HEALTH, WELFARE AND DEPRIVATION OF LIBERTY
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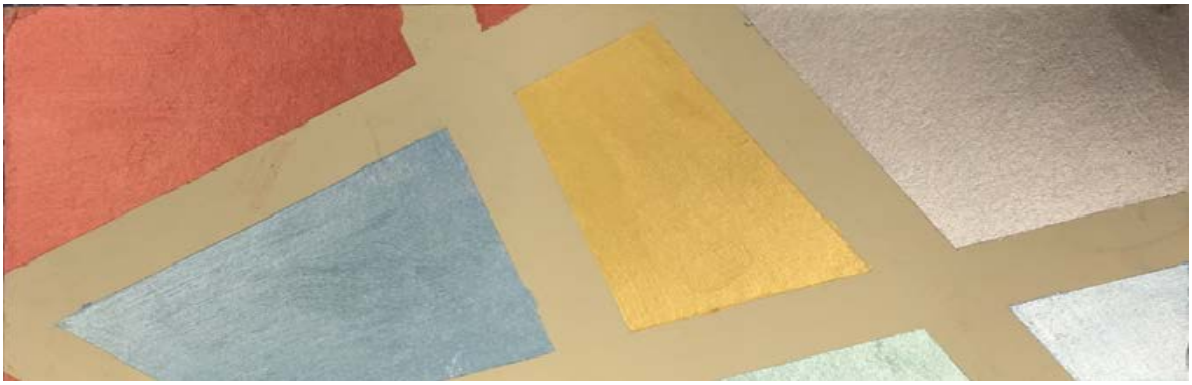

Welcome to the December 2024 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: the Court of Appeal grapples again with sexual capacity, and important reminders of best interests as good governance and operating in an imperfect world.

(2) In the Property and Affairs Report: Simon Edwards retires, and deputyship updates;

(3) In the Practice and Procedure Report: flight risk, and a coercive control dilemma regarding a lasting power of attorney;

(4) In the Mental Health Matters Report: a Mental Health Bill update, detainability and the courts, and Right Care, Right Person under scrutiny;

(5) In the Wider Context Report: Assisted dying / assisted suicide developments, capacity and surrogacy and two important Strasbourg cases;

(6) In the Scotland Report: Kirsty Mcgrath retires, and a blank space for developments regarding legislative reform in Scotland.

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.

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.

Her fellow editors know that you will join us in congratulating Arianna on her recent appointment as a Recorder: she will sit in Family cases on the North Eastern circuit (alongside sitting as a fee-paid First-Tier Tribunal judge, (Mental Health) and fee-paid Court of Protection judge).

As is now standard, there will be no January report (but Alex will give essential updates on his website); we hope that at least some of you will get something of a break over the December period.

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

Capacity, sexual relations and public protection – another go-round before the Court of Appeal

Re ZX (Capacity to Engage in Sexual Relations) [2024] EWCA Civ 1462 Court of Appeal (Sir Andrew McFarlane P, Baker and Andrews LJJ)

Mental capacity – sexual relations

Summary[1]

This was a leapfrog appeal from a Tier 2 Judge to the Court of Appeal; a relatively recent innovation. It concerns the thorny issue of capacity to engage in sexual relations. At first instance HHJ Burrows had been confronted, to his considerable (and understandable) disquiet, with the need to determine whether an 18 year old man had capacity to make decisions about engaging in sexual relations with others. His discomfort arose from the fact that the local authority was having to have recourse to the Court of Protection to respond to a situation where the man in question was posing a (largely self-reported, but on the face of it non-trivial) sexual threat to others, but where neither mental health services nor the criminal justice system could respond.

The independent psychiatric expert, Dr Ince, changed his mind following the decision of Theis J in *A Local Authority v ZZ* [2024] EWCOP 21, which Dr Ince considered had changed the law. In particular, Dr Ince took the view that there was sufficient evidence to demonstrate that what ZZ said within an assessment setting could not be relied upon, and that he continued to display a range of behaviours that disregarded the norms and education provided to him. HHJ Burrows considered that:

> *In order for me to reach the conclusion that ZX lacks capacity to consent to sexual activity I need to be satisfied on the basis of all the evidence I have read and heard that ZX is not be able to satisfy the JB test and particularly "in the moment" in the real world, rather than in a mental capacity assessment with Dr Ince.*

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

At paragraph 115 HHJ Burrows held that:

> *At the moment this judgment is written, I am satisfied that his behaviour in connection with sexual activity in combination with his mental disorder* [identified earlier in the judgment as conduct disorder, ADHD and attachment difficulties] *means that he is unable to use and weigh relevant information concerning his would be or actual sexual partner's refusal to, or withdrawal of, consent in in real time.*

Three grounds of appeal were put forward:

- That HHJ Burrows had applied the wrong legal test to the decision, and in doing so erroneously lowered the standard and quality of evidence that was required to rebut the presumption of capacity enshrined in s.1 MCA.
- That HHJ Burrows was wrong to conclude that ZX lacked capacity to consent to sexual relations by reason of being unable to use or weigh information "in the moment".
- That HHJ Burrows was wrong to consider wider issues relating to the protection of the public and the non-availability of mental health services and/or involvement of the criminal justice system when determining whether ZX had capacity to make the decision; and to accept the evidence of Dr Ince given Dr Ince's reliance on these considerations.

Baker LJ, giving the lead judgment identified as a starting point that:

> *58. The assessment of capacity to engage in sexual relations presents challenges to psychiatrists and judges alike. The evaluation of whether P is unable to understand, retain, weigh and use the information identified in JB because of an impairment of, or disturbance in, the mind or brain is never straightforward and often difficult.*

However, he continued:

> *In this case, there were specific difficulties which made the assessment undertaken by Dr Ince and the judge even more arduous than usual. I regret to say, however, that the decision that ZX lacks capacity to engage in sexual relations was flawed and will have to be reconsidered.*

He made clear that:

> *59. The approach to be followed when assessing capacity in this area under sections 2 and 3 of the MCA is as prescribed by the Supreme Court in JB. It has not been materially amended by any subsequent decision. The decision in Re PN did not change the law. In some cases, as suggested by Poole J, it may be appropriate to focus on whether P is able to use the relevant information "in the moment", (i.e. when he is initiating, or about to initiate, sexual activity with another person) and, if not, whether that inability is due to an impairment of, or disturbance in, the mind or brain. The second limb of the information specified in JB includes not only "the fact that the other person must be able to consent to the sexual activity" but also that the other person "must in fact consent before and throughout the sexual activity". That is consistent with a focus on whether P is able to use the information "in the moment". It is also entirely consistent with the observation of this Court in Re M, endorsed by the Supreme Court in JB, that "the notional decision-making process attributed to the protected person with regard to consent to sexual relations should not become divorced from the actual decision-making process carried out in*

that regard on a daily basis by persons of full capacity".

