



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

- (1) In the Health, Welfare and Deprivation of Liberty Report: *Cheshire West 2*, the return of LPS and where the buck stops with termination;
- (2) In the Property and Affairs Report: accessing Child Trust Funds and LPA fee increase;
- (3) In the Practice and Procedure Report: where (not if) brain stem death testing should take place;
- (4) In the Mental Health Matters Report: progress of the Mental Health Bill and the duties owed by AMHPs;
- (5) In the Children's Capacity Report: resources for children transitioning to adult in the palliative context.
- (6) The Wider Context: the Terminally Ill Adults (End of Life) Bill before the House of Lords, and CQC despairs at the state of care.
- (7) In the Scotland Report: an update on AWI reform.

You can find our past issues, our case summaries, and more on our dedicated sub-site [here](#), where you can also sign up to the [Mental Capacity Report](#).

Editors

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

Scottish Contributors

Adrian Ward
Jill Stavert

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

Contents

Cheshire West 2 2

Return of the LPS? 2

Research corner: Evolving judicial approaches to longstanding anorexia nervosa 11

Cheshire West 2

From 20-22 October, the Supreme Court considered *The Reference by the Attorney General for Northern Ireland* (UKSC/2025/0042). The Reference considered whether people who lacked capacity to make decisions about their care and treatment can give valid consent to what would otherwise be an Article 5 ECHR deprivation of liberty. The Supreme Court was also invited by the Secretary of State for Health and Social Care to set aside the *Cheshire West* ‘acid test’ altogether.

The written cases for the parties can be found on the [Supreme Court page](#) for the case, as can recordings of the hearing. We do not have a date for judgment. Not least as members of the team were involved for two different parties (the Attorney General and the charities Mind, Mencap and the National Autistic Society) we will not give running commentary upon the case, but will, of course, do so when judgment is handed down.

Return of the LPS?

On 18 October 2025, DHSC announced that [there would be a second consultation](#) on the Liberty Protection Safeguards (or ‘LPS’) in the first half of 2026. The statutory framework for the LPS has been in statute in the MCA since 2019 and [a consultation on revising the MCA Code of practice and implementing the LPS](#) was previously undertaken in 2022. While it had been anticipated that the LPS would come into effect in 2023, DHSC announced in April 2023 that their

implementation would be delayed [beyond the life of the Parliament](#) (which dissolved in May 2024). In June 2025, Minister Stephen Kinnock [stated to the Lords Mental Health Bill scrutiny committee](#):

We have made it clear that we are going to continue with DoLS. Basically, we have to look at whether replacing them with LPS will achieve the stated objectives of the exercise, and I am not entirely convinced about that. It is under review.

DHSC’s most recent statement appears to make clear that the LPS will be taken forward, and that these will strengthen the existing system and help to address backlogs. The announcement also sets out that the consultation “[c]omes as *Supreme Court reviews what counts as a deprivation of liberty in a case put forward by Northern Ireland.*” The announcement stated that the consultation will be used to inform an updated MCA Code of Practice, updating the current edition from 2007.

For a recent example of the Ombudsman’s reactions to severe backlogs in conducting MCA assessments and completing DoLS assessments, see the complaint determined in relation to Southampton City Council in August 2025, which found that, as at June 2025, the local authority had 382 outstanding Mental Capacity Act assessments and 404 outstanding DOLS applications, and robustly identified why this was not acceptable:

It is a concern some people may be unnecessarily deprived of their liberty or could be subject to less restrictive arrangements if the necessary safeguards and assessments were completed. Others may be left vulnerable if they do not have the capacity to make significant decisions about their lives and circumstances because the Council has not completed an MCA. If a person lacks the capacity to make a particular decision, measures need to be put into place to ensure any decision is made in their best interests. Delays leave those individuals vulnerable to poor or inappropriate decisions being made by them or on their behalf. The potential injustice in such circumstances could be significant.

