



Welcome to the November 2024 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: anticipatory declarations; systemic failure in considering PDOC patients, and the CQC and DoLS.

(2) In the Property and Affairs Report: Senior Judge Hilder reversing reverse indemnities and considering the scope of deputies' authority in the context of Personal Health Budgets;

(3) In the Practice and Procedure Report: costs and delay and capacity in cross-border cases;

(4) In the Mental Health Matters Report: the Mental Health Bill is introduced;

(5) In the Wider Context Report: Strasbourg suggests that the Supreme Court was wrong in the *Maguire* case.

(6) In the Scotland Report: Scottish Government's law reform proceeds at breakneck speed, and a symposium for Adrian.

There is one plug this month, for a [free digital trial](#) of the newly relaunched Court of Protection Law Reports (now published by Butterworths. For a walkthrough of one of the reports, see [here](#).

His fellow editors congratulate Alex on his receipt of a Honorary Fellowship of the Royal College of Speech and Language Therapists (and he uses this opportunity to give his usual plug for their vital role as capacity supporters).

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](#).

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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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Anticipatory declarations and supporting P in her wish to protect herself

Leicestershire County Council v P & Anor [2024] EWCOP 53 (T3) (Theis J)

Mental capacity – assessing capacity

This is both an interesting and an important decision.¹

It is interesting because it is the first reported English² case considering Dissociative Identity Disorder and capacity (although, in fact, it appears that the appropriate diagnosis was Complex PTSD with dissociative characteristics).

It is important because Theis J, the Vice-President of the Court of Protection:

1. Confirmed, (contrary to a slightly surprising submission on behalf of the local authority) that ss.5 and 6 MCA 2005 are not limited to emergency situations;
2. Confirmed, (again, contrary to the submission on behalf of the local authority, and obiter observations of Mostyn J) that the Court of Protection does have jurisdiction to make ‘anticipatory’ declarations;

3. Gave (at paragraph 137) useful guidance as to when the court should consider making anticipatory declarations, as follows:

(5) Whether the jurisdiction to make an anticipatory declaration should be exercised will depend on the facts of each case. The court will need to carefully consider the underlying principles of the MCA which is to protect and, where appropriate, make decisions for those who lack capacity in relation to a matter, but take all necessary steps to preserve the autonomy of those who have capacity. In The Shrewsbury and Telford Hospital NHS Trust Lieven J refused to make such a declaration as there was nothing more than a ‘small risk’ that the woman might lose capacity which was ‘insufficient’ to justify an anticipatory declaration, it risked the woman’s autonomy being overridden and there were other ways of managing the situation, such as inviting the woman to enter into an advanced declaration or relying on necessity.

(6) In deciding whether to exercise the jurisdiction under s15(c) the court will need to carefully consider a number of factors, including:

(a) Whether there are other ways in managing the situation, for

¹ Tor having been involved in this case, she has not been involved in the writing of this note.

² There had been a previous reported case from Northern Ireland: *A Health and Social Care Trust v P and R* [2015] NIFam 19.

example whether s5 MCA can be utilised. As Lady Hale made clear in *N v A CCG* [2017] UKSC 22 [38] '...Section 5 of the 2005 Act gives a general authority, to act in relation to the care or treatment of P, to those caring for him who reasonably believe both that P lacks capacity in relation to the matter and that it will be in P's best interests for the act to be done. This will usually suffice, unless the decision is so serious that the court itself has said it must be taken to court. But if there is a dispute (or if what is to be done amounts to a deprivation of liberty for which there is no authorisation under the "deprivation of liberty safeguards" in Schedule A1 to the 2005 Act) then it may be necessary to bring the case to court...'. This provision is not limited to only address emergency situations but there are clearly limits.

(b) The need to guard against any suggestion that P's autonomy and ability to make unwise, but capacitous decisions is at risk or any suggestion that the court is making overtly protective decisions.