Further:

60. Similarly, the decision in Re ZZ did not change the law in this regard. In that case, Theis J allowed an appeal because of a series of errors by the judge at first instance. I am unclear why it was considered necessary or appropriate in the present case to send Dr Ince a 3-page summary of the decision. In their submissions to this Court, Mr O'Brien and Ms France-Hayhurst stress that it was never suggested to Dr Ince that Re ZZ had changed the law, the "test" in JB, or the "threshold". But it is plain from the transcript of the hearing on 2 May that Dr Ince thought it had. His response to receiving the 3-page note was to study the whole judgment on BAILII. He said that "in the light of the ZZ judgment I've revised my view around capacity to engage in sexual relations". Later he said that he thought the decision had "changed where the bar is". This misinterpretation undermined the reliability of his conclusions in his addendum report.

In turn:

61. In his judgment, the judge correctly stated that Re ZZ had not changed the law but was rather an application of the existing law. But he did not give sufficient consideration to whether Dr Ince's misunderstanding about the judgment undermined the reliability of his revised opinion. I accept Ms Butler-Cole's submission that the erroneous basis on which Dr Ince proceeded significantly raised the bar as to what a person needs to understand in order to have capacity.

62. For those reasons, the whole process of assessing capacity in this case was flawed. The judge should have declined to proceed on the basis of an assessment conducted on an erroneous basis. I also accept Ms Butler-Cole's submission that, given the radical change in Dr Ince's understanding of the basis of assessment between his first and addendum reports, the proper course would have been to direct a further interview and assessment before the court reached a conclusion.

Baker LJ then went to make clear, in any event, why HHJ Burrows' approach was flawed on its own terms:

64. The central planks of Dr Ince's analysis were (1) that ZX's impulsivity was the reason for concluding that, "in the moment" of sexual activity with another person, he was unable to use or weigh the fact that the other person must be able to consent to the sexual activity and must in fact consent and (2) that this impulsivity was due to his diagnoses of ADHD, conduct disorder and attachment difficulties. The judge rejected Dr Ince's view that ZX was acting impulsively, holding instead that he was "cunning", "opportunistic" and "capable of planning sexual contact with other people within the context of such liaisons being forbidden", but nevertheless concluded that he lacked capacity in this area. His conclusion was flawed for two reasons.

65. First, the judge erred in basing his conclusion on the basis of ZX's history of offending. That pattern of conduct is not by itself indicative of an inability to understand, weigh or use information about consent. It is at least as consistent, if not more consistent, with having the ability to understand and use the information but choosing not to do so. Whilst not endorsing the terms in which the judge described ZX's conduct, Ms Butler-Cole acknowledged that there were "multiple examples of ZX expressing his intention to offend". The

judge concluded at paragraph 114(10) and (11) that "there is a good deal of evidence from ZX himself and his brother that he has engaged in non-consensual sexual activity with other people over the years" which "considered within Dr Ince's conceptual framework (post ZZ, in any event) does allow me to conclude that ZX does not "pass" the test in JB at limb (2)". But a key element in Dr Ince's "conceptual framework" was ZX's impulsivity. If that is removed, the only evidence is the history of non-consensual sexual activity. There is no explanation in the judgment of why the judge concluded that this history established that a young man who was "cunning", "opportunistic" and "capable of planning sexual contact with other people within the context of such liaisons being forbidden" was unable to understand, use or weigh information about consent.

66. Secondly, even if the judge was entitled to find on the basis of the history of non-consensual sexual activity that ZX was unable to use or weigh information about consent, he failed to establish a clear causative nexus between that inability and his mental disorders as required by s.2(1) of the MCA as explained in JB. At paragraph 114(5) of the judgment, he listed a number of deficits in ZX's cognitive functioning identified by Dr Ince as attributable to the presence of a neurodevelopmental disorder, including not only poor impulse control but also impaired working memory, inattention, difficulties with planning, cognitive flexibility, and emotional regulation. The judge asserted at paragraph 114(6) that these features "would certainly apply where he was involved in sexual activity and there was an absence or withdrawal of consent by the other party". That is not a sufficiently clear causative nexus between what the judge found to be an inability to use or weigh the information and ZX's neurodevelopmental disorders. I agree with Ms Butler-Cole that there is no sufficient analysis in the judgment of what other features of ADHD and ZX's other disorders, aside from impulsivity, resulted in his being unable to make a decision despite understanding and retaining all the relevant information about engaging in sexual relations.

67. The judge's failure to focus on the need to establish a clear causative nexus between ZX's inability to use or weigh information needed to make a decision to engage in sexual relations and an impairment of, or a disturbance in the functioning of, his mind or brain leads me to conclude that there is force in the assertion in the first ground of appeal that he applied the wrong test and proceeded on the basis stated in the judgment that "there must be a connection between the disturbance in the functioning of the mind or brain and using and weighing of the relevant information" (emphasis added). "A connection" is insufficient. The presumption of capacity can only be rebutted if there is a clear causative nexus between the inability to make a decision and an impairment of, or a disturbance in the functioning of, the mind or brain.

Baker LJ took a different approach to the third ground, however. He endorsed the following concerns of Poole J in Re PN:

following JB, there may be a natural desire to protect those with whom P might want to have sexual relations, in particular in cases where P has a history of sexual offending. Lord Stephens repeatedly refers to the MCA 2005 protecting not just P, but others …]. However, it seems to me, although the issue of the consent of others to sexual relations has entered the list of relevant information, the Court of Protection must not allow the desire to protect

> *others unduly to influence a clear-eyed assessment of P's capacity. The unpalatable truth is that some capacitous individuals commit sexual assault, even rape, but also have consensual sexual relations. An individual with learning disability, ASD, or other impairment, may act in the same way, but it is only if they lack capacity to make decisions about engaging in sexual relations that the Court of Protection may interfere. If P would otherwise have capacity, then the court should not allow its understandable desire to protect others to drive it to a finding that P lacks capacity, thereby depriving P of the right they would otherwise have to a sexual life. The Court of Protection should not assume the role or responsibilities of the criminal justice system.*

However, Baker LJ was not "*persuaded by* [the Official Solicitor's] *argument that the judge took wider issues relating to the protection of the public into account when determining whether ZX had capacity to engage in sexual relations*."