Termination, best interests and where the buck stops

Re KP (Termination of Pregnancy) [2025] EWCOP 35 (T3) (Poole J)

Best interests – medical treatment

Summary¹

Even by the standards of the Court of Protection, *Re KP* is a difficult case. It concerned a 19 year old woman who, in Poole J’s understated summary had “*experienced very many challenges in her life,*” starting at birth when hypoxia led to an acquired brain injury. She was now 17 weeks pregnant. The questions before Poole J were:

- (1) whether she had mental capacity (i) to decide whether to terminate or continue the pregnancy, and (ii) to consent to a contraceptive implant being inserted under her skin;

- (2) If she lacked capacity to make either of those decisions, what decision was in her best interests.

If these issues were not ethically challenging enough, the evidence was that:

4. [...] KP has not been diagnosed with Dissociative Identity Disorder (previously known as Multiple Personality Disorder) but she is known to have adopted a number of different personas. These personas or identities inhabit her. They have names and she lives as them for varying lengths of time. In 2024, her persona was that of a three year old girl. She stopped eating, drank from a baby’s bottle, and required a pacifier to calm her. Currently she has the persona of a 13 year old girl, as explained below.

KP, who lived in a residential placement, was the subject of Court of Protection proceedings in which she had been found to have capacity to make decisions as to contact and to engage in sexual relations. She met a man online, and started to engage in sexual relations; whilst she denied having vaginal intercourse and that she needed to use contraception, she became pregnant. Initially, KP was excited about her pregnancy. However,

8. Then, in early August 2025, KP experienced light vaginal bleeding (spotting) and became convinced that she had miscarried. She funded a further scan which showed a foetal heartbeat but KP struggled to accept that it belonged to the baby. She does now accept that she is carrying a live baby but she is clear that she wishes to have a termination of the pregnancy. She first

¹ A judgment of Tor’s being referred to in the comment section, she has not contributed to this note.

asked for a termination on 8 August 2025.

9. The experience of spotting and belief that she had miscarried appears to have triggered a significant deterioration in KP's mental health as well as a change in her stated wishes and feelings about continuing the pregnancy. Following the spotting and belief that she had miscarried, KP's persona became that of a 13 year old girl. She remains in that persona. KP has said that "a child cannot have a child" as a reason why she cannot continue the pregnancy. She believes that her child will be removed from her and taken into the care system which, given her own experiences in care, causes her great distress. She very much wants to avoid that happening. She has claimed to have tried to terminate the pregnancy herself by insertion of a coat hanger. This was not witnessed but blood was seen on her bedsheets. She says that her internet research has taught her that she could bring about a termination by taking a large quantity of a certain kind of over-the-counter medication. She has cut her abdomen. Incidents of self-harm and staff interventions have markedly escalated. She has expressed deep frustration that her wish to have a termination is not being followed

10. Although it was rapid, KP's deterioration was not immediate. For a short while she appears to have had some insight that she was deteriorating and asked Ms B to stick by her and not to allow her to make unwise decisions. She reported that she had miscarried, without others knowing, when she was only 12 after being sexually abused. I should note that the Family Court has previously found allegations made by KP in relation to sexual and other abuse not to be proved. However, this recalled experience seems to have contributed

to her deterioration and the adoption of the 13 year old persona.

In the face of considerable concerns as to KP's capacity, and also real concerns about the potential impact on the relationship between KP and her treating team as regards the implications of KP having or not having the termination, an application was brought to the Court of Protection. In the course that application, an attendance note was prepared by the solicitor instructed by the Official Solicitor on behalf of KP. As Poole J noted:

19. I have been provided with a very helpful attendance note by Ms Burridge-Todd, a solicitor instructed to represent KP in the COP welfare proceedings, who saw KP on 23 September 2025 to discuss the decisions before this Court. KP was very clear that "I want the abortion. I've always wanted it ... it is pissing me off that I have had to wait for this, it should have been done weeks ago." She also stated that she wanted the contraception implant: "put it in when I am under." She said she had had an implant before. She described herself as "loud, gobby, opinionated and hilarious." She said, "I don't mind others making decisions for me, so long as they have my best interests at heart. They can't be snowflakes about it. I am sick of that game." She seemed to blame a lack of restrictions for her having become pregnant and now to want more restrictions to keep her safe. KP was sure that she did not want to speak to the judge hearing her case.

