(No 2)* [2021] 4 WLR 11) (paragraph 82).

(2) The situation where a child (by which the Court of Appeal must mean a child of 16 or 17) lacks capacity to make the decision to consent to puberty blockers/cross-sex hormones applying the MCA 2005, although the Court of Appeal observed – somewhat cryptically – that "[w]*e do not think that a comparison between the exercise of assessing Gillick competence and the process envisaged under the Mental Capacity Act 2005* […] *assists in this case*." The Court of Appeal referred to the judgment of Sir James Munby in *Re X (A child)(No 2)* [2021] 4 WLR 11 in relation to this point (the reference to paragraph 72 of that judgment must be a typographical error), in which Sir James observed that he considered that:

> *the tests of capacity and of Gillick competence have nothing very obvious in common, not least because they are rooted in different areas of scientific knowledge and understanding. Capacity, or, more precisely, lack of capacity, derives from what Butler-Sloss LJ referred to in Re MB as "some impairment or disturbance of mental functioning", what in section 2(1) of the 2005 Act is referred to as "impairment of, or a disturbance in the functioning of, the mind or brain." Gillick competence, in contrast, is tied to the normal development over time of the typical child and teenager. In the first, one is therefore in the realm of psychiatry. Indeed, it is notorious that Thorpe J's analysis in In re C,*

> *from which everything since has flowed, was modelled on the analysis provided in the expert evidence of a psychiatrist, Dr Eastman. In the other, one is not in the realm of psychiatry, rather that of child and adolescent psychology.*

In this regard, it is of note that the focus of these observations was upon the distinction between the normal maturation process and the potential for a (by definition) abnormal impairment or disturbance in the functioning of the mind or brain. In MCA-speak, in other words, these comments related to the so-called 'diagnostic' element. The Court of Appeal did not address the so-called 'functional' element. Even if not a legal requirement, it is suggested that doctors are likely to find it useful to probe whether a child is *Gillick* competent to be able to make the decision in question by asking whether they can understand, retain, use and weigh the necessary information.

(3) Children covered by s.8 Family Law Reform Act 1969, which provides that the consent of a minor over 16 to 16 "to any surgical [or] medical treatment … shall be as effective as it would be if he were of full age."

As (in a different context) a previous Court of Appeal had been in relation to the case of Leslie Burke, this Court of Appeal was equally robust in identifying that – in essence – the lower court had been lured out of its role in determining a dispute before it into seeking to resolve ethical dilemmas.

The Court of Appeal's identification that the responsibility for determining whether a young person has the *Gillick* competence to consent to treatment (of any kind) lies with the clinician proposing that treatment is robust and clear. However, to the extent that the judgment could be read as saying that the courts simply cannot consider the question at all, it is more problematic. It would certainly come as a surprise to judges of the Family Division who have considered for themselves over the years whether they are satisfied as to the *Gillick* competence of a child to accept or refuse medical treatment (see, for instance, the judgment of Baker J (as he then was) in *An NHS Trust & Anor v A & Ors* [2014] EWHC 1135 (Fam), in which the judge took into account both clinical evidence and "informal oral evidence" on the part of the young man in question when considering his competence). The concept of *Gillick* competence has also escaped the gravitational pull of medical decision-making, and has been considered by judges, for instance, in relation to the ability of a young person to consent to the adoption of her child, and, again, it would likely come as a surprise to such judges that they have no ability to resolve a dispute as to whether valid consent has been given. In the circumstances, therefore, it is suggested that the proper approach (in line with the position in *Re Y*, expressly referred to by the Court of Appeal) is that where there is consensus, there is no need to approach the courts, but, there is dispute or debate, or the issue of competence is finely balanced that (1) the court can be approached to reach a resolution of the question; and (2) the courts can determine – with the benefit of appropriate evidence – what is (as the House of

Lords identified in *Gillick*) ultimately a question of fact.[2]

It should be noted in any event that even if the Court of Appeal did, in fact, intend to say that the court can never take on the role of determining (guided by the relevant clinical evidence) whether a child is or is not *Gillick* competent in respect of the decision in question, this cannot apply to the question of whether a person of 16 or over has or lacks the mental capacity to make a decision. Section 15(1)(a) MCA 2005 expressly empowers the Court of Protection to make exactly such a decision.