> *71. Plainly the judge was deeply concerned about the risk posed by ZX to vulnerable people. This is evident from the transcript of Dr Ince's evidence and from the judgment (including, for example, his expression of shock in paragraph 39 of the judgment quoted above). At paragraph 64 of his judgment, citing the passage from PN quoted above, he stated that requirement (2) in JB "leads to the somewhat odd conclusion that one should allow those the Court is considering to be able to commit serious sexual offences unless they lack the capacity to understand that the other person's consent to sexual activity is needed." I am satisfied, however, that, although he remained concerned about the risk posed by ZX, he did not allow these concerns to influence his decision about capacity. At paragraph 114(12) of his judgment, he said:*
>
> > *"I have to avoid what has been called the protection imperative. I must not tailor my formulation of the capacity assessment to ensure a particular outcome".*

The Court of Appeal could not, itself, determine ZX's capacity and instead:

> *73. […] There must be a fresh psychiatric or psychological assessment, which will be further informed by the recent finding by his treating psychologist that that ZX meets the criteria for intellectual disability or learning disorder. The assessment should be conducted on the basis of the principles set down by the Supreme Court in JB. As part of that, it would be helpful in this case if the assessor could attempt to establish whether ZX has the ability to use information about consent "in the moment", that is to say when he is engaged in sexual activities with another person, relevant to the decision whether to engage in sexual relations.*

Comment

As Neil and Alex have discussed in chapters they have contributed to in a recent book, sexual capacity remains an area of almost impossible legal and ethical complexity. This judgment shows that the Court of Appeal is very live to the need to ensure that the Court of Protection does not become an arm of the criminal justice system, but it is very clear that it is going to continue to have an uneasy relationship with it going forward. It is also very clear that public authorities aware of sexual risks posed by those for whom they have statutory responsibilities will continue to have to steer a very careful line – and (a line to which recourse to human rights

arguments unfortunately makes no clearer or broader.

The judgment is also of importance for reinforcing the need for clarity in explanation as to precisely how a person's inability to make a decision is caused by the relevant impairment or disturbance in the functioning of their mind or brain.

Best interests decision-making as an aspect of good clinical governance

NHS North Central London Integrated Care Board v Royal Hospital for Neuro-Disability & Anor [2024] EWCOP 66 (T3) (Theis J)

Best interests – medical treatment

Summary[2]

This is the most recent in a sequence of decisions given by the Vice-President, Theis J, regarding best interests decision-making in the context of CANH. It concerned, again, delay in best interests decisions being made arising out of a lack of an effective system for such decisions being made at the Royal Hospital for Neurodisability. These were considered by Theis J in *NHS North West London Integrated Care Board v AB & Others* [2024] EWCOP 62. The particular feature of XR's case was that he had not been visited since 2018 and had no known family or friends who could provide details as to his wishes, feelings, values and beliefs.

Theis J noted that:

> *66. I agree with the submissions of all parties that in the particular circumstances of this case the court should not make any inferences on the limited information it has about XR regarding his wishes and feelings. To do so would bring with it a high risk of speculation. The reality is that despite the extensive efforts made by the RHN and the Official Solicitor little reliable information is known as to what XR's wishes and feelings would be regarding the decision the court is faced with now. I am satisfied no further enquiries can or should be made and this is one of those relatively rare cases where it is not possible to ascertain or assess XR's wishes, feelings, beliefs and values under s4(2) and (6) MCA or those of his family or friends.*
>
> *67. Whilst I recognise and carefully weigh in the balance the strong presumption in favour of preserving life I am satisfied when considering the evidence as a whole that it is not in XR's best interests to continue to be in receipt of CANH. This is because the benefits of such treatment continuing are significantly outweighed by the considerable burdens for XR caused by the daily care interventions, of which there is detailed evidence, that are required to continue in the context where there is no prospect of any change in XR's diagnosis or prognosis. I accept the evidence of both Dr Hanrahan and Professor Wade of a trajectory of decline in XR's position where the burdens of such treatments and interventions are likely to increase. For the reasons set out above XR's wishes and feelings are unknown and, as a consequence, cannot be factored in the court's consideration of what is in his best interests. The issue between Dr Hanrahan and Professor Wade as to whether XR can experience pain is considered in the context of there being a risk of the possibility that XR may experience pain but it can be no higher*

[2] Note, Katie having been involved in the case, she has not contributed to this note.

> *than that and in the light of the other considerations that factor, in the circumstances of this case, does not have a material bearing on the balancing exercise undertaken by the court in reaching a decision as to what is in XR's best interests.*
>
> *68. I am satisfied this case was rightly the subject of an application to the Court of Protection. The decision maker, Dr A, considered the position to be finely balanced. Even though others took a different view that clinical decision and judgment should be respected. It is important that having properly considered the relevant Guidelines/Guidance clinicians should not feel under pressure either way regarding decisions that they have reached. Having said that, it remained unclear what system, if any, was in place for seeking disclosure of XR's records, who was undertaking that, and what role the IMCA played. In this case it is right to record that the Official Solicitor was able to gain more information about XR through the third party disclosure orders made once these proceedings were commenced. In the end it made no difference to the information that was available, although it could easily have done, and if the application had not been made would have risked relevant information not being available in reaching a best interest decision.*

An issue arose as to whether the court could or should give guidance as to what should happen "where those charged with making a best interest decision considered it to be finely balanced due to the lack of information about a patient's likely wishes, feelings, beliefs and values" (paragraph 69). The Official Solicitor urged the court to issue such guidance; on the application of the RHN, permission was given for a draft of any proposed guidance to be sent to Professors Turner-Stokes and Wade in their capacity as the Chair and co-chair of the 2020 RCP PDOC Guidelines. In a letter dated 27 October 2024 they informed the court and the parties that the RCP is already in dialogue with the British Medical Association (BMA) and the General Medical Council (GMC) and is convening an appropriate multi-agency sub-group to develop updated supplementary guidance to address issues raised in recent cases. The letter cautioned against issuing any guidance based on a single case with the views limited to those involved in the case.