(c) To carefully consider the declaration being sought, and whether the evidence establishes with sufficient clarity the circumstances in which P may lack capacity and in the event that P does the circumstances in which contingent best interest decisions would need to be made. This is to guard against the risk that if the facts on the

ground were analysed contemporaneously the court may reach a different conclusion.

4. Declined, on the facts of the case, to make anticipatory declarations, and in so doing made observations which are of wider relevance:

138. [...] (6) P remains protected by the existing statutory framework in s5 and 6 MCA that give general authority to those caring for P who reasonably believe both that P lacks capacity in relation to the matter and that it will be in P's best interests for the act to be done. Using this framework will have the advantage that decisions are taken contemporaneously both as to capacity and best interests, having up to date information on matters such as P's wishes and are more appropriate to guard against such infrequent occasions as in this case. I recognise that s5 and 6 may not have been intended to provide a complete catch all means by which carers can implement a care plan and are arguably more designed to provide protection from liability for carers to carry out certain but not all tasks, but on the particular and unusual facts of this case that legal framework better provides for P as it has the advantage of decisions being made contemporaneously, particularly where, as here, the risks being guarded against happen relatively infrequently so need to be considered in the context of an extended time frame. I fully take into account the submission that by making an anticipatory declaration it could provide more certainty for carers but there is nothing preventing the crisis plan including the same information, whether or not an anticipatory declaration is made, as, in effect, the carers or others are going to need to be

making the same capacity assessment whether a declaration is made or not.

These latter observations are particularly helpful, because they reflect, in fact, what happens in the majority of situations involving fluctuating capacity which do not come to court. If they are truly situations of fluctuating capacity (as to which see our [guidance note](#) at paragraphs 55 – 60), then those seeking to provide care and treatment to the person will inevitably be proceeding on the basis of whether they reasonably believe at the relevant point in time that the person has or lacks capacity to consent to the relevant intervention.

A further point of interest in the case is that the woman herself (who was found to have litigation capacity and was therefore instructing her representatives directly) made very clear that she wished to be protected from the risks that she was at the point when she was dissociating and therefore lacking capacity to make the relevant decisions (see paragraph 138(3)). Whilst not framed in precisely these terms, the judgment was therefore endorsing the creation of an advance choice document (included within a crisis plan) in which the woman was, herself, making clear that she wished robust steps to be taken in the name of her best interests to protect her. Such advance care planning is something which can be equally important in the context of other conditions, such as bipolar disorder, where the person themselves can identify both when they are well and unwell, and also wishes to endorse robust steps to protect them (including from themselves) when unwell. This can give rise to ethical dilemmas (see this [Radio 4 documentary](#)), but can be enormously important in arming social care and health professionals

with the knowledge that they are doing the ‘right thing’ at the time that the person is unwell.

A systemic failure as regards PDOC patients?

NHS NW London ICB v AB & Ors [2024] EWCOP 62 (T3) (Theis J)

Best interests – medical treatment

Summary³

Following a “*wholesale systemic review of their practices and procedures*” (paragraph 9) prompted by Hayden J’s scathing criticisms in *North West London Clinical Commissioning Group v GU* [2021] EWCOP 59, a further application for the determination of the best interests of a patient in a state of prolonged disorder of consciousness (“PDOC”) receiving clinically assisted nutrition and hydration (“CANH”) at the Brain Injury Service at the Royal Hospital for Neuro-Disability (“RHN”) has been heard before the Vice President, Theis J.

This case concerned AB, a then 50-year-old mother of three who, in 2015 suffered a catastrophic brain haemorrhage during an exercise class. After a period in intensive care, AB was transferred to the RHN where she remained, in PDOC, receiving CANH via a percutaneous endoscopic gastronomy (“PEG”) for the next nine years.

In May of this year, and following the [GU](#) inspired review of existing practices at RHN, the relevant Integrated Care Board (“ICB”) NHS North West London ICB brought an application for a determination of whether or not AB’S CANH should be continued.