In terms of capacity, the parties (in KP's case, the Official Solicitor as her litigation friend) were agreed that she lacked capacity to make the decision. Displaying his characteristic caution, Poole J did not just accept this:

29. The Applicant Trust and the Official Solicitor both contend that KP lacks

capacity to make the decision to terminate her pregnancy and to have a contraceptive implant. I agree. This is a difficult issue and I do not intend to criticise Dr A's written assessment but it was only after hearing the oral evidence from her and Ms B that I was persuaded that KP lacks capacity in relation to these decisions. Dr A's written assessment was less compelling: she referred to KP's inability to understand and weigh up "decisions" rather than the information relevant to the decisions. She referred to an inability to retain information because of a possible change in persona by the time the termination procedure was commenced. However, a change of persona might lead to a change of decision rather than an inability to retain the information relevant to that decision. Nevertheless, having heard Dr A and Ms B give evidence, it is clear that KP cannot understand, or weigh or use, information about the reasonably foreseeable consequences of deciding to undergo termination of pregnancy or deciding not to do so. Information relevant to the decision regarding termination of a pregnancy includes information about what termination risks, and what continuation of the pregnancy risks. KP cannot understand information about the potential impact of termination (or of continuation of the pregnancy) on her mental health. She cannot understand that she might feel differently in the future about the decision than she does now or that the consequences of her decision might include a negative impact on her mental health. That inability is related to her changing personas. When in the grip of a particular persona she cannot foresee a change in persona and therefore cannot understand how, in a different persona or without any adopted persona, she will view or experience the outcome of a decision made earlier. For the same reason she cannot weigh or use such

relevant information. A decision to terminate a pregnancy or to continue necessarily has long term consequences and so the relevant information includes information about those consequences. The same is true, albeit to a lesser extent, of the decision about contraception. No amount of support is capable of helping KP understand and weigh or use this relevant information. Her inability is because of an impairment of or a disturbance in the functioning of her mind or brain.

Revealing, and poignantly:

30. The evidence of both witnesses established that KP had prepared hard for her capacity assessment with Dr A. She was determined to be found to be capacitous. She had carried out research and she had prepared answers. She is capable of retaining relevant information once she has understood it, at least for a sufficient period to enable her to make a decision. She stuck to her script and said to staff afterwards words to the effect that it was exhausting to do so. She was able to repeat information about the mechanics of termination but not about the impact on her of termination or of continuation of the pregnancy. Having heard the evidence of Ms B it is obvious that Dr A's perception that KP was defensive and giving only the shortest answers, was due to KP having prepared certain answers with a view to "passing" her capacity assessment, and then rigidly sticking to them throughout. As Dr A experienced, KP was unable to engage when asked about relevant information that she had not prepared for.

KP lacking capacity to make decisions about termination or contraception, it fell to Poole J to make decisions of what was in her best interests.

His analysis is sufficiently nuanced that it needs to be set out in full:

33. A termination of pregnancy would be lawful and, as Munby J noted, its lawfulness is not only a necessary requirement before any consideration could be given to making a best interests decision about undergoing a termination, but also indicates what medical opinion is of the balance of harm to the mother involved in the decision whether or not to terminate the pregnancy. However, I have a duty, outwith the ambit of the Abortion Act 1967, to consider KP's best interests in the widest sense and just because the termination would be lawful under the 1967 Act, it does not follow that the Court must give its consent on P's behalf.

34. I know that Dr A and the clinicians at the Trust whose care KP is under, support the proposal for a termination. Her adoptive mother and her boyfriend, who is the father of the unborn baby, also support the proposal for termination. Their main shared concern is the adverse impact on KP's mental health from the continuing pregnancy.