This meant, in turn that Theis J took the following position:

> *89. Not without some hesitation, I am, at this stage, going to decline the invitation for judicial guidance as I recognise the robust process referred to by Professor Turner-Stokes and Professor Wade has been started. The message from this judgment is for that to take place without undue delay, and for a timetable and framework for that review process to be published as a matter of urgency so that any revised Guidelines can be in place sooner rather than later and there is transparency about the timeframe for when that will take place.*
>
> *90. Pending that, this case and AB provide an important timely reminder to any facility responsible for a patient in PDOC to carefully and proactively consider the relevant Guidelines/Guidance (both the 2020 RCP PDOC Guidelines and the Vice President's Guidance), to ensure there is a rigorous process for best interest decisions in operation by those responsible for that patient's care which is in accordance with the relevant Guidelines/Guidance, and that any decisions for applications to the Court of Protection are, if required, promptly brought before the Court without undue delay or drift.*

> *91. It is also important in the relatively unusual cases such as this, where the wishes and feelings of the patient are not readily available, to have clarity about who is responsible for making enquiries and seeking records about that person to avoid delay and ensure there is consistency in approach to obtaining this important information. In such circumstances a relevant part of the decision whether to make an application to the Court of Protection could involve the power of the court to make third party orders for disclosure and the rigorous support the Official Solicitor can provide to ensure that is done.*

Theis J also emphasised that:

> *92. In my judgment the ICB has an important, critical role to play. As the Clinical Lead for the ICB set out in her statement 'The ICB will undertake as a minimum an annual review of the care commissioned to **ensure that the care package remains appropriate to meet the service user's assessed needs'** (emphasis added). For these reviews to be an effective mechanism they should include active consideration by the ICB at each review to be vigilant that the care package includes an effective system being in place for best interest decisions to be made in these difficult cases so that drift and delay is avoided. The ICB should not just be a bystander at these reviews.*
>
> *93. As Hayden J stated in GU:*
>
> > *[103] '…where the treating hospital is, for whatever reason, unable to bring an application to the court itself, it should recognise a clear and compelling duty to take timely and effective measures to bring the issue to the attention of the NHS commissioning body with overall responsibility for the patient.' And*
> >
> > *[105] 'Regular, sensitive consideration of P's ongoing needs, across the spectrum, is required and a recognition that 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'.*
>
> *94. The wholly unacceptable delays in GU, AB and now this case send out a blunt but clear message that such delays in effective best interest decision making are unacceptable and wholly contrary to the patient's best interests which there is a clear statutory obligation on the responsible care providers to protect.*

Comment

Whilst the Royal Hospital is under the judicial microscope, and understandably, we are very aware that there are a much larger number of people in PDOC who are receiving CANH in other hospitals and, above all, nursing homes, where no proper best interests decision-making process has taken place. The message from Theis J therefore applies as much to those providers – and ICBs – as it does to the Royal Hospital.

Best interests, wishes and feelings: a worked example in an imperfect world

Aberdeenshire Council v SF (No 4) (Residence) [2024] EWCOP 67 (T3) (Poole J)

Best interests – residence

Summary

This is the most recent in a long-running series of decisions concerning SF, a Scottish woman in her 40s with moderate intellectual disability, autism spectrum disorder, associated periods of severe anxiety, and a diagnosis of difficult to treat schizoaffective disorder (bipolar type). In June 2023, Poole J held that SF was habitually resident in Scotland, notwithstanding that she had been living in England and Wales for a number of years, first as a patient detained in hospital under the Mental Health Act 1983 and then, from 2022, in a supported living placement in the community. At the time of that judgment, because of her condition and the circumstances of her care, SF was not integrated in a social or family environment in England. In a second judgment, Poole J held that a Scottish Guardianship Order made on 16 June 2021 (the SGO) which authorised SF's mother, the Second Respondent, EF, to consent to the deprivation of SF's liberty, should not be recognised and enforced in this jurisdiction. In a third, ex tempore judgment given on 27 June 2024 (not available online), Poole J held that SF had then become habitually resident in the jurisdiction of England and Wales. He considered that she had made "astonishing progress" at her current community placement and had become integrated into a social environment in England.

After years of searching for suitable accommodation and care in Scotland there was now available to SF a choice of residence and carers but, because Poole J held that she did not have capacity to make the decision for herself, he had to make the decision in her name and in her best interests:

> *4. There are two options: SF can either remain in her current placement, "X", in the Northeast of England, or she can be moved to a new placement, "Y", nearer to her family in the Northeast of Scotland. She has been at X for over two years now. After an initially difficult period of settling in at X, she has made considerable progress. All agree that she has benefitted hugely from the care at that placement, provided by Orbis. However, her mother, aged 74 and with health problems, finds it increasingly difficult to make the long journey from her home in Northeast Scotland to visit SF at X and SF is also located far from her brother and the rest of her family and old friends who live in the same area as her mother. If she remains at X, SF will be likely to continue to receive excellent care and to live a life of activity far beyond what was imaginable just two years ago but contact with her family would be likely to diminish. If she were to move to Y, she would be much closer to her mother, brother and the rest of the family, but there would have to be a carefully managed transition period and it cannot be known how she will settle in and progress at Y. All accept that SF would struggle with the change. The offer at Y is of accommodation, provision of care, and the availability of activities similar to those at X, but SF would be in the hands of a new and unfamiliar team in new accommodation. The connections she has made at X would be lost and she would have to start over again. There would be a risk that she would not respond well to the new carers and environment.*

As Poole J identified:

> *5. There are risks, benefits, and disadvantages from either option and neither choice is obviously the right one for SF. In approaching this difficult choice, the Court must apply the relevant statutory provisions under Mental Capacity Act 2005 (MCA 2005) s4, guidance from caselaw, and do its*

best to make a decision in SF's best interests.

