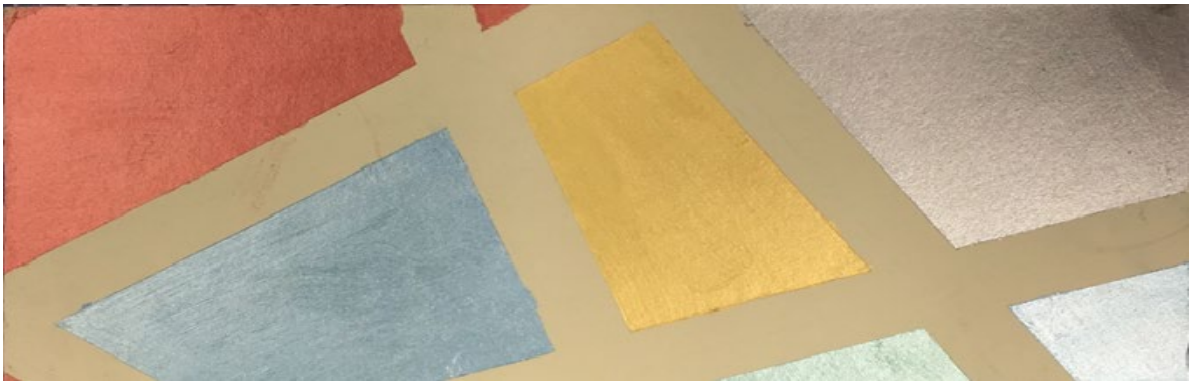


Welcome to the November 2026 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: key themes from post-AGNI caselaw to date, and two medical treatment decisions showing doctors getting it right;

(2) In the Property and Affairs Report: self-dealing in the rearview mirror, dismay at deputy delegation and blithe ignorance of the obligations on a deputy as regards settlement of monies;

(3) In the Practice and Procedure Report: personal welfare orders after HB;

(4) In the Mental Health Matters Report: the Mental health conditions, ADHD and autism prevalence review; and Royal College of Psychiatrists on coercion and human rights;

(5) In the Children's Capacity Report: information-sharing as regards children, and new procedural rules relating to children in ECtHR cases;

(6) In the Wider Context Report: deprivation of liberty before Strasbourg, guidance on eating and drinking at acknowledged risk, and an important change of position relating to Jehovah's Witnesses;

(7) In the Scotland Report: the death of a Bill that never was, and a new appointment for the Mental Welfare Commission.

With huge thanks to Neil Allen, we have set up a running table of post-AGNI cases allowing rapid identification of the types of scenarios being considered, and the results. The case-tracker can be found here, a page where we also host an 'AGNI annex' summarising and commenting on the cases decided in October.

All our other content that you might need – our Reports, our case-law summaries, and our guidance notes – can be found via here.

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

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Deprivation of liberty before the ECtHR

Kaganovskyy v Ukraine (No. 2) [2026] ECHR 39 is a case which has only recently come to our attention, decided between the Supreme Court hearing in *AGNI* in October 2025 and the hand down of its judgment in June 2026.

Mr Kaganovskyy had paranoid schizophrenia and in 2012 was declared legally incapable by a court in Kyiv. On 6 August 2014, at his family guardian's request, he was admitted to a State-run social care home. Nobody asked him formally to consent, but he did not object. He needed permission to leave the grounds, though at first he regarded his stay as voluntary (paragraph 9). In February 2017 he applied to court to restore his legal capacity. From around 1 April 2017 staff stopped him leaving the premises, later on his guardian's written instructions, which also barred visits from his lawyers unless the guardian was present (paragraphs 12–15). Between 27 June and 6 July 2017 he was held in a closed unit, a period already found to be an unlawful deprivation of liberty in *Kaganovskyy v Ukraine* (no. 2809/18, 15 September 2022). Otherwise the ban on leaving lasted until about 27 June 2018. He died at the placement in December 2019.

Ukrainian law treated a guardian's placement of an incapacitated person in a social care home as voluntary, and the courts played no part (paragraphs 26–28). The ECtHR reiterated that "*the notion of deprivation of liberty within the meaning of Article 5 § 1 does not only comprise the objective element of a person's confinement in a particular restricted space for a length of time which is more than negligible. A person can only be considered to have been deprived of his or her liberty if, as an additional subjective element, he or she has not validly consented to the confinement in question*" (paragraph 57, emphasis added).