35. KP is suffering a mental health crisis as demonstrated by her escalating self-harm and dysregulation. She has long suffered from mental health challenges but, having demonstrated an improvement, she has more recently deteriorated during the pregnancy. On the evidence received there is no prospect of a sudden or marked improvement whilst she remains pregnant. That is not to say that she is likely to improve immediately upon termination of the pregnancy, but it is foreseeable that so long as she remains pregnant her mental health will continue to be poor and may well deteriorate further.

36. Her current mental health state puts her at risk of physical harm. The evidence is that she has harmed herself due to the pregnancy. On the balance of probabilities, whether in a genuine attempt to produce a termination or not, she has inserted something into herself causing bleeding. She has cut her abdomen. She is distressed by not having her wishes to undergo termination respected. I was told by Ms B that KP has recently reported feeling the baby's movements and that this has added to her distress. As the pregnancy continues the physical impacts of it on KP will only become more evident to her and, in all likelihood, more distressing.

37. I have to contemplate the prospect of KP's pregnancy going to term, or almost to term, and her delivering a child. In her present mental state and given her present adamant wish to terminate the pregnancy and her distress that her wishes are not being respected, that is a very troubling prospect. A decision that it is not in her best interests to undergo a termination of pregnancy is a decision to continue the pregnancy. If a further application were made for a decision to terminate at a later stage in the pregnancy, that would have to be on the basis that KP had suffered even greater harm than she has suffered to date. The termination of pregnancy would be more problematic at a later stage and after 24 weeks termination would only be lawful if necessary to prevent grave permanent injury to KP. In the absence of any change rendering a later termination lawful and in KP's best interests, it is likely that KP would eventually give birth either by elective Caesarean section or after going into labour. Thus, one foreseeable consequence of overriding KP's present wishes would be to authorise - she and others might say to force - a mother against her will to carry a child for a further 20 weeks or so and

then to give birth. A very strong justification would be required for such a significant interference with KP's Convention rights.

38. A termination would prevent further physical harm to KP caused by self-harm due to her unwanted pregnant state and/or attempts to self-induce a termination of pregnancy. There is a real risk of such physical harm occurring. It has already begun. As the pregnancy continues the risks of severe bleeding or other forms of harm from KP's own interventions will only increase. There is a real risk that KP could harm the baby by her attempts to induce a termination. If KP were to harm the baby then that in itself could have a severe adverse effect on her mental health both in the short and longer term.

39. In her current mental state KP could not look after a new born baby. As noted, there are no grounds to expect that her mental state will improve whilst she remains pregnant. It seems to me likely that if the pregnancy were to result in a live birth, then the baby would be the subject of an interim care order and be removed from KP's care. That is what she says she fears the most because she does not want to put another child through what she has gone through as a child in care. Having her baby removed from her would be highly detrimental to KP's welfare and her mental health.

40. Set against these considerations is the concern, articulated on behalf of the Official Solicitor, that it would be contrary to KP's best interests to terminate a pregnancy which, when she was not mentally unwell, she wanted to continue. There is a prospect of her regaining capacity in the future and being distraught that her wish to continue the pregnancy had not been followed. Her currently stated wishes must be treated with great caution since

she is currently incapacitous and adopting the persona of a 13 year old girl rather than speaking for her 19 year old self, as previously she did. This was the concern expressed by Ms B at the MDT meeting on 28 August 2025 (paragraph 16 above).

41. This is not an easy issue but in my judgement these concerns, whilst relevant to the best interests analysis, do not justify the weight the Official Solicitor has given them:

i) KP was keen on continuing the pregnancy only for about 17 days. The pregnancy was confirmed on 22 July 2025 and by 8 August she stated she wanted to terminate the pregnancy. The pregnancy was not planned and there was no indication prior to 22 July 2025 that KP wanted to become pregnant and have a baby. Her positive view of the pregnancy was short-lived. It cannot be said to have been deeply or long held.