Describing a “*systemic failure in the RHN to have the relevant framework in place for making these*

³ Katie having been involved in the case, she has not contributed to this summary.

best interest decisions in a timely way"; noting that, "prior to the recent changes there was simply a vacuum within the RHN, with no system for best interest decisions to be made" (paragraph 10) Theis J heard that, despite almost annual assessments of AB's PDOC, all of which showed no change in her consciousness from minimally conscious minus, no best interests review had been initiated until 2023 – seven and a half years after her admission.

Noting changes that had been brought about in the hospital in 2022 onwards, following its widespread review, Theis J observed that "decisions need to undertake the balance whether treatment which may have enhanced the patient's quality of life or provided some relief from pain may 'gradually or indeed suddenly reach a pivoting point where it becomes futile, burdensome and inconsistent with human dignity. The obligation is to be vigilant to such an alteration in the balance' (per Hayden J in GU [105]). Whilst not detracting from the excellent care afforded to AB it is unacceptable that decision making structure did not happen in AB's case for many years due to the essential framework for that to be done simply not being present in the RHN" (paragraph 12).

The court heard that AB had suffered some 20 plus infections during her admission; she had a long-term sacral sore and required suctioning via tracheostomy 3 times daily. While she was noted to move away from noise, to smile, to look up when her name was called, all of these responses were considered generalised and reflexive rather than as actual emotional responses to the outside world; she was noted to exhibit signs of discomfort during care, to grimace on movement and to have suffered a number of protractions as her PDOC persisted. While AB's continued survival was attributed to the resilience of her brainstem function, it was noted that her "loving, planning... brain, has not been there since 2015" (paragraph 29).

While the majority of her family supported the withdrawal of CANH, her son PB was recorded as "expressing the view that AB "would want it to be natural", when she is 'ready'" although agreeing AB's current quality of life was not acceptable 'at all for anybody' but felt AB would want CANH to continue" (paragraph 35). Otherwise, the court had no evidence as to AB's past wishes and feeling regarding life sustaining treatment.

Noting the burdens of treatment to AB, the minimal awareness that allowed for the experience of distress but provided no indication of experience of pleasure Theis J concluded

85. These amount to significant burdens to AB that arise both from her condition and from her treatment. Those burdens are, in my judgment, likely to get worse. I agree with the submissions of the Official Solicitor that AB now has little or no quality of life. Her life expectancy is inherently unpredictable, even with the high quality of care she is receiving and she is exposed to an increasing number of unpleasant, uncomfortable and undignified experiences through the level of nursing care that is required to keep her alive. AB's Article 2, 3 and 8 ECHR rights have been upheld by the RHN's adherence to the RCP PDOC Guidelines and the external review by Dr Nair and Mr Mitchell. The Article 8 rights of AB's family have been protected through their full participation in these proceedings.

86. Considering the wide canvas of evidence, balancing the competing considerations outlined above I have, with deep sadness, reached the conclusion that AB's best interests in the widest sense require CANH to be withdrawn, as to continue to provide it is not in AB's best interests due to the very significant and increasing burdens her condition and treatment involves that

outweigh the presumption of maintaining life.

Comment

Theis J’s conclusions were, arguably, inevitable in the face of unanimous medical evidence as to AB’s condition and prognosis and an almost unanimous response from family members to the prospect of discontinuing life-sustaining treatment.

It is perhaps regrettable that the Vice President did not go further and provide guidance in such a case as to whether, in fact, a fully litigated application was warranted in the circumstances. The judgment refers to a potential further twenty-odd such cases in the pipeline (at paragraph 70). Given the medical consensus, it is at least arguable that the treatment available to AB was fast becoming treatment that no reasonable doctor should be agreeing to provide, such that, ultimately, there might be no “best interests” decision for the Court of Protection to make.