On the objective element, he could never discharge himself and needed authorisation even for short absences. Had he left without it, he would have been brought back. Staff also medicated him and moved him between the residential and enhanced supervision units. They therefore exercised "*complete and effective control over the applicant's care, residence and movements*," and "*his entire stay in the institution bore all the objective features of a deprivation of liberty*" (paragraph 59).

On the subjective element, the court had to "*assess whether the applicant validly consented to his confinement throughout the period under consideration*". His lack of legal capacity did not mean that he was de facto unable to understand his situation (paragraph 60). The court held:

> *In this connection, the Court would first observe that even if the applicant, as a person who lacked legal capacity, tacitly agreed to his admission to the institution, such initial agreement cannot be regarded as irrevocable or as depriving him of the protection of Article 5 § 1, particularly once he objected to his continued confinement. Also, the fact that for almost two years and seven months after his admission (August 2014-April 2017) the applicant did not contest his stay at the KPRI, even assuming that during that time he regarded it as voluntary, is not decisive in respect of any subsequent period.* (paragraph 62)

From April 2017 "*it was obvious that the applicant no longer wished to remain confined*." He tried to leave, told the courts he wanted to be discharged, and through his lawyers made a criminal complaint (paragraph 63, contrasting *Mihailovs v Latvia* and *Storck v Germany*). The Government produced no entry-exit logs, so his approximate dates were accepted (paragraph 64). He was held to be deprived of his liberty during the relevant periods.

The court held that the deprivation of liberty was contrary to Article 5. No formal decision was ever made (paragraph 76). He was detained "solely on the basis of the consent and instructions given by his guardian" (paragraph 79), and no court scrutinised that consent (paragraphs 80–81). Nor was there evidence of medical necessity or of the annual psychiatric review that domestic law required, so the *Winterwerp* criteria were not shown to be met (paragraphs 82–84). Article 5(4) was breached because no procedure allowed a court to review the detention; the Court saw "no justification for denying comparable judicial safeguards" to care home residents when psychiatric patients had them (paragraph 90). Article 5(5) was breached because he had no enforceable right to compensation (paragraphs 97–98).

Comment

As the judgment was handed down after the hearing in *AGNI*, the Supreme Court only considered the earlier *Kaganovskyy* judgment (at [182]). The case focused on his complaint regarding the 2017-2018 period, so there is no detailed consideration of the 2014-2017 period. Whether he had mental (as opposed to legal) capacity to decide on residence and care throughout is unclear. In 2012 he was "unable to comprehend and control his actions" (paragraph 6) and prior to 2016 the care home described him as tense, ambivalent, anxious and "senseless" in his speech and actions, lacking any critical awareness of his health or his behaviour (paragraph 10).

Paragraph 62 on valid consent is interesting because it shows that "even if" he had tacitly agreed, and "even assuming" he regarded the earlier period as voluntary, this cannot be regarded "as irrevocable or as depriving him of the protection" of Article 5, "particularly once he objected to his continued confinement". The case illustrates how valid consent is a continuing

issue, so there can be a de facto withdrawal of it, and how the issue is consent to "the confinement in question."

State of Care 2025-2026

The CQC's annual State of Care report has been published for 2025-2026. It makes slightly surreal reading in terms of DoLS because, as CQC note, they are "reporting on findings from our monitoring activities and assessments of local authorities for April 2025 to March 2026, as well as government statistics from April 2024 to end of March 2025, before the judgment [in *AGNI*] was delivered." However, CQC does not simply look in the rearview mirror, but also notes that:

> *As the legal and policy landscape around deprivation of liberty continues to evolve, it is important that the system remains focused on delivering rights-respecting and person-centred care now and in the future.*
>
> *The recent Supreme Court judgment represents a significant shift in case law, with potentially far-reaching consequences for the operation of DoLS. While the extent to which this judgment will affect individuals at the heart of the system remains to be seen, these changes do not lessen the responsibility of providers, professionals and local authorities to uphold and protect people's rights. As we noted in our initial statement following the Supreme Court judgment, providers should continue to ensure that they meet the requirements of the MCA, irrespective of whether people are deprived of their liberty. This includes consistently delivering rights-respecting and person-centred care that is informed by people's views, wishes and preferences.*
>
> *Through our reporting on DoLS, we have continued to identify concerns about inconsistent MCA practice, delays in authorisation processes, weaknesses in record-keeping, workforce capability issues and poor communication with people and their families. These challenges risk undermining how effectively people's rights are protected and can lead to poor experiences of care, regardless of whether people are cared for under arrangements that amount to a deprivation of liberty. At the same time, we are already seeing providers and local authorities adapting to the changes introduced by the recent Supreme Court judgment and responding to the evolving landscape.*
>
> *Further reform remains on the horizon, as the Liberty Protection Safeguards (LPS) have been expected to replace the current DoLS system for several years. While the timetable for LPS implementation remains uncertain, strengthening MCA practice across health and social care should remain an immediate priority. We will continue to use our role to monitor the operation of DoLS during this period of transition and to work with stakeholders to understand any longer-term implications of both recent and proposed changes.*
>
> *Ensuring that the MCA and its principles are fully understood and consistently applied is fundamental to protecting people's rights, promoting autonomy and delivering positive outcomes for people, including for those who may no longer fall within the scope of the safeguards. In this context, an updated MCA Code of Practice would be a significant step towards supporting providers and professionals to apply the MCA more consistently, confidently and effectively in practice.*

One other area merits particular emphasis, namely inequality including these two chilling sets of statistics:

> *For adults living with SMI, the risk of dying prematurely is almost 5 times higher compared with others. There is huge variation in annual health checks for people on an SMI register by ICB area – ranging from only 53% of people to 81%.*
>
> *In March 2026, 80% of people aged 14 and over who were on their GP's learning disability register had received a health check in the previous 12 months. These figures also vary by ICB area, from 70% to 86%. But, as at March 2024, it was estimated that only around a quarter of the 1.3 million people with a learning disability in England were recorded on their GP's learning disability register.*[1]

Even if it is not possible to fix these inequalities overnight, three action points commend themselves:

- Read *Get Me To Hospital* to make sure that you are not inadvertently letting concerns about capacity get in the way of ensuring parity of access to physical healthcare for those with cognitive impairments.
- Any time you might be involved (in any capacity) in a Court of Protection case concerning a person with a SMI, ask when their last annual health check was;
- Any time you might be involved (in any capacity) in a Court of Protection case concerning a person with a learning disability, ask whether they are recorded on their GP's learning disability register (and if they are not, why not).

The care sector and COVID-19

The UK Covid-19 Inquiry published the most recent of its reports on 20 October 2026, examining the impact of the pandemic on the adult social care sector in the four nations of the United Kingdom.

A woman with dementia, fit and active before lockdown, had not left her care home for over a year. "They won't let me out," she told her granddaughter, "it's like a prison" (para 4.71).

Strikingly, and more than a little depressingly, the Inquiry's report on the adult social care sector never mentions the Mental Capacity Act 2005,[2] deprivation of liberty, DoLS, the Court of Protection or Article 8 ECHR, and 'best interests' appears once, in a GP's letter that the Inquiry quotes as an example of how not to do it.

The report runs to eight chapters and makes eight recommendations. Most concern planning, isolation facilities, sick pay, inspection, workforce data and a register for care workers. Three areas matter to readers of this Report: visiting, DNACPR decisions and safeguarding.

Visiting

The Inquiry describes the impact of visiting restrictions as "catastrophic" for many (para 4.105). The restrictions were necessary at the outset to protect life (para 4.103). But by early April 2020 it was clear that they would last for an unprecedented period, and the harm from isolation was "obvious from the outset" (para 4.104). Some residents "did not leave their care homes or even their rooms for months on end" (para 4.70). Guidance on visits out did not arrive in England, Wales and Northern Ireland until December 2020 (para 4.67).

[1] Why it appears that there are no more up to date statistics than this is, itself, telling.

[2] Or equivalent in the other nations.

Recommendation 4 asks the four governments to publish guidance for a future pandemic, led by four core principles:

- measures should be "the least restrictive possible, both in terms of severity and the length of time for which they apply";
- residents should have "the right to in-person visitors, except in the most grave or exceptional of circumstances";
- restrictions should be decided "at the most local level possible, based on local risk assessments and considering individual circumstances"; and
- communications must explain the measures and their purpose.