Finally, the Court of Appeal in this case was clearly troubled by the fact that the Divisional Court had embarked upon an abstract exercise in relation to the question of identification of what information a young person should be able to process to be able to consent to the administration of puberty blockers. It is in this regard striking that the appellate courts are entirely comfortable with the idea of setting down the types of information that a person should be able to understand, retain, use and weigh to make a decision for purposes of the MCA 2005. Perhaps the difference is that they do not seek to reduce these to declarations; or perhaps the difference is that they do not enter into medical debates. But it is a difference which will no doubt fall for further consideration in due course.

Human rights in care settings

The Joint Committee on Human Rights has launched a new inquiry to investigate whether the human rights of residents and their families are respected in care homes in England.

During the Covid-19 pandemic, the Joint Committee on Human Rights reported on the detention of young people with disabilities or autism and called for further action to end blanket bans on visiting people in residential care homes, including a statutory right to an individualised risk assessment before any restrictions on visiting are imposed.

However, human rights concerns extend beyond those which came to the fore during the pandemic. There are also ongoing concerns about the application of Do Not Attempt Cardiopulmonary Resuscitation notices, poor use of treatment escalation plans, over-medication, and Deprivation of Liberty Safeguards.

The new inquiry will examine how the human rights of those accessing social care are currently undermined or put at risk, and what can be done to enhance legal protections. It will examine how well care providers ensure the human rights of the people under their care and how regulators ensure high standards in the sector. The inquiry will cover the broad range of social care services including support for older people and people with long-term medical or mental health disabilities.

The Joint Committee invites written submissions on the following questions:

- What human rights issues need to be addressed in care settings in England,

[2] There was, of course, no such debate in this case in relation to whether a specific child patient was actually *Gillick* competent to give consent (and in *AB v CD*, decided subsequently, and endorsed by the Court of Appeal in this case (see paragraph 48) the court did not have to confront the issue head-on: see paragraph 51).

beyond the immediate concerns arising from the Covid-19 pandemic?

- How effective are providers at respecting the human rights of people under their care?
- How effective are regulators in protecting residents from human rights breaches and in supporting patients and residents who make complaints about their care provider?
- What lessons need to be learned from the pandemic to prevent breaches of human rights legislation in future?

The deadline for submissions is 1 November 2021.

For further details, see here.

Short note: competence or capacity?

In *An NHS Trust v D (A Minor: Out of Hours Application)* [2021] EWHC 2676 (Fam) MacDonald J heard an application in the very early hours of the morning for an urgent order to carry out blood tests and administer treatment to a 16 year old looked after a child, accommodated in a children's home by the local authority. The local authority had parental responsibility for her and her parents were not involved with her. As the doctor giving evidence on behalf of the applicant Trust identified:

> *She reportedly took 16 tablets of 500mg of paracetamol at her care home at 0400am on the 4th October 2021. There was a long delay in presentation and she arrived in the department at 15:32. She refused investigations and she refused the antidote treatment for paracetamol toxicity. She was seen by the CAMHS team and was deemed to have capacity but they wanted to keep her in overnight to "cool off" and to reassess in the morning. The patient left the department at 20:00 and is back at her children's home with her key worker and is refusing to come back.*

Following the child leaving hospital after refusing treatment, the Trust submitted (paragraph 6):

> *that the local authority were less than helpful when contacted by the Trust, a duty solicitor for that local authority indicating that, notwithstanding the situation I have described above, no further action would be taken by the local authority save for observing D in the placement. I am conscious that the local authority is not represented before the court, but on the face of it this is an extraordinary position for a local authority with parental responsibility for a child to have taken in light of the level of concern expressed by D's treating doctors.*

The optimum window for administering treatment comprising the 24 hour period following ingestion of paracetamol had almost expired, the matter coming before the court some 22½ hours after the child took the overdose. She was at that point refusing to attend hospital for treatment. The police and ambulance service were confirmed they are willing to convey her to the hospital for blood tests and any treatment required once a court order is in place.