Having set out the law and the evidence, Poole J made clear that:

28. A key issue is the wishes and feelings of SF. The evidence shows that she has expressed different wishes and feelings about moving back to Scotland at different times. The evidence also shows that she has been influenced by EF and GF [her parents] *to express her wishes and feelings in favour of a move to Scotland. Having heard from EF and GF, I am sure that they sought to persuade SF to say that she wants to move to Y because they believe it is best for her. They have not acted maliciously but rather in what they believe to be her best interests. Nevertheless, their influence has been quite strong and has made it harder to discern SF's true wishes and feelings. Having given this matter very careful consideration I have concluded that:*

i) SF is conflicted - she loves living at X and being supported by the Orbis carers. She greatly enjoys the activities in which she participates in the community around X. She has a good life at X. She does not want to leave X. On the other hand she wants to see her mother and brother. She has been given to believe that she will see more of them if she moves to Scotland and may not see them if she remains in England. Naturally she wants to see them more rather than less. If she could both stay at X and see more of her family, that is what she would choose. She struggles to accept that she cannot have both.

ii) Day to day, SF does not think about moving to Scotland. She does not pine for Scotland. She has some unhappy memories of living there.

iii) She can make plans for the future - as demonstrated by her saving up for her trip to Scarbrough with the encouragement of staff - but largely she lives in the present. She does not ruminate on moving to Scotland or to Y. It is only when prompted that she applies her mind to the issue. She would like to see more of her family but when she does not see them, she gets on with the day and enjoys her life at X and in the community around X.

iv) SF is easily influenced and wishes to please her family. Before EF and GF sought to influence SF, she had consistently said she wanted to stay at X. I recognise that she might have been influenced by her carers at X and that at that time no-one around her was advocating for a move to Scotland, but there is no evidence that she was influenced in the way in which EF and GF have sought to influence her. My judgement is that SF's own wishes, before she was influenced to say otherwise, were to stay where she was living. She may not have appreciated the implications for contact with her family members, but she wanted to stay where she was.

He made clear that:

29. Assessing all the evidence relating to SF's wishes and feelings, I find that SF's wish is to remain living at X and to be cared for by her current care team. She does not want to leave X but she does want to continue seeing her mother and brother there. She has no great desire to return to Scotland itself and is very happy living at X in England.

There were undoubtedly both risks and benefits to both SF staying in England & Wales, and going to the placement in Scotland, but ultimately, Poole J identified that:

> *35. I remind myself that the Court's role is not to do the best for EF or the family, but to make a decision on SF's behalf in her best interests. There is a loss to SF whichever choice is made. That has come about because of the need to transfer her care to England several years ago and the delays in finding a suitable placement in Scotland. Such an opportunity to move back to Scotland might not arise again for a number of years. Scotland is SF's home country and all her family live there; none lives in England. Nevertheless, SF does not want to leave X and she has no great desire to return to Scotland itself. The placement at X works very well for her and she is happy there. She may not be happy at the alternative placement, Y. She does not deal well with change, indeed it is liable to cause her distress. Until she settled in to X she was much more frequently agitated and distressed, and she frequently required restraint and seclusion. It may be that a change in medication has assisted her to achieve stability, but it is also quite clear that the excellent care she has received at X has been instrumental in transforming her life. The process of removing her from X and transferring her to Y risks a significant deterioration in her condition and her welfare. It cannot be known that the combination of factors that have so enhanced her life at X will be replicated at Y.*
>
> *36. In her day to day life what matters most to SF is the place she lives, the people she has around her when she wakes up, when she eats, and when she goes out, the places she visits and the people she meets there. She has shown herself to be a sociable person who delights in the company of her current care team and in activities out of the home. Her family mean an awful lot to her too and she loves seeing and spending time with them. I recognise the sacrifice of time with her mother and family that will be suffered by SF if she remains at X but in my judgement what is more important to her and to her welfare are the care, support, and experiences she has between visits - they are what give her life the character that it now has. It is a life that she enjoys and wants to continue. Placement X is working for SF and it would be contrary to her best interests to remove her from it. She has stability in her life for the first time for many years and the funding for her current placement is secure. I am satisfied that whilst this decision interferes with her right to a family life, it respects her right to a private life and that any interference with her right to a family life is proportionate and justified as being in her best interests.*

Poole J concluded his judgment both by recognising that:

> *38.This decision will be hard for EF and GF to accept. I am sorry that there is no solution that suits them as well as SF's best interests.*
>
> *39. I have written a letter to SF to explain my decision. She has written to me and we have met at her request. It is a courtesy to respond and by doing so I can give her my decision directly and in language suitable to aid her understanding.*

Comment

Unlike in the earlier judgment about recognising and enforcing the Scottish Guardianship Order, this decision makes no new law. It is, however,

an excellent worked example of a sensitive analysis of best interests where no option is ideal.

Anorexia and ketamine

Barnet, Enfield and Haringey Mental Health NHS Trust v CC & Ors [2024] EWCOP 65 (T3) (Hayden J)

Best interests – medical treatment

This case concerned a 21 year old woman, CC. Her clinicians were concerned as to her capacity to make decisions about medical treatment "*due to her overwhelming fear and distress, generated by her anorexia nervosa and compounded by her autism and depressive disorder*." The independent expert, Dr Cahill:

> *9.* […] *considered that CC lacked capacity to make decisions about her treatment concerning nutrition and her physical health. He emphasised that there are many "different facets and overlaps" to her condition. He observed that "to discuss capacity in general terms is impossible given the many different aspects of the case, likely comorbid psychiatric comorbidities and different clinical decision to be made". A great deal of effort and energy has been expended on identifying labels. I have been told that in clinical practice, it is widely recognised that females with ASD and disordered eating often present in an atypical way. CC, all agree, presents atypically. She does not believe that she truly has anorexia, she believes her central problem to be depression.*
>
> *10. The labels are, to some degree, a distraction. Dr Cahill considers that CC has the ability to outline the advantages and disadvantages of particular facets of her treatment, but is, ultimately, unable to use and weigh the information necessary to arrive at a decision. This is considered by Dr Cahill to be a consequence of her anorexic/ disordered eating/ ASD thinking. He considers that she is fixated on the "numbers" (relating to body mass index (BMI)) whether that be due to "a drive to be thin", i.e. anorexia, a need for control; a combination of anorexia and ASD; a desire to die; an emotionally unstable personality disorder (EUPD)/ ASD/ depression. Ultimately, CC is, in Dr Cahill's view, unable to make decisions about her nutrition. Dr Cahill was not convinced that CC's nutritional restriction is a facet of suicidal behaviour. He thought it more likely to be an expression of **"not wanting to feel as she does any longer"** (my emphasis) and her inability to articulate it. In addition, her poor physical health impedes her real insight into the seriousness of her current situation, and the desperation of her body's requirement for nutrition.*

Having reviewed the law, Hayden J identified that:

> *25. It is important that I emphasise that CC told me that she believes that she has capacity to understand her medical treatment. When by way of example she was confronted with her vacillation on the question of her attitude to dying, she told me she contradicted herself, but asserted, rightly, that did not mean she was incapacitous. "We all contradict ourselves", she said. She was also able to summarise the full range and detail of her various conditions, in an impressive and eloquent manner. Despite what ultimately emerged as a consensus, amongst the psychiatrists, that CC lacked capacity, I have nonetheless given it a great deal of careful thought and consideration. Evaluating capacity in the context of eating disorders is a challenging process, which demands, to my mind, particular subtlety of thought. It is too easy to infer incapacity by focusing on the consequences for the*