ii) I have determined that KP now lacks capacity to make a decision on termination of her pregnancy but it is not clear to me (a) that when KP discovered she was pregnant and for 17 days thereafter, she did have capacity, nor (b) that she had lost capacity by the time she first stated she wanted a termination on 8 August 2025. Her capacity to make such a decision was not assessed at those times. The most recent assessments by Dr Rippon had concluded that she continued to lack capacity to make decisions about her residence and care. Those are very different decisions and I accept that a person is presumed to have capacity unless otherwise established, but the ebbs and flows of KP's mental health make it difficult to know what information relevant to termination of pregnancy she

understood or could weigh or use before and at the time she changed her view about termination. In the transcript of the MDT meeting on 28 August 2025 it is recorded that KP had been assessed as having capacity to consent to an ante-natal scan on 27 August 2025. There was considerable uncertainty amongst professionals as to whether she did or did not have capacity to make a decision on termination of her pregnancy. Dr A's assessment was on 12 September by which time her mental health had deteriorated further. Hence, KP might have had capacity to decide to undergo a termination of her pregnancy over a month earlier on 8 August when she said she wanted a termination.

iii) Ms B's insights about KP lead me to conclude that KP adopts personas as a way of avoiding taking responsibility for her own actions and decisions when in great difficulty or crisis. It is a response to past trauma. It appears that her fear of having miscarried triggered the adoption of the persona of a 13 year old girl. This happened to be about the age she was when she recalls having previously miscarried after having been sexually abused. She now tells Ms B that she wishes her freedom to be restricted and to be treated as a child. The adoption of a child's persona frees KP from facing issues and making difficult, adult decisions. After her initial enthusiasm for the pregnancy she may well have become overwhelmed by the responsibilities the pregnancy brought with it. The persona of a 13 year old frees her real self from having to make a decision about termination. Someone else has to make that decision. It does not follow that her real self did want to continue the pregnancy or that what the 13

year old persona is telling us does not correspond with the real 19 year old KP's wishes and feelings.

iv) It would not have been irrational for KP to change her mind about termination of pregnancy as her mental health declined. She might have felt capable of continuing the pregnancy and looking after a baby when well but later, when she deteriorated, realised that she was not well enough to do so.

v) I accept that the Court should not assume that the "real KP" would now choose termination. But, neither can it be a safe assumption that the "real KP", unburdened with the adoption of a persona or different identity, would now choose to continue the pregnancy.

vi) It is rather speculative to assume that upon an improvement in her mental health, KP will return to the view she briefly held from 22 July to 8 August 2025. No-one can say when her current persona will cease to inhabit KP, whether she will then adopt another persona, or what that persona will be. No-one can say when her mental health will improve, let alone what view she will have about a termination as and when her mental health is better or when she is inhabited by another persona.

vii) I accept that it is possible that if KP undergoes a termination of pregnancy now, then at some point in the future she may deeply regret that it has happened. On the other hand, it is also possible that if KP does not undergo termination now, then in the future she may deeply regret that the pregnancy was allowed to continue. KP's present views and wishes are clear but her future views and wishes cannot reliably be predicted.

42. I have no evidence that KP holds beliefs or values that would be likely to influence her decision if she had capacity and which should be taken into account when considering her best interests. I am not aware of her practising any religion or holding any ethical beliefs opposing termination or contraception in principle.

43. The Court does not have the luxury of time - there is no opportunity to wait and see if KP's mental health improves or if she can regain capacity to make a decision about termination.

44. KP's history of dysregulation and challenging behaviour is such that were she to have a live birth after this pregnancy, there is as very real prospect that she would be unable to care for the child throughout its infancy and childhood. She might in the future be in a better position to have a child and look after it safely and well but that is not likely in the present circumstances. It would be highly detrimental to her mental health for KP to have her child removed from her care.

45. The evidence satisfies me that if termination of pregnancy is to be performed then it would be in KP's best interests for it to be a surgical rather than a medical termination. That would be less distressing and difficult for KP. I have to take into account the possibility that KP will not be compliant during the processes necessary for a surgical termination and that elements of the care plan involving the brief use of physical restraint will need to be deployed. Such experiences will cause her distress.