In the circumstances, it is perhaps not surprising that MacDonald J had no hesitation in making the order sought. What is perhaps slightly odd, however, is that the clinicians – and the court – proceeded on the basis that the touchstone was

the child's *Gillick* competence. As Sir James Munby made clear in *An NHS Trust v X (No 2)* [2021] EWHC 65 (Fam), however, once a young person reaches the age of 16, the issue of *Gillick* competence falls away. The young person is assumed to have the legal capacity to give consent to medical treatment (applying s.8 FLRA 1969) unless they are shown to lack the mental capacity to do so applying the tests in s.2-3 MCA 2005. Applying this approach would have been unlikely to have made a substantive difference on the facts of this case, but the route would have been different.

Deprivation of liberty and children – the limits

Nottinghamshire County Council v LH, PT and LT; Nottinghamshire v LH, PT and LT (No. 2) [2021] EWHC 2584 (Fam) and [2021] EWHC 2593 (Fam) (Poole J)

Article 5 – deprivation of liberty – children and young persons

Summary

In these two judgments, decided five days apart, Poole J considered the authorisation of the deprivation of a deprivation of liberty of a 12-year-old girl, LT, in an acute psychiatric unit. LT did not have a psychiatric condition requiring hospitalisation, and her admission was unplanned and unsupported "*by any clinical evidence that it was either necessary or appropriate from a treatment perspective*" (paragraph 1). LT had diagnoses of Autistic Spectrum Disorder and Attention Deficit Hyperactivity Disorder; she was also described as 'extremely anxious' and suffering from panic attacks. She was also considered likely to have 'attachment issues' and to be showing symptoms of trauma.

LT's history leading to her admission was tragic. Her mother had historically made reports of struggling to care for care for LT and her sister, and had been struggling with her own mental health. LT's mother had reported to the local authority that she was feeling suicidal due to LT's behaviour and violence towards family members. As Poole J observed:

> *6. ...From June 2021 problems within the home, and the challenging nature of LT's behaviour, escalated alarmingly. There were numerous reports of LT being violent in the home, absconding, running out in front of traffic, and requiring restraint by police officers due to her aggression. On 15 August 2021, despite two support workers being present in the family home to assist, LT managed to jump from her upstairs bedroom window. LT's mother made repeated requests for LT to be accommodated by the local authority as she was unable to cope with her at home.*
>
> *7. On 7 September 2021, the mother's partner, H, reportedly strangled LT. K told police that she saw LT's eyes roll backwards and she was frothing at the mouth. He was subsequently arrested and is on police bail with a condition excluding him from the family home. He has a history of alcohol abuse and is currently in a psychiatric unit as a voluntary patient having expressed suicidal thoughts.*

On 14 September, LT was alleged to have assaulted her sister, K. When police were called, LT absconded, ran into traffic and attacked the arresting officers. "*It took six police officers to*

restrain this 12 year old girl over a period of two hours. In the police car LT began trying to ligature herself with the seatbelts. She was taken to a "place of safety" under s. 136 of the Mental Health Act 1983, namely to a suite at A Hospital that is allocated for that purpose" (paragraph 8). Though LT was not considered detainable under the Mental Health Act, she was admitted to an acute adolescent psychiatric ward.