> *patient of non-compliance with treatment. In this sphere, there is always, in my judgement, a pull towards paternalism. This requires to be resisted. The force is distinctly strong and stark when, as here, considering the risk to the life of such an obviously talented young person. The MCA does not require me to determine capacity on the balance of probabilities, rather, it requires me to apply that test in evaluating whether the presumption of capacity has been displaced. This is the statutory bulwark protecting personal autonomy.*
>
> *26. Ultimately however, I agree with Dr Cahill that there is a distinction to be made between insight into a decision, and an ability to weigh the information surrounding it. The former engenders the decision, the latter is ultimately formulation of the question. The impact on CC of her ASD has, despite her efforts, eluded her understanding, in the way that Dr Cahill describes (see emphasis in paragraph 10 above). It is an important and integral element of her eating disorder. It is this inability to weigh and balance the impact of her ASD into the decision surrounding her treatment, that has, ultimately, robbed her of capacity on the issue. It is intensely frustrating to her, and profoundly distressing, not least because in this context, this, otherwise, impressively articulate young woman cannot identify the correct words to articulate her feelings.*

What then followed was not, as might have been expected from other cases before the Court of Protection concerning anorexia, a decision as to whether continued force-feeding was in CC's best interests. Rather, it emerged that the real issue was whether she should undergo treatment with Esketamine. As Hayden J noted in relation to her treating psychiatrist, Dr W:

> *38. One treatment option which Dr W has advocated, enthusiastically, is Esketamine. This is a psychedelic drug and would require panel approvement at the hospital. Dr W told me, in evidence, that he did not think there would be a problem in getting the approval of the panel. I was rather surprised at Dr W's confidence. Esketamine, as a treatment for resistant anorexia nervosa, has very little evidence base. There have been no trials in this country and, inevitably, no peer review. Dr W has had only one patient who he has treated in this way. The treatment, he tells me, was successful. He has discussed Esketamine treatment with CC. She is immensely enthusiastic about it. Indeed, it has become the repository of all her hopes. She is so intensely invested in it, that a decision not to go forward is one she finds extremely difficult to contemplate. Dr W is acutely aware of all of this.*
>
> *39. In his oral evidence, Dr W made a strong case for CC, in her quest to be treated with Esketamine. He was plainly concerned as to how CC might react if this treatment plan was not confirmed as being in CC's best interests. Dr W is very committed to his patient's care and anxious about her prognosis. I should also state that CC has been in the courtroom for most of the hearing. She has listened attentively.*

Hayden J dug somewhat further into this:

> *42. In his oral evidence, Dr W said that he considered that he had a good working relationship with CC, and that she got on well with the eating disorder nursing team. He told me that Esketamine is a licensed drug which can be used in a psychiatric emergency. Its primary use is in anaesthetics, in which context, it has been used regularly for*

over 20 years. Dr W described it as "a safe drug". In the context of anaesthesia, I do not doubt that is an accurate description, but I consider it to be a bold claim, on the available evidence, for its limited use in treatment of resistant anorexia. Dr W said that he thought that its impact on CC might be to make her "giggly" and lightly "intoxicated". This, I took to be based on the response of his previous patient. Dr W amplified the range of likely responses. Esketamine, he told me, has a "dissociative effect" on patients, i.e. it alters consciousness. It can create a "lightness of the body", a sense of "floating". He also described what he termed "an enhanced feeling of being in the room". The drug "heightens the senses", "material may be felt more keenly against the skin", "smells will be experienced more strongly". Esketamine is a psychedelic drug and, as such, causes "visual distortions, hallucinations, and fragmented consciousness". Side effects may include psychological issues, a risk of future substance misuse (described by Dr W as theoretical), raised blood pressure, arrhythmia (thought to be a "remote" risk).

43. Whilst the hallucinations might be benign or even pleasant, it is also possible that they might be distressing and cause agitation. Both would require careful management and supervision. As Dr W reminded me, CC already has 1:1 supervision. Nonetheless, a pleasant hallucination might, he suggested, cause CC to want to go outside and she would have to be restrained to prevent her from doing so. An unpleasant experience would require her to be talked down by soothing words or, if necessary, by medication (benzodiazepine).

44. Alarming though all this sounds, it is not difficult to see why it might be worth trialling if the alternative is speedy deterioration and death. Neither would it be right to clothe this balance in ambiguous language. It requires to be confronted, as CC and her family have done.

Dr Cahill was considerably more cautious than Dr W:

45. In his review of CC's antidepressant medications, Dr Cahill considered that none of them had worked because there had not been sufficient focus on the impact of ASD (for all the reasons discussed above). In his evidence, he told me that nothing was likely to work unless the ASD was brought into sharper focus and with the assistance of an Occupational Therapist. He noted that there was no Occupational Therapist in place, and identified that as a key role, including in coordinating support. The Trust has immediately recognised this and has ensured that an Occupational Therapist will soon be appointed and able to identify reasonable adjustments for CC to maximise therapeutic potential. I regard this as a key piece of evidence. Although we are dealing with a very different type of drug in Esketamine, if Dr Cahill is correct, it still runs a risk of failing, if the impact of ASD is not addressed in advance. That outcome has the potential to be catastrophic for CC. To invest so much hope in Esketamine, only for it to fail, would leave CC with no hope and no alternative plan that she could begin to contemplate. If Esketamine is to be tried, it must have the best possible opportunity to be successful. That is not the situation here. At the moment, there is a real risk that to move forward to such a treatment regime might be setting her up to fail.