CQC and DoLS

In its most recent State of Care Report, the CQC has a lengthy and detailed ‘area of concern’ section on DoLS, the key findings being as follows:

- *Too many people are waiting too long for a Deprivation of Liberty Safeguards (DoLS) authorisation, despite multiple examples of local authorities trying their best to reduce backlogs and ensure sustainable improvement.*
- *We remain worried about the rights of people at the heart of the DoLS system. We continue to see people in vulnerable circumstances without legal protection, which not only affects them but also their families, carers, staff and local authorities.*

- *The system has needed reform for over 10 years. Unless there is substantial intervention, we are concerned that these challenges will continue.*

In relation to backlogs, the CQC notes that:

Variation in backlogs between different local authorities means people in similar situations may have different experiences of the DoLS system because of where they live. Many factors contribute to this variation, including budget allocation, the make-up of local populations, and the number of hospitals and care homes in an area. Local authority backlogs also have a knock-on impact on hospital and care home staff: while waiting for DoLS applications to be reviewed, they have to balance keeping people safe with protecting their rights. Our inspectors told us about staff feeling stressed and confused trying to navigate the DoLS system when waiting for an authorisation. Worryingly, our inspections and assessments have also highlighted instances where backlogs in processing existing applications mean some care providers have stopped submitting new applications. This means people have restrictions placed on them without an application or any legal safeguards.

To understand the reasons for the backlog, CQC surveyed representatives from the National DoLS Leads Network and heard the views of over 50 respondents from supervisory bodies across England. This section is worth setting out in full:

We heard widespread concern from the local authorities that they are often significantly under-resourced to process increasing volumes of DoLS applications, as their funding has not increased in line with the number of people requiring assessments. One local authority told us:

DoLS is a broken system. It was designed for a pre-Cheshire West time with relatively few applications. It is impossible to make it work with the resources we have, leading to a big backlog...The situation is so bad that, if we just stopped getting any applications and just assessed people from the backlog, we would be doing this for around 18 months just to clear it.

Insufficient staffing levels were also identified as a primary barrier to performance. Many supervisory bodies are struggling to recruit enough assessors, with some local authorities relying significantly on independent assessors to manage the volume of applications. Some respondents noted high staff turnover within DoLS teams, describing working in this area as a "marmite experience" where members of staff either thrive, or more often, leave the service.

Amid these challenging circumstances, a member of our external stakeholder group described local authorities going "above and beyond to create systems that are as safe as possible." NHS England data shows that the number of applications completed by local authorities has increased over the last 5 years by an average of 9% each year. But while DoLS backlogs decreased by 2% in 2023/24, the number of people waiting for an authorisation remains significant. In our assessments of local authorities, we have seen multiple examples of supervisory bodies trying their best to reduce backlogs and ensure sustainable improvement. For example, many local authorities adopt risk-based approaches and tools to prioritise applications. We also saw local authorities recruiting and training more best interests assessors. Respondents to our National DoLS Leads Network survey frequently cited the ADASS screening tool as a way of helping local authorities to prioritise applications, by categorising them as either high, medium or low priority.

However, this method relies on detailed, accurate DoLS applications. We heard that many local authorities are not always confident that the information services provide on DoLS applications is correct. This increases the risk that people who urgently require an assessment are not being appropriately prioritised. Although tools can help local authorities to identify those in need of urgent attention, the statutory 21-day timeframe applies to all standard DoLS applications and the need to prioritise may be another symptom of a broken DoLS system.

We are also concerned that the use of prioritisation tools may result in some groups of people, such as people with a learning disability or living with dementia, being disproportionately affected by delays in processing DoLS applications. A respondent from the National DoLS Leads Network noted that while these people usually meet the requirements for DoLS, they often do not meet the prioritisation criteria and may be "overlooked". We also heard from a member of our external stakeholder group about some assessments being carried out virtually. While this may offer greater flexibility, virtual assessments are not always suitable for the people who are being assessed. A member of our external stakeholder group reflected that differences in the way local authorities approach DoLS makes it difficult to support managers of care homes spread across different counties. Local authorities told us that ongoing issues with the level of understanding of the safeguards among health and social care staff can exacerbate the backlogs. We heard that applications from care homes and acute hospitals are not always appropriate, and we have also seen evidence of this, with some staff unclear on the circumstances that require a DoLS authorisation. This risks people who need the safeguards getting lost in the high volume of referrals, or not

having an application made when they need one. Local authorities found that the quality of mental capacity assessments made by providers before they submit an application was sometimes poor, which can also result in unnecessary applications. It also means that they may need to contact providers to get information that should have been included in the application, thereby delaying the process and requiring additional resources from all parties.