In hospital, LT was being staffed by three support workers provided by the local authority and was surrounded by adolescents with acute psychiatric conditions. LT's presence was said to be distressing to the other patients on the ward and to be 'triggering' them, and the unit had to operate at less than full capacity due to the resources being diverted to LT's care (resulting in psychiatric inpatient care being unavailable to adolescents who needed and would benefit from such care). Since her admission approximately eight days prior to the first judgment, LT had attempted to ligature at least ten times, with restraint then being used to remove these. LT had been aggressive towards staff, and drugs were being used to sedate her. It was considered that being on the ward was "*'having a detrimental effect on LT's mental health and she is rapidly learning maladaptive coping mechanisms*"(paragraph 1). It was considered that LT's condition would not improve on the ward, and "*result in a long term negative impact on her behaviour. There is a high risk of her becoming not only institutionalised but also becoming one of many sad revolving door cases*" (paragraph 1).

The local authority had applied for authorisation of LT's deprivation of liberty on the ward because it had no alternative option for her residence, alongside an application for an interim care order, which was granted. The court had initially authorised LT's deprivation of liberty from 17 to 23 September and the local authority's application had been supported by both LT's mother and her guardian. LT herself was distressed, and wish to go home. The court accepted the position of the local authority that the risk to her of doing so was grave, as she was both beyond parental control and it appeared her mother was not able to protect her.

By 23 September, there was again no prospect of a community option becoming available in the short-term. Her treating clinicians considered that she needed a safe, therapeutic placement, but had no need for hospital treatment.

The court considered that the case had 'striking similarities' to *Wigan MBC v Y* [2021] EWHC 1982 (Fam), in which the court had declined to authorise a child's deprivation of liberty in hospital. It was agreed by all parties that, as a matter of fact, LT was deprived of her liberty, there was no consent to it and it was imputable to the state. Poole considered that LT's being on the psychiatric unit had been "*wholly unsuitable from the first day LT was accommodated there, and the urgent need to move her from the unit has been evident now for over a week*" (paragraph 12)

While Poole J accepted that the High Court does exercise the inherent jurisdiction to authorise the deprivation of a child's liberty in unregistered placements, which the courts are ill-suited to monitoring, on the grounds that there is no other available solution, he declined so in this case:

> *14.* […] *the proposed continued accommodation of LT in a psychiatric unit cannot possibly be described as a*

> *means of properly safeguarding her. Depriving her liberty in that setting would not provide her with a safety net - it would not keep her safe or protect her. To the contrary every hour she is deprived of her liberty on this unit is harmful to her. Her accommodation on the unit has exposed her to new risks of harm and will continue to do so. I cannot find that it would be in LT's best interests to be deprived of her liberty on the psychiatric unit.*
>
> *15. If the inherent jurisdiction is a means of meeting the need as a matter of public policy for children to be properly safeguarded then, in my judgment, it is also appropriate to take into account the adverse impact of continued authorisation on the other vulnerable children and young people on the unit.*

The local authority had no other plan to propose in the event that the court refused to grant the deprivation of liberty, and Poole J that it was "*deeply uncomfortable to refuse the authorisation and to contemplate future uncertainties*" (paragraph 17. He reiterated that the local authority must comply with its duty to provide accommodation and safeguard her as a looked-after child.

The court published a second judgment in relation to LT five days later. Despite the lack of an authorisation of her deprivation of liberty, LT had remained on the unit, and her presentation had deteriorated. "*Her continued presence is causing escalations in the behaviour of the patients on the unit. She is now being taunted by other patients who are dissatisfied with the amount of support that LT is receiving and the disruption her presence on the unit is causing. LT required restraining on 23 September 2021. This has caused LT to become agitated. She threw a drink-filled cup towards a patient. She has again tried to self-ligature*" (paragraph 3). Her treating clinicians considered that her repeated attempts to self-ligature were a new behaviour caused by her being on the unit, a place described as noisy and over-crowded, where she lived with peers who were hostile to her.