Decision-makers should start from the presumption that the harm of anything other than short-term isolation "may well be as significant, grave and devastating as the risks posed by the infection", especially for people with dementia, cognitive and communication disabilities, and those at the end of life (para 4.107). Visits by essential carers should be distinct from general visiting and should continue "unless the circumstances make it impossible or the risk is simply too great" (para 4.109).

Providers should ascertain residents' "wishes and feelings" about the trade-off between risk and quality of life. "Issues of capacity are likely to arise and create further complexities". Those views "will inevitably not be determinative" but "must be taken into account" (para 4.111).

On the law since the pandemic, the Inquiry welcomes regulation 9A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in force in England from 6 April 2024 (paras 4.66 and 4.76). It also notes DHSC's own review of March 2026, which found that "more needs to be done to address gaps in awareness and understanding, variation in decision making, and weaknesses in monitoring and enforcement" (para 4.78). Scotland has gone further. Under the Care Reform (Scotland) Act 2025 ("Anne's Law"), every care home resident must have at least one essential care supporter, with a legal presumption that suspending their visits is likely to cause serious harm (para 4.54). The Inquiry asks the other three nations to "consider" equivalent duties (para 4.55).

DNACPR and advance care planning

The Inquiry found no national instruction to impose blanket DNACPR decisions but found many reports of their inappropriate use. Decisions based on age, disability or health condition, or made without a personalised assessment of the person's wishes and feelings, were "unacceptable and must not happen again" (para 7.52). Among 2,048 adult social care providers in England, the number of people with a DNACPR in place rose from 16,876 to 26,555 between 17 March and December 2020 (para 7.51).

The evidence includes the following:

- A GP wrote to care home residents that if no plan was returned "within a suitable time frame, a best interests decision may well be made by the clinicians involved" (para 7.40).
- One surgery wrote to care homes for people with learning disabilities about blanket DNACPR decisions, and later retracted the letters (para 7.50).
- Relatives described being "coerced to comply", feeling that a brother "was forced to sign documents", and being "advised this was in mum['s] best interest" (para 7.63).
- A GP twice asked a mother about the CPR preferences of her daughter, a woman in her

twenties with learning difficulties (para 7.65).

- "Blanket ReSPECT forms" were completed with no comments and no residents' signatures (para 7.39).[3]
- Some DNACPR decisions were read as "do not treat" (para 7.74).

The CQC found that older people, people with dementia and people with a learning disability "were not supported to the extent they needed to be" in advance care planning conversations (para 7.34). The Inquiry declined to recommend an investigation into pandemic DNACPR decisions, which would require a manual review of each person's records (para 7.61).

Recommendation 7 calls for mandatory end-of-life care training for health and social care professionals. At a minimum, it should give them the communication skills "confidently to conduct and document conversations about advance care and, where appropriate to the professional's role, decisions on [DNACPR]".

Safeguarding

Routine inspections stopped. So did visits from families and from health and care workers, who would otherwise have played "an additional supervisory and oversight role". Safeguarding referrals fell sharply (para 5.72). The CQC described the pandemic as a "hotbed" in which closed cultures could develop. About 19% of a sample of its inspections up to 14 July 2020 raised closed cultures as an issue (para 5.78). Recommendation 5 asks the four regulators to keep on-site inspection going wherever possible in a future public health emergency, and to minimise the risk that remote or hybrid inspection misses safeguarding issues.

Eating and drinking with acknowledged risks of choking or aspirating

The BMA has published guidance addressing decision making in England and Wales after the case of *JJ v Spectrum Community Health CIC*.[4] It provides advice on how doctors and healthcare professionals can continue to ensure patient-centred care when making decisions about patients eating and drinking with acknowledged risks of choking or aspirating.

As the BMA notes:

> *This guidance has been developed following reports that healthcare staff are being encouraged to adopt an excessively cautious approach when making decisions about patients eating and drinking with acknowledged risks of choking or aspirating. This follows from a 2022 legal case (JJ v Spectrum Community Health CIC). This case involved a highly unusual set of circumstances, and the legal question considered was whether healthcare staff were obliged to comply with JJ's request for food that would expose him to significant risk, NOT whether the staff could comply with the request.*
>
> *This case has presented a difficult dilemma for healthcare professionals. They are under a statutory duty to act in the best interests of patients who lack capacity and are expected, where possible, to respect the autonomous, informed wishes of patients who have capacity. Now, following the case of JJ, some healthcare professionals are facing pressure to shift the balance of*

[3] Note, though, that ReSPECT forms deliberately do not include a place for the signature by the person to avoid the inadvertent creation of a (very likely) invalid ADRT.