Another factor that has a negative impact on the backlogs is a lack of communication between providers and local authorities. When providers apply promptly for DoLS renewals, it can help reduce workloads for supervisory bodies. Yet, we heard this does not always happen in practice. In addition, local authorities are not always informed of important changes following submissions, such as a person dying, being discharged, admitted to hospital or their condition changing. These people therefore remain on the waiting list for DoLS when they may no longer need to be. In other circumstances, providers may also not communicate important changes such as objections or increased restrictions, preventing local authorities from giving priority to some assessments that need it.

It is not entirely clear from this section whether or not the CQC endorses the use of the ADASS (or any other) prioritisation tool.

The variation in the application of DoLS was also a theme CQC picked up in relation to the services themselves.

Our assessments highlighted some differences between hospitals and care homes in the way DoLS are applied. Because the length of stay in an acute hospital tends to be shorter than in a

care home, DoLS backlogs mean often patients are not assessed before they are discharged or moved elsewhere. This means that people at the heart of the process may not practically benefit from the protection afforded by the safeguards for most of their hospital stay, despite the work and resources used by providers and local authorities to follow the process in line with the law. Where a person has a DoLS authorisation in place during a hospital stay, we have seen the positive effects of this on their care. For example, in one case the authorisation meant staff were more aware of the patient's needs, which was evident in care records. By better understanding the patient and tailoring their care, staff were able to prevent escalations.

However, we also identified a lack of communication about DoLS at some acute hospitals, which affected numerous patients on the ward. For example, we found that people sharing a ward with someone subject to a DoLS authorisation did not always know that certain restrictions, like not being able to open locked doors, only applied to one person. In mental health inpatient settings, we continue to see different interpretations of the interface between the Mental Health Act and the Mental Capacity Act, with the safeguards being used more frequently in wards for older adults.

Although staff should be familiar with the conditions for a DoLS authorisation, this is not always the case. We identified limited oversight of DoLS at some services and we are concerned that the safeguards are viewed as a 'management issue' rather than something every team member needs to engage with to protect people's human rights. A local authority also told us that frequent staff and management changes in care homes represents a

challenge, as local authorities do not have the resources to regularly undertake in-depth work with providers to improve their understanding and application of DoLS

While there is a clear need for further training, we found examples of a lack of training on DoLS in anticipation of the introduction of the Liberty Protection Safeguards. A member of our external stakeholder group explained that providers had invested energy preparing for LPS and some were finding it difficult to adjust to uncertainty around its implementation at such a late stage. However, it is vitally important that services ensure staff have adequate knowledge of DoLS to protect people's human rights – both now and in the future.

It is clear that there are wider problems than merely DoLS as regards the understanding of the MCA:

Concerns around providers' knowledge of DoLS and the MCA are mirrored in an analysis of our regulatory enforcement data on Notices of Proposal. At the point of registration, we expect all providers to demonstrate a clear understanding of the MCA and, when applicable, DoLS. As the regulator, we will serve a Notice of Proposal to impose conditions on a new provider or refuse registration if they cannot demonstrate this. We analysed a sample of 139 Notices of Proposal issued in 2023/24 to new adult social care providers and managers applying to register with CQC. This found that almost half the Notices (66) were based on a lack of compliance with standards outlined in the Mental Capacity Act (MCA). In many cases, applicants also failed to demonstrate compliance with other regulations.