The local authority had considered applying for a Secure Accommodation order, but had located no placement willing to house her, and following inquiries, it appeared unlikely one would become available. It intended instead to place LT as the sole resident of a currently vacant children's home which could accommodate up to four children. Poole J recorded that "[t]*he staff on site are unqualified and have no experience of managing children who self-harm but the local authority plans to rely on agency nurses, using the same agency as currently provides nurses to work alongside the NHS staff to care for LT on the psychiatric unit*" (paragraph 4) The agency nurses had training in restraint, and other staff were also to be given training. "*In effect, the local authority is creating a bespoke placement for LT as a bridging provision before a more settled solution can be found*" (paragraph 5).

LT was to be subject to significant restrictions, including 3:1 staffing, locked doors and windows, and removal of any items which might cause her harm. It was considered by both the local authority and hospital staff that LT remained at risk in the family home, and appropriate measures for her safety could not be put in place there.

Poole J authorised the deprivation of liberty in this placement under the inherent jurisdiction, but was adamant that the inherent *jurisdiction*

"*cannot be treated as a rubber stamp to authorise the deprivation of a child's liberty whenever the court is told that there is no other option available*" (paragraph 11). He continued to decline to authorise her placement in the psychiatric unit, despite the community placement being unavailable for a short period of time.

As had others before it, the court directed that a copy of the judgment be distributed widely to those with a role in commissioning services for children.

Comment

These judgments are more examples of the increasingly common cases relating to applications for the use of the inherent jurisdiction to authorise deprivations of liberty for children, in circumstances in which the arrangements are accepted by all parties to be inappropriate. There have been cases since the judgment in *Wigan* (*W (Young Person: Unavailability of Suitable Placement)* [2021] EWHC 2345 (Fam)) in which courts have authorised short-term detentions in hospital as being in a child's best interests while searches for placements were found. However, we would note that, like the child in *Wigan*, LT was notably quite young, receiving no therapeutic benefit and extraordinarily distressed by her detention in hospital.

We would note that while the proposed placement in this case was a registered children's home, it was effectively replacing its entire management and staffing to care for LT since its last Ofsted inspection. In our experience, the difficulties in placing children can be exacerbated due to concerns of potential providers of bespoke placements that they may be subject to prosecution by Ofsted, a concern which was a particular feature in *Birmingham City Council v R, S & T* [2021] EWHC 2556 (Fam). There, Lieven J noted that the child, T, who was 16, had been placed in what appeared to be a supported living accommodation, which had been able to provide her with reasonably consistent and positive care, and led to her reengagement in education. The placement had initially stated it would seek to apply for registration as a children's home, but had not done so for approximately the first year of T's residence, and ultimately decided against doing so. Ofsted had threatened to prosecute the placement if T were to remain there. The local authority had been unable to find any alternative option for T's care which was Ofsted registered, and it was considered that any move was likely to be highly detrimental to T. Lieven J continued to authorise T's deprivation of liberty and noted:

> *27* […] *a concern about Ofsted's position. I would not be making an order to authorise the deprivation of T's liberty at the placement for 4 weeks if I understood Ofsted's concerns to be around the quality of the care provided and T's safety. However I have very limited information about Ofsted's position and think therefore it is of the greatest importance that Ofsted let the court and BCC know their position as to any prosecution and why it was threatening prosecution against NFL. I hope if Ofsted's concerns were not about the quality of care but were rather about the principle of registration then this judgment will assist in explaining to them why I have continued to authorise the DOL.*

A final – wider – point is that it is not immediately obvious why many of the factors that apply in cases such as *Wigan* and *LT* are not applicable in relation to adults who are deprived of their liberty in placements which are unsuited to their needs. Analytically, there is no difference in ECHR terms for judges considering whether to authorise deprivations of liberty under the MCA – just because no other option available does, or should, not mean that the court's hand can be forced. It could be stayed if – applying the logic of *Re T* from the Supreme Court – the alternative was to put it in breach of the positive obligations it owed the child under Articles 2 and/or 3 ECHR but that should be the limit.