[4] Full disclosure, Alex was involved as a member of the BMA Medical Ethics Committee.

decision making to give more weight to protecting themselves and/or their employers, potentially to the detriment of their patients. This guidance seeks to find a way through this dilemma, enabling doctors to continue to meet their obligations to the patient and engage in patient-centred care, whilst minimising the risk of legal challenge.

Jehovah's Witnesses and blood transfusions

Anyone working with Jehovah's Witnesses needs to be aware of a significant clarification in their approach to blood products which took place in September. Whilst the Governing Body of the Witnesses has confirmed that their long-standing refusal of whole-blood transfusions on religious grounds remains unchanged, the Governing Body has made clear that it considers that the decision to accept red cells, white cells, plasma or platelets from another person's blood is a matter of personal conscience. Likewise, each Witness must decide whether or not to donate blood for the clearly expressed purpose of providing components or fractions for use by another person.

Although most blood donations in the UK are whole blood donations, the separation of these into individual components means that the vast majority of transfusions now only use components such as red cells, plasma, and platelets.

Appropriately tailored and sensitive questioning will be needed in any case where a Witness is reluctant to accept blood, so as to unpick whether their refusal to do so is based upon the current position of the Governing Body.

Capacity and sexual consent – guidance and research

A reflective practice toolkit has been published for social care providers and frontline social work practitioners in England supporting older people in residential care homes. Written by James Codling, Dr Laura Pritchard-Jones and Prof Bev Clough, it provides grounded, legally coherent, and extremely thoughtful prompts to help practitioners seeking to navigate these exceptionally thorny issues.

Under the same heading, we also draw people's attention to a research project being conducted by Hannah John at Manchester Metropolitan University. She is exploring how capacity assessments to engage in sex are understood and carried out in practice. The longer-term aim is to interview both practitioners and people with learning disabilities to explore their experiences and perspectives. The first stage is to recruit practitioners in England and Wales who have led at least one capacity assessment around sexual decision-making involving a person with a learning disability. If you are such a person, please fill out Hannah's survey here.

APSOs in Wales

Jess Antrobus, Adult Safeguarding Senior Manager at Powys County Council and a PhD candidate at Keele University, is recruiting participants for a doctoral research study exploring the origins, development and use of Adult Protection and Support Orders ('APSOs') in Wales. Introduced through the Social Services and Well-being (Wales) Act 2014, APSOs provide a legal power of entry, authorised by a magistrates' court, enabling professionals to gain access to and speak privately with an adult at risk where there are concerns about abuse or neglect. Despite being a unique safeguarding power within Wales, APSOs remain a relatively under-researched area of adult safeguarding

practice. This study aims to explore how the APSO was developed, how it is understood by professionals, and what influences decisions about its use in practice. There are two opportunities to contribute:

(1) Semi-structured interviews (for professionals involved in the development, strategic oversight, or practical use of APSOs);

(2) Focus groups (for local authority and police safeguarding professionals. Previous experience of using an APSO is not required)

Jess is keen to hear from professionals working within adult safeguarding across Wales who may be interested in contributing to this research. Your insights will help develop understanding of a little explored area of safeguarding law, policy, and practice. If you would like further information about the research, are interested in participating, or would like Jess to deliver a presentation on the study, please contact her at j.antrobus@keele.ac.uk.

Research corner: autonomy and the lawyer's role

Bethane Harland and Iko Onuh-Goddard, *Autonomy and the Lawyer's Role: Enabling Choice or Exercising Control? Insights from Adult Social Care Practice*, (2026) Amicus Curiae 459-476

Both lawyers working in and those working with local authorities will find much to chew on in the fascinating article just published by two adult social care solicitors at Brighton and Hove Council reflecting on their role in supporting social workers navigating the tension between autonomy and protection in adult social care law and practice.

Short note: intermediaries in the Business and Property Division

In *Isbilen v Turk & Ors* [2026] EWHC 2722 (BP), the (unusual) situation arose where the court had to contemplate whether the Defendant required an intermediary. As Adam Johnson J noted, intermediaries are well known in family and criminal proceedings, but are a rarity in the (now) Business and Property Division. He confirmed that the guidance given by the Court of Appeal in appeal from the Family Division: *M (A Child): Intermediaries* [2025] EWCA Civ 440 was applicable by analogy, such that the basic test is whether the appointment of an intermediary for any aspect of the proceedings is necessary to achieve a fair hearing. The rest of the (short) judgment is an interesting working through of whether, on the particular facts of the case, Mr Turk did require one: the short answer being that he required intermediary assistance during the period of his oral evidence in court.