In turn:

> *46. Ms Paterson KC, acting on behalf of the Official Solicitor, has been able to identify a properly convened medical trial of the use of Esketamine in resistant anorexia that is due to commence in London quite soon. I understand that approaches will be made to see if CC may be included within the trial. Dr Cahill considered that the Esketamine treatment was not, at this point, in CC's best interests. I agree. I also regard that conclusion as inevitable in the light of his reasoning.*

Hayden J, however, wanted to make clear that he "signalled":

> *47.* […] *to CC, in very clear terms, that she must not perceive my decision as ideologically resistant to what may yet prove to be, and I hope will be, a progression in the treatment of this awful and insidious condition. Esketamine may well be an option for CC, perhaps even in the near future, but if it becomes an option, it must have the best possible chance to succeed, following the plan which Dr Cahill has suggested, and which I am persuaded is in CC's best interests. That plan is to be refined and considered further at a directions hearing in a few weeks.*

Hayden J, finally, made a point of noting that:

> *48. […] It is also important that I emphasise that she is surrounded by committed doctors and nurses. Nurse A gave evidence before me by video link at short notice and on CC's request. He had been on the screen for barely a matter of minutes before it became entirely obvious to me why CC had such confidence in, and affection for, him. He is plainly a crucial part of CC's support. His understanding of CC and his commitment to her care was extremely impressive. CC personally, and the system more generally, is lucky to have him. I indicated, at the conclusion of the evidence, that I wanted him to see the judgment in order that he could fully understand my decision and discuss it with CC if she wishes to do so.*

Comment

In the context of concerns as to whether the Terminally Ill Adults (End of Life) Bill could encompass at least some with anorexia within its scope, this case is a useful reminder of the need to explore all treatment options in relation to the condition – even if it is also a useful reminder that such treatment options need to have a proper evidential grounding.

Short note: when there is no good birth option

The dilemma facing Cusworth J in *Mid Yorkshire Teaching NHS Trust v SC & Anor* [2024] EWCOP 69 (T3) was that neither option – natural or Caesarean section – was a good one for the woman at the heart of the proceedings. She had a very firm (but delusional) belief that she was carrying not one but four babies. She made clear to the Official Solicitor's representative, Ms Coates, that "[i]*f I have the c-section, I'll get 1 and they will take the other 3 away and sell them. That is what they want to do. I need more power more rights"*. Cusworth J was clear that she lacked capacity to make the decision about her birth arrangements, and that:

> *25.* […] *I do take fully into account what SC has said to Ms Coates, her unhappiness and suspicions about the way that she has been treated by the staff who have seeking to care for her. I also remind myself, importantly, of the significance of the decision that the court is here being asked to make. As MacDonald J properly said in North Bristol NHS Trust v R (above) at [84]*
>
> > *'...for the court to authorise a planned Caesarean section is a very*

> *serious interference in a woman's personal autonomy and Art 8 rights. As the Vice President noted in Guys and St Thomas NHS Foundation Trust & Anor v R, Caesarean sections present particular challenges in circumstances where both the inviolability of a woman's body and her right to take decisions relating to her unborn child are facets of her fundamental freedoms.'*
>
> *26. Notwithstanding that very important consideration, I am nevertheless satisfied that in these circumstances, it is very clearly in SC's best interests for the planned Caesarean to go ahead on Monday as the Applicant Trust and the Official Solicitor both agree. The views that she has expressed are I am clear very much influenced by her mental illness, and her delusional belief that she is carrying four small babies that can be delivered by her vaginally with no difficulty or risk. The increased risk of uterine rupture after having had two previous Caesarean sections is very real, which could cause real danger both to her life and that of her unborn child. The medical evidence in favour of a planned Caesarean is overwhelming.*
>
> *27. Further, and whatever course is taken, the reality that SC is carrying only one child, and that the local authority plan to make an application for its removal from her, will no doubt have a devastating but unavoidable impact on her health and well-being. In those circumstances, any attempt at vaginal delivery, aside from being fraught with medical risk, may also be the cause of further trauma for SC if, even after coming through that procedure successfully for the first time, she is nevertheless unable ultimately to care for her child. Consequently, I am satisfied that the birth should take place in the safest and least traumatic circumstances for SC, so that her ability to recover in future is not further impaired by additional traumatic memories.*

Short note: miracles and medical realities.

In refusing permission to appeal the decision of Arbuthnot J that continuation of life-sustaining treatment was no longer in the best interests of a woman identified as XY, the Court of Appeal has made some pertinent observations about when miracles have to give way to medical realities. In *XY (Withdrawal of Treatment)* [2024] EWCA Civ 1466, the two central grounds of appeal were that:

1. The judge failed to give sufficient weight to evidence presented by XY's family regarding her responsiveness to familiar voices and stimuli.
2. XY's identity as a person of faith, her belief in miracles, and her family's testimony about her desire to continue fighting for life were inadequately addressed.

Baker LJ addressed the first ground thus:

> *47. Turning to the first ground on which Mr Thomas concentrated his submissions, the judge was plainly fully aware of the extent of the evidence from family members about XY's responsiveness. As Mr Thomas emphasised, this evidence came not only from A but from other family members and friends. A number of them, in particular A herself, have been very regular visitors, spending several hours each day by her bedside. A was able to give evidence about specific incidents when she had seen her mother move in a way which suggested she was responding to stimuli. I do not, however, accept Mr Thomas' submission that this evidence before the judge was*

unchallenged. It may be that A was not cross-examined on her observations. But the challenge came from the unanimous evidence from the clinical and nursing staff that they had seen nothing to indicate any awareness in XY, and from the clinical and expert evidence that the evidence from CT scans and EEG recordings was indicative of a PDOC at the lowest end of the spectrum. Whilst it is likely to be true that nurses were not constantly present at the bedside in the way that A has been for many hours, there has been a high level of specialist nursing attendance, as is established procedure in an ICU.

48. The judge gave conspicuously careful attention to all of the evidence about this issue. Her decision to prefer the evidence of the clinical and nursing staff about the extent of XY's responsiveness, and the interpretation of the evidence advanced by Dr Bell and Professor Wade, was plainly open to her on the evidence. There is no real prospect of the Court of Appeal finding that she was wrong to reach that conclusion.

As to the second ground:

54. The judge was obliged to consider the family's clear evidence about XY's faith in the context of her present circumstances which, as Mr Mylonas submitted on behalf of the Trust, she could never have envisaged. As Ms Roper submitted for the Official Solicitor, the fact that she had a religious faith, and believed that it is God's choice when someone lives and when someone dies, does not lead to an inference that she would have wanted to continue treatment in these circumstances. There is also force in Ms Roper's further submission that the family's views about what XY would have wanted are situated in their belief, contrary to all the medical evidence accepted by the judge, that there is a prospect of recovery.