Deprivation of liberty – the Jersey perspective

Minister for Health and Social Services v B and Ors (Capacity) [2021] JCA 011 (T. J. Le Cocq, Bailiff of Jersey, President; James McNeill, QC, and Jeremy Storey, QC)

Article 5 – deprivation of liberty

Summary

A 30-year-old man in Jersey had developed significant developmental regression, was non-verbal and had a spastic tetraparesis. Following various hospital admissions, he required assistance with all activities of daily living which included nutrition and hydration via a percutaneous endoscopic gastrostomy. A best interests dispute resulted in legal proceedings which determined that he should reside at a care establishment rather than to return home. His father was appointed as his delegate (similar to a deputy) for health and welfare, as well and property and affairs. At first instance, the Minister for Health and Social Services sought an order authorising "*the imposition of a significant restriction on P's liberty*" on the basis that he was under constant supervision and control and not free to leave his placement.

In Jersey (which is bound by the ECHR but to which the Mental Capacity Act 2005 does not apply), significant restrictions on a person's liberty must be authorised either by the Minister or by the court. Rather than base a deprivation of liberty on Article 5 ECHR, Article 39 of the Capacity and Self-Determination (Jersey) Law 2016 sets out the circumstances in which an authorisation is required:

> *39. Significant restrictions on liberty*
>
> *(1) A measure listed in paragraph (2) amounts to a significant restriction on P's liberty if it applies to P on a regular basis.*
>
> *(2) The measures mentioned in paragraph (1) are that -*
>
> > *(a) P is not allowed, unaccompanied, to leave the relevant place;*
> > *(b) is unable to leave the relevant place unassisted, by reason of P's physical impairment or mental disorder, and such assistance as it may be reasonably practicable to provide to P for this purpose is not provided;*
> > *(c) P's actions are so controlled in the relevant place as to limit P's access to part only of that place;*
> > *(d) P's actions are controlled, whether or not in the relevant place, by the application of physical force or of restraint as defined in Article 9(2);*

(e) P is subject, whether or not in the relevant place, to continuous supervision;
(f) P's social contact, whether or not in the relevant place, with persons other than those caring for him or her in the relevant place, is restricted.

(3) A measure applicable to all residents at a relevant place (other than staff employed at the place) which -

(a) is intended to facilitate the proper management of that place; and
(b) does not excessively or unreasonably disadvantage P in particular,
shall not be regarded as a significant restriction on P's liberty.

(4) For the purposes of paragraph (2)(b), and for the avoidance of doubt

(a) P is not to be regarded as subject to a significant restriction on liberty where P is wholly incapable of leaving the relevant place because of physical impairment; and
(b) any limit as to the time or duration of any assistance provided to P, which does not excessively or unreasonably disadvantage P, shall not be taken to mean that assistance is not provided.

(5) The States may by Regulations amend this Article. (emphasis added)

Article 57 provides that the court may make an order authorising the imposition of a significant restriction on a person's liberty if that person "*lacks capacity in relation to giving consent to the arrangements for his or her care or treatment*;" and "*it is both necessary in the interests of P's health or safety, and in P's best interests, to impose significant restrictions on P's liberty*."

At first instance, it was held that such authorisation was not required and one of the issues on appeal was whether this was correct. Interestingly, the Minister did not contend that P was deprived of his liberty for Article 5 ECHR purposes. Indeed, it was accepted that the restrictions arose because of P's personal physical impairment. As the Court of Appeal observed (at paragraph 37): "*it would be wonderful if* [he] *were to wake up one morning and find that he was able to get out of bed and leave the care establishment. If he did then no one could prevent him from doing so*". Instead, it was contended that the continuous supervision amounted to a significant restriction on liberty which did require authorisation.