46. Termination of pregnancy is a once and for all decision - a termination cannot be reversed. KP might become pregnant again and, in different

circumstances, may continue a pregnancy to a successful birth but the baby she is now carrying will be lost forever. The consequences of deciding to terminate the pregnancy are profound and are liable to affect KP in ways which are not entirely predictable. Similarly, a decision not to terminate the pregnancy would have profound, lifelong consequences. The Court has to consider the best interests of KP at this particular time but, in accordance with MCA 2005 s4(2), has to "consider all the relevant circumstances" which must include the potential long term impact on KP of deciding one way or the other.

47. This is not a straightforward decision but having considered all the relevant circumstances, KP's past and present wishes and feelings, any views and values likely to influence her decision if she had capacity, and the views of those engaged in caring for her or interested in her welfare, I have decided that it is in KP's best interests for her termination of her pregnancy to be performed as soon as it can be arranged and in accordance with the care plan submitted by the Applicant Trust. Having analysed the relevant considerations I have concluded that particular weight should be given to protecting KP's current mental health. There is uncertainty as to what her longer term response to termination will be but there is certainty as to her current wishes and her current poor mental health to which her continuing pregnancy is clearly a very significant contributor. I am very concerned that KP would perceive any other decision as forcing her to continue an unwanted pregnancy. KP is a severely traumatised young woman and to compel her to continue her pregnancy and to give birth to a child against her will would be likely to cause further significant trauma. It is possible that she will respond very negatively to having had a termination

but that cannot be reliably predicted. What is predictable is that her ongoing dysregulation and self-harm is likely to continue and worsen as the pregnancy continues.

Poole J made a specific point of making clear that:

49. It is important that KP understands, now and in the future, that she is not currently capable of making a decision whether or not to terminate her pregnancy. The decision cannot wait and so it is being made now, on her behalf in her best interests. The decision maker is me, a Judge in the Court of Protection. I am responsible for the decision to consent on her behalf to a termination of her pregnancy. Her care team and Ms B are not responsible for the decision. They have given their full support to KP. The medical and nursing team at the Applicant Trust are likewise focused entirely on caring for KP. Many skilled and caring individuals are doing their best to help her but they have left the decision whether or not to terminate the pregnancy to the Court. That is the Court's role and a decision has to be made. For the reasons given I have decided that it is in KP's best interests for a termination of pregnancy to be performed.

In a postscript to the judgment, Poole J noted that:

After the hearing but before the publication of this judgment, KP underwent surgical termination of her pregnancy and insertion of a contraceptive implant under her skin without complications. Physical restraint was not required. Although she became upset after the procedure this was reported to be consistent with the experience of many women who undergo a termination of pregnancy.

She then returned home with no further issues reported.

Comment

The complexities of this case are manifold, including as to the relative weight to be placed upon past and present (and possibly future) wishes and feelings.

One question is as to why this case came to court at all, given that until the Official Solicitor became involved, there was no dispute as to KP's best interests, and there was no suggestion that any treatment would take place against her wishes. In *Cardiff and Vale UHB v NN* [2024] EWCOP 61(T3) in which Victoria Butler-Cole KC (sitting as a Deputy Tier 3 Judge) made:

43. A final observation: the application in this case was to authorise a possible future deprivation of liberty which did not, in fact, materialise. It would be reasonable for NN or her mother to ask what purpose was served by the proceedings and what benefit they had for NN. It is incumbent on those concerned with obstetric cases to give the most careful scrutiny at the earliest possible stage to whether orders are actually required from the Court of Protection, and if so, the substance of those orders. In this case, the minutes of various professional meetings held in June and July 2024 suggest that there was a mistaken belief that any best interests decision about termination of pregnancy for a person without capacity required court authorisation. If there is a professional consensus about the treatment proposed, no intention to impose treatment on P against her wishes, and no disagreement from those concerned with P's welfare such as close family members, the provisions of s.5 and s.6 MCA 2005 permit medical best interests decisions to be taken without court involvement, having followed the requirements of the MCA

and any associated professional guidance: An NHS Trust v Y[2018] UKSC 46.