The Court of Protection gets a look in later in the discussion:

Several local authorities felt that more challenges to DoLS authorisations have been brought to the Court of Protection in recent years. When a DoLS authorisation is in place, people have a right to have these arrangements reviewed by a court. It is positive that people are aware of their rights to challenge a deprivation of liberty and are supported to do so. However, a local authority also told us that this can be a time-consuming process, which has a further impact on their resources.

Earlier in this report, we raised concerns about older teenagers who may fall through the gaps when accessing mental health services. Similar concerns about the quality of transitions from children to adult services have emerged through our DoLS survey, with one local authority noting that a 'start again syndrome' may happen when a young person enters adult services. They said the information provided by children's services is often insufficient for planning a DoLS application, which can lead to delays in the DoLS process when the person turns 18. At present, the Court of Protection is also responsible for authorising a deprivation of liberty for young people aged 16 and 17 who lack mental capacity, as DoLS only applies to adults. We heard some frustration from local authorities about delays in LPS implementation, as the new scheme would have helped to speed up authorisations for these young people. Like the DoLS process for adults, we have heard that there continue to be delays associated with the Court of Protection authorisation process.

The concluding remarks are stark:

The DoLS system has needed reform for over 10 years. Unless there is substantial intervention, we are concerned that these challenges will continue, leaving people at the heart of this process without the key human rights safeguards that the DoLS system was intended to offer.

In 2023/24, approximately half of the total number of DoLS applications completed were closed without any assessments happening. This means that, in many cases, the DoLS application process may not bring increased safeguards for people's human rights, despite the efforts and resources used by care homes and hospitals to submit applications, and local authorities' work to process and triage these.

With the volume of applications continuing to increase, the current system means that local authorities remain the only organisations able to process them, and many have told us they do not have sufficient resources to cope with the demand. Supervisory bodies told us that increased funding, an updated Code of Practice, better training and regulatory oversight are all factors which could help to improve outcomes for people while we wait for the LPS to be implemented.

While we heard that DoLS remains an "overly bureaucratic system", local authorities across England have also implemented some improvements to help existing processes run more smoothly. These include:

- making assessments proportionate and using equivalent assessments when appropriate
- streamlining administrative processes, using IT systems and updating forms

- developing strong working relationships between local authorities and providers to improve communication, especially when circumstances change or when a renewal is due
- workshops and training for providers to reduce the number of inappropriate applications they receive and improve the accuracy of applications.

Despite these efforts, we remain concerned that the number of people requiring the legal protection afforded by DoLS continues to increase and the system is unable to cope with this demand. Ongoing issues with the DoLS system will disproportionately affect certain groups, such as disabled people and older people, who are more likely to need the safeguards. A recent [report by Age UK](#) highlighted that in 2022/23, 84% of DoLS applications were made for people aged 65 or over, and almost 50,000 people died while waiting for their application to be processed. Reflecting on the operation of DoLS, the charity said, "The reality therefore is that the rights of some of the most vulnerable older people in our society have been and continue to be routinely denied."

Too many people are waiting too long for a DoLS authorisation, while variation in the level of knowledge of staff means that others may not have a DoLS authorisation in place when they need one. For many, the current DoLS system is not providing the vital safeguards they need. After a decade of chronic and widely documented issues, urgent action is required to ensure the system does not continue to fail people in the future.

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

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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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Conferences

Members of the Court of Protection team regularly present at seminars and 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](#).

Adrian will be speaking at the European Law Institute Annual Conference in Dublin (10 October, details [here](#)).

Peter Edwards Law have announced their autumn online courses, including, Becoming a Mental Health Act Administrator – The Basics; Introduction to the Mental Health Act, Code and Tribunals; Introduction – MCA and Deprivation of Liberty; Introduction to using Court of Protection including s. 21A Appeals; Masterclass for Mental Health Act Administrators; Mental Health Act Masterclass; and Court of Protection / MCA Masterclass. For more details and to book, see [here](#).

Advertising conferences and training events

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

Our next edition will be out in 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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