The appeal court held that Article 57(2) specifically required that there be a necessity to impose significant restrictions which was not the case here. However, here, the "*restriction in fact arises wholly as a result of* [his] *individual physical impairment and not because of the supervision*". The supervision "*is not supervision intended to restrict his liberty, but supervision intended to ensure his wellbeing*". The Court of Appeal considered that the concept of "*continuous supervision*" in Article 39(2)(e) "*is not in our judgement about supervision for safety purposes but is instead about intrusive supervision which would amount to a breach of the patient's right to respect for private and family life*". Accordingly, no authorisation was required.

Comment

English law is not binding in Jersey but Article 5 ECHR is. Thus, whilst the courts took into account the likes of *Aintree* in relation to the approach to best interests, and *Cheshire West* in relation to deprivation of liberty, they were not bound by the English approach. It is therefore interesting to note that neither the Minister nor the appeal court considered the care arrangements to amount to a deprivation of liberty for Article 5 ECHR purposes. The Minister's approach might be explained by the nuances of the legislation, containing as it does from the concept of "significant restriction on liberty" a statutory exclusion (Article 39(4)) for the situation where the person is wholly incapable of leaving the relevant place because of physical impairment, if appropriate assistance is not withheld. Those responsible for enacting the legislation must presumably have been taken to consider that this position did not amount to a deprivation of liberty, as otherwise the legislation would have been enacted with a built-in breach of Article 5 ECHR.

Whatever the Minister's position, however, the Court of Appeal's analysis represents a first principles analysis of Article 5 at significant odds with the currently understood position in England & Wales. That having been said, it is not beyond the bounds of possibility that the Government may seek to rely upon this approach if and when the long-awaited Code of Practice is published to set out how the Government intends the concept of deprivation of liberty to be understood by those applying the LPS.

Book review

Mental Health, Legal Capacity and Human Rights (Michael Ashley Stein, Faraaz Mahomed, Vikram Patel and Charlene Sunkel, eds, Cambridge, 2021, Hardback, £85)

[*A version of this book review will be forthcoming in due course in the International Journal of Mental Health and Capacity Law, so this serves as a sneak preview – the most recent issue of the journal can be found here*]

This is perhaps the most useful book that has been published in recent times in what is now a very crowded area, and (something which is sufficiently rare to merit noting) lives up to the billing on the back that it offers a comprehensive, interdisciplinary analysis of legal capacity in the realm of mental health. Edited by Michael Ashley Stein (Harvard Law School) Faraaz Mahomed (Wits University) Vikram Patel (Harvard Medical School) and Charlene Sunkel (Global Mental Health Peer Network), this hefty – 412 page – book includes chapters by a very wide range of contributors. This range is particularly important for two reasons.

The first – and very unusually for works in this area – is that the editors have deliberately sought contributions from across the spectrum of perspectives. This means that a chapter from Tina Minkowitz outlining clearly and crisply the argument that the Convention on the Rights of Persons with Disabilities (CRPD) "*strictly prohibits substitute decision-making and any form of involuntary admission or treatment in mental health settings*" (p.44) and advocating reparations for psychiatric violence is followed directly by a chapter from

Gerald L Neuman describing (in his words) how "*the Committee* [on the Rights of Persons with Disabilities]'s *absolutism endangers many of the people living with moderate or severe dementia whom it supposedly benefits*" (p.56). The book could therefore serve as a primer for anyone new to the issues raised by the passage of the CRPD in a way that texts that seek to gloss over real differences do not. The opening chapter by the editors itself serves as an elegant and stimulating tour d'horizon of the state of the debate.