55. In those circumstances, there is no real prospect of the Court of Appeal concluding that the judge erred in her approach to XY's beliefs and values and wishes and feelings. On the contrary, she gave those issues particularly careful and sensitive attention. Although she did not recite the evidence about XY's religious faith in detail, I have no doubt that she had it in mind and took it into account. In the course of summarising submissions, she recorded A's case that "faith is a considerable component of who XY is" and that she "would choose life in these circumstances". In her final analysis, the judge acknowledged that XY was "a woman of faith". But in considering the weight to be given to her faith, and to the family evidence about her wishes and feelings, the judge made a number of pertinent observations. She observed that XY "has never stated her views about clinically assisted nutrition and hydration or on sustaining her life artificially in the circumstances where she is totally dependent on others". This led the judge to conclude that "we do not know how she would feel in the current situation that she finds herself in" and "we do not know how she would feel about the continued treatment when the specialists and experts say it is futile" and to "question whether this loving mother and grandmother would have wanted the burden of the treatment to continue." In these observations, the judge was plainly following Baroness Hale's observation in the Aintree case. XY's wishes might well have changed in the light of the stresses and strains of her current predicament.

56. This evaluation was plainly open to the judge on the totality of the evidence. The applicant and other members of the family remain convinced that, because

> *of her faith, XY would have wanted the treatment to continue. I have no doubt that the judge took their strong views about XY's wishes and feelings into account, as she was required to do under s.4(7). But she was entitled to entertain doubts about what XY would have really wanted in these terrible circumstances.*

The urban myth of DoLS

R (Ibrahim) v Nursing and Midwifery Council [2024] EWHC 2991 (Admin) (High Court (Administrative Court) (Richard Kimblin KC, sitting as a Deputy High Court Judge))

Article 5 – DoLS authorisations

R (Ibrahim) v Nursing and Midwifery Council [2024] EWHC 2991 (Admin) is a case which shows how the Deprivation of Liberty Safeguards are still not well understood. It concerned an appeal by a Registered Mental Health Nurse against the decision of the Nursing and Midwifery Council imposing a 12-month Conditions of Practice Order with a review. The NMC imposed this after an event 2017 when he prevented a patient from leaving her room at University College London Hospital. The patient in question, 'Patient A', had CNS lymphoma, suffered from paranoid schizophrenia and was on a palliative care pathway. The nurse "accepted that he prevented Patient A from leaving her room for 1-2 minutes somewhere between 2:45am and 4am. He did so because Patient A had thrown a yoghurt at him and was moving towards him in anger" (paragraph 31). The NMC found that the appellant's actions accounted to misconduct, and that his fitness to practise was impaired.

The submissions made to the High Court on the appeal attacked the NMC's order on the basis that:

> *a. The patient was a proven physical risk to herself and others and was at risk of absconding;*
>
> *b. The patient was subject to a Deprivation of Liberty Safeguards ("DOLS") assessment that permitted deprivation of liberty under the Mental Capacity Act 2005;*
>
> *c. The DOLS order required 2:1 care as a condition of that order;*
>
> *d. Shortly before the Registrant's shift, Colleague C unilaterally downgraded Patient A's care to 1:1 without adherence to the proper procedures;*
>
> *e. The patient had no care plan;*
>
> *f. The Registrant was informed of (a) and (b), but not of (c), (d), or (e) when he came on shift;*
>
> *g. The Registrant was therefore in a position where he could not leave the patient in order to remedy any of the above matters, had little support from other overworked staff. He prioritised the safety of his patient and of those around her.*

In reaching his conclusion that the NMC panel erred, Richard Kimblin KC (sitting as a Deputy High Court Judge) noted that:

> *39. It is also of obvious significance that the Appellant was placed in the sole care of Patient A, contrary to the level of provision which had been signed off by an experienced and expert body of medical professionals in the DOLS. In my judgment, this is a circumstance of such clear materiality that it had to be fully grappled with in the Panel's decision. The DOLS is a carefully considered and reasoned document which has a statutory basis. While this case is not directly concerned with a departure from the DOLS in that the*

charges do not allege that any party was in error for allowing circumstances to exist in which the care provision was reduced from 2:1 to 1:1, it is an authoritative statement which plainly should have been followed unless and until it was varied. The Appellant was correct to rely on it.

40. Still further, it is relevant that the Appellant was new to the ward and had no care plan from which to work. These matters show that the Appellant was put into a challenging situation with arguable systemic failings which were not of his making.

41. Arguments arising from the above were clearly and cogently articulated on the Appellant's behalf via written submissions, as I have set out, and were supplemented orally. Given that the Appellant recorded absconding behaviour in the clinical notes and that is consistent with the similar absconding behaviour referred to the DOLS notes, which the Appellant had not seen when he made his entry, the Panel had to engage with the reality of what the Appellant faced and the extent to which that was a situation which, arguably, he should not have had to face, alone.

42. It is a matter of fact that the Panel did not mention these arguments in their findings section. The Panel had to grapple with them. The Appellant is entitled to know why such important arguments, on which his defence rested, were apparently rejected.

43. In order to find the NMC's allegations proved, the Panel was required to decide whether the Appellant had clinical justification for keeping the patient shut in her room. I find that it is not possible to see how the Panel could have made a fair and rational decision while omitting to address the terms of the DOLS order, the inadequacy of staffing, and the patient's history of dangerous and aggressive behaviour.

The factual findings were therefore quashed; Richard Kimblin KC also found that the panel had failed to grapple with the appellant's case as regards impairment. He declined to remit the case for reconsideration and quashed all the material parts of the order, as well as ordering the NMC to pay the appellant's costs.

Comment

The case provides a revealing snapshot of what life is all too often like on wards in acute hospitals. The reference in the appellant's case (then picked up by the High Court) to the DoLS making 2:1 care a 'condition' of the DoLS authorisation is, however, more than a little unlikely – what is much more likely is that the authorisation was recognising that, at the point that the authorisation was sought, the hospital considered that 2:1 care was necessary. That is very different to a requirement that 2:1 care be imposed. Indeed, earlier in the judgment was a reference noting that the DoLS authorisation provided that "*the Managing Authority (UCLH) was to consider lessening the care to 1:1 'if Patient A becomes more settled'*" (paragraph 32). The local authority granting the authorisation was expressly recognising that it was a matter for clinical judgment as to whether Patient A could be cared for in a less restrictive way. Indeed, it would also be a matter for the hospital whether Patient A could or should be discharged altogether; the hospital would not need to go back to the local authority to release her from the authorisation.[3] In other words, and as should

[3] Separate questions would arise as to whether other bodies would need to be involved in the discharge decision, depending on where Patient A would have gone to next: see further here.

always be remembered, a DoLS is not a warrant to detain which must be obeyed by the care home or hospital, but rather a recognition that a set of circumstances amount to a deprivation of liberty which is permissible for so long it is necessary and proportionate.

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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 February. 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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