It is definitely not the case that assumptions should not be made about the need for court applications to be made just because of the nature of the treatment. However, it is understandable in this case why the clinicians did so (not least because KP’s circumstances were already before the court), the primary reason being to seek to secure an ongoing relationship between KP and those working with her. In the circumstances, one presumes that the team were relieved that, by contrast with another situation in which a person lacking capacity was expressing ambivalence about termination, in which Hayden J expressly refused to make a best interests decision on her behalf, Poole J made it clear that the buck did stop with him, and that it was for him to do so.

approaches to both mental capacity assessments and determination of best interests indicate a meaningful shift towards a more individualised and ethically responsive approach and suggest ways to augment this approach.

Research corner: Evolving judicial approaches to longstanding anorexia nervosa

In a new article, Professor Emma Cave and Dr Jacinta Tan have built on an earlier article from 2017, at which point they identified three key criticisms of the cases decided to the Court of Protection as at that point, and offering corresponding recommendations. The new articles assesses a second, ongoing set of cases in light of those recommendations, while also considering new issues, including emergent treatment approaches and the debate surrounding the controversial ‘terminal eating disorder’ framework. Although judges in the Court of Protection do not adopt this framework, the authors note that they do recognise that prolonged, compulsory life-sustaining treatment may – under certain circumstances – conflict with the patient’s best interests. Cave and Tan argue that recent

Editors and Contributors



Alex Ruck Keene KC (Hon): alex.ruckkeene@39essex.com

Alex has been in cases involving the MCA 2005 at all levels up to and including the Supreme Court. He also writes extensively, has numerous academic affiliations, including as Visiting Professor at King's College London, and created the website www.mentalcapacitylawandpolicy.org.uk. To view full CV click [here](#).



Victoria Butler-Cole KC: vb@39essex.com

Victoria regularly appears in the Court of Protection, instructed by the Official Solicitor, family members, and statutory bodies, in welfare, financial and medical cases. She is Vice-Chair of the Court of Protection Bar Association and a member of the Nuffield Council on Bioethics. To view full CV click [here](#).



Neil Allen: neil.allen@39essex.com

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



Arianna Kelly: Arianna.kelly@39essex.com

Arianna practices in mental capacity, community care, mental health law and inquests. Arianna acts in a range of Court of Protection matters including welfare, property and affairs, serious medical treatment and in inherent jurisdiction matters. Arianna works extensively in the field of community care. She is a contributor to Court of Protection Practice (LexisNexis). To view a full CV, click [here](#).



Nicola Kohn: nicola.kohn@39essex.com

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



Katie Scott: katie.scott@39essex.com

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



Nyasha Weinberg: Nyasha.Weinberg@39essex.com

Nyasha has a practice across public and private law, has appeared in the Court of Protection and has a particular interest in health and human rights issues. To view a full CV, click [here](#)



Adrian Ward: adrian@adward.co.uk

Adrian is a recognised national and international expert in adult incapacity law. He has been continuously involved in law reform processes. His books include the current standard Scottish texts on the subject. His awards include an MBE for services to the mentally handicapped in Scotland; honorary membership of the Law Society of Scotland; national awards for legal journalism, legal charitable work and legal scholarship; and the lifetime achievement award at the 2014 Scottish Legal Awards.



Jill Stavert: j.stavert@napier.ac.uk

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

Conferences

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

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

Advertising conferences and training events

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

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

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

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

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

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

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

LONDON

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

MANCHESTER

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

SINGAPORE

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

KUALA LUMPUR

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

39 Essex Chambers is an equal opportunities employer.

39 Essex Chambers LLP is a governance and holding entity and a limited liability partnership registered in England and Wales (registered number 0C360005) with its registered office at 81 Chancery Lane, London WC2A 1DD.

39 Essex Chambers' members provide legal and advocacy services as independent, self-employed barristers and no entity connected with 39 Essex Chambers provides any legal services.

39 Essex Chambers (Services) Limited manages the administrative, operational and support functions of Chambers and is a company incorporated in England and Wales (company number 7385894) with its registered office at 81 Chancery Lane, London WC2A 1DD.