The other reason that the range of the book is so important is because it brings in perspectives from outside what is sometimes a hot and airless bubble of debates relating to issues in American and European countries. It is perhaps a shame that there is only one contribution from South America, as reforms there in the field of legal capacity are often lauded as coming closest to achieving CRPD compliance. But the contribution there is, from Alberto Vasquéz Encalada, in relation to the potential for legal capacity law reform in Peru to transform mental health provision is undoubtedly stimulating, even if the chapter leaves this common law-lawyer wanting to understand more about (for instance) precisely how the apparently very broad concept of "medical emergency" is actually interpreted in practice, applying as it does across the board – including psychiatric emergencies – to disapply the need for informed consent in respect of "any sudden or unexpected condition that requires immediate attention as it imminently endangers life, health, or that may leave disabling consequences for the patient." As ever, when analysing reforms, it is important to be able to put them within the wider context of the laws (and practices) that apply in the jurisdiction in question.

Even if South America feels under-represented, and there is no chapter addressing the debates from a Muslim country, there is otherwise an embarrassment of riches to delight: there are contributions from authors discussing Cameroon, Ethiopia, Ghana, India, Japan, Kenya, South Africa and Zambia. Amongst these, I would single out, in particular, the chapter by Ravi et al entitled "Contextualising legal capacity and supported decision-making in the Global South: Experiences of Homeless Women with Mental Health Issues from Chennai, India." This – all-too short – chapter was of particular interest for the way in which the authors both show how an organisation significantly pre-dating the CRPD (The Banyan) was, in effect, supporting decision-making avant la lettre, and, on the basis of their work, advance the challenge that "[f]*or a document that is extremely futuristic and representative of the needs of persons with disabilities, the General Comment on Article 12 is not robust in terms of representation from ultra-vulnerable populations or those from the Global South. This leads to a silencing or abstraction of practical issues faced by the aforementioned population and treatment responses of those states that have ratified it*" (p.122-3). This challenge may not be popular, but it is one which it is necessary to engage.

A further merit of the broad church approach taken in the book is that it allows the reader to compare for themselves theory and reality, to compare micro-level work and macro-level policy, and to pose for themselves the

question of whether evolution is better than revolution. In this regard, of particular interest – to me at least – were the chapters by Piers Gooding on the barriers to researching alternatives to coercion in mental health care, and also the chapter by Laura Davidson seeking what she identifies as a "*practical legal approach towards the global abolition of psychiatric coercion*," a chapter in which she ends up, in essence, making a plea for the CRPD Committee to "*acquiesce in pragmatic progressive realisation*," as the only basis upon which the global elimination of psychiatric coercion can move from pipe dream to reality (p.94).

Whilst the book has a very wide range, it also has an importantly limited scope, the editors making clear at the outset that the focus of the book is on those with psychosocial disabilities. In an important footnote (fn 1, p.2) they note that intellectual disabilities and degenerative conditions such as Alzheimer's "*are likely to be affected by changes in decision-making regimes and should, therefore, be considered in debates relating to legal capacity*," and that whilst in practical terms such was not possible for the book "*it is conceivable that many of the findings and assumptions relating to mental health may apply to intellectual disabilities, dementia and other conditions which affect capacity. However, this is not a universal truth, and conclusions drawn here about the mental health care system should be interrogated further before being applied to social care models for the intellectually disabled or for those whose condition may not improve with time*." In this regard, and whilst – by the editors' criteria – the chapter by Gerard L Neuman should perhaps not have been included, it is of no little importance that it fundamentally challenges the applicability of such "truth." If it does, then on what "truth" about the relationship between mental capacity and legal capacity can legal systems be built other than a recognition that, at least at some points, anyone can lack mental capacity to make a decision, and that legal systems need to be able to respond?

That the book provokes such questions is a measure of its strength, and readers from all backgrounds with an interest in these critically important issues will find themselves informed, stimulated and challenged in equal ways. Especially in the circumstances of the pandemic (which features in the chapter by Barsky et al on redefining international mental health care in its wake) the editors are to be congratulated on bringing together, and home, such an important work.

[Full disclosure, I was provided with an inspection copy of this book by the publishers. I am always happy to review books in the field of mental capacity and mental health law (broadly defined)].

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Conferences

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

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

Advertising conferences and training events

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

Our next edition will be out in November. 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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