Isle of Man Assisted Dying

Following Royal Assent having been given to the equivalent (but much more developed) legislation in Jersey, Royal Assent has now been given to the Isle of Man Assisted Dying Act. Whereas Jersey has a set (and tight) timeline, no date has yet been agreed for the Manx law to be implemented: see this statement from the Manx Government:

> *The Act will not come into force until all practical, clinical and safeguarding arrangements have been agreed.*
>
> *This is a significant and sensitive moment for the Island, but it marks the start of a careful process, not the end of one. There is still a great deal of detailed work to do before the law can come into force, and this will take time to get right.*

The Department of Health and Social Care will now begin that work, setting up a formal policy and implementation programme with clear governance and accountability. This includes working out the practical details, from the training and support needed for healthcare professionals, to how medicines will be safely managed, to the safeguards and independent oversight that will keep people protected.

It also includes understanding how these new arrangements will fit alongside existing health and care services, and what they mean for the Island financially and practically.

Some of this work depends on other safeguarding laws being in place first. Assisted dying cannot begin until specific parts of the Capacity Act are in force, which is currently expected by April 2028.

The service will not begin until government is confident it is genuinely ready. This will require listening carefully to those affected, drawing on clinical, legal and safeguarding expertise, and remaining open with Tynwald about the decisions still to be made.

Protection of liberty in Ireland

On 29 September 2026, the Irish Government approved the preparation of a General Scheme of a Protection of Liberty Safeguards Bill. Materials relating to the proposals can be found here. It should be noted that these proposals predated the decision of the UK Supreme Court in *AGNI*: decisions of that court self-evidently are not binding in Ireland, but we know that a close eye has been kept on the Anglo-Welsh saga for many years, and it will be interesting to see whether the latest twist finds a reflection across the Irish Sea.

An EU cross-border regulation on the protection of adults hoves into view

On 20 October 2026, the European Parliament plenary session, formally adopted at first reading a Regulation of the European Parliament and of the Council on jurisdiction, applicable law, recognition and enforcement of measures and cooperation in matters relating to the protection of adults (COM(2023) 280).

In crude terms, the Regulation will 'domesticate' within the EU the 2000 Hague Convention on the International Protection of Adults, although with some modifications, to reflect, in particular the changed international landscape following the coming into force of the Convention on the Rights of Persons with Disabilities.

The new Regulation will introduce a streamlined set of rules that will apply within the EU, in particular to establish which court has jurisdiction, which law is applicable, under what conditions a foreign measure or foreign powers of representation should be given effect and how authorities can co-operate.

It is expected that the Council will also formally adopt the Regulation at first reading, after which it can be published in the Official Journal of the European Union and enter into force.

The Regulation would apply 18 months after its adoption. Member states would then have four years to make their communication channels electronic, and five years to create a register and interconnect it with registers of other member states.

For further details, see here.

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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, ICBs 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.



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



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Annabel has a well-established practice in the Court of Protection covering all areas of health and welfare, property and affairs and cross-border matters. She is ranked as a leading junior for Court of Protection work in the main legal directories, and was shortlisted for Court of Protection and Community Care Junior of the Year in 2023. She is a contributor to the leading practitioners' text, the Court of Protection Practice (LexisNexis). To view full CV click here.



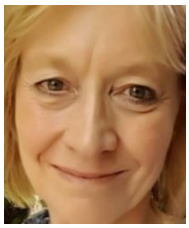
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Alex regularly appears in health and welfare and property and affairs cases in the Court of Protection. He has appeared in leading cases to do with deputyship and published a textbook about LPAs. His recent doctoral thesis explores the impact of changes to mental capacity law in England and Wales. To view a full CV, click here.



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



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Jill is the inaugural Executive Director (Law and Policy) at the Mental Welfare Commission, having previously been Professor of Law, Director of the Centre for Mental Health and Capacity Law and Director of Research, as well as a long-standing member of the Law Society of Scotland's Mental Health and Disability Committee. 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.

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