ThirtyNine
ESSEX STREET

ISSUE 39 NOVEMBER 2013

Mental Capacity Law Newsletter

Editors: Alex Ruck Keene, Victoria Butler-Cole, Neil Allen and Michelle Pratley

Introduction

This is a milestone issue of the newsletter, because in it we report upon the first decision of the Supreme Court on the MCA 2005: *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67, the first case under the MCA 2005 to come before the Court. Amongst other cases, we also cover a further iteration in the on-running saga of capacity to consent to sexual relations, and the important case of *MH v UK*, which may – we suggest – have significant ramifications for the operation of the DOLS regime (whatever the Supreme Court ultimately decide as to the scope of that regime following the hearing on 21-3 October).

We also provide you with our usual round-up of significant guidance and developments from both this jurisdiction and further afield covering such matters as the consultation on important changes to the procedures for making LPAs, Article 12 of the UN Convention on the Rights of Persons with Disabilities, and costs in the Court of Protection. We should, though, perhaps note our other commitments have defeated us in providing our usual summary of the evidence being given before the House of Lords Select Committee this past month. We will catch up next month.

Finally, we welcome feedback on the format for dispatch of the newsletter that we experiment with this month.

Where transcripts are publicly accessible, a hyperlink is included. As a general rule, those which are not so accessible will be in short order at www.mentalhealthlaw.co.uk. We include a QR code at the end which can be scanned to take you directly to our previous case comments on the CoP Cases Online section of our website.

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Supreme Court considers MCA 2005 for first time

Aintree University Hospitals NHS Foundation Trust v James [2013] UKSC 67

Best interests – medical treatment

Summary

Mr James was a 68 year old man who was seriously ill and had been in intensive care for some 7 months when his treating clinicians applied to the Court of Protection for declarations as to the lawfulness of withholding further invasive treatment and CPR. Regular readers will recall that the first instance judge refused to make the 'absolute' declarations sought, but the Court of Appeal was satisfied, having had regard to new evidence as to Mr James' condition, that the declarations were in his best interests. The Supreme Court granted permission to appeal, notwithstanding that Mr James had died shortly after the Court of Appeal hearing.

The Supreme Court's judgment (given by Baroness Hale, with whom the other Supreme Court Justices agreed) reaffirms a number of well-established propositions concerning the MCA 2005 and, in particular, medical treatment decisions:

a. the MCA 2005 is concerned with enabling the court to do for the patient what he could do for himself if of full capacity, but it goes no further. On an application under the Act, therefore, the court has no greater powers than the patient would have if he were of full capacity. Patients cannot demand that doctors administer treatment which the doctor considers is not appropriate;

b. any treatment which the doctors do decide to give must be lawful. The question for the Court of Protection is not whether it is lawful to withhold treatment, but whether it is lawful to give it, since without consent (or a best interests decision on behalf of an incapacitated treatment) medical treatment of any sort cannot be administered;

c. P's own wishes are of central importance in best interests decision making, notwithstanding that the MCA 2005 does not impose a test of substituted judgment. There is a need to see the patient as an individual, with his own values, likes and dislikes, and to consider his best interests in a holistic way.

The Supreme Court considered what the meaning of the terms 'futility' and 'no prospect of recovery' in the Code of Practice to the MCA 2005 meant, in the context of the provision of life-sustaining treatment. The approach taken by the Court of Appeal, which viewed futile treatment as treatment that would not cure or at least palliate the life-threatening disease or illness from which the patient is suffering, was rejected. Futility was to be considered as treatment which is 'ineffective' or 'of no benefit to the patient'- '*A treatment may bring some benefit to the patient even though it has no effect upon the underlying disease or disability*'. When considering whether a patient has a prospect of recovery, 'recovery' meant the resumption of a quality of life which that patient would regard as worthwhile, not one that others (including doctors) would regard as worthwhile. The question is not whether there is a prospect of recovering 'such a state of good health as will avert the looming prospect of death if the life-sustaining treatment is given.'

Recognising that the definition of 'best interests' is necessarily elusive, the Supreme Court stated that:

> '*The most that can be said, therefore, is that in considering the best interests of this particular patient at this particular time, decision-makers must look at his welfare in the widest sense, not just medical but social and psychological; they must consider the nature of the medical treatment in question, what it involves and its prospects of success; they must consider what the outcome of that treatment for the patient is likely to be; they must try and put themselves in the place of the individual patient and ask what his attitude to the treatment is or would be likely to be; and they must consult others who are looking after him*

or interested in his welfare, in particular for their view of what his attitude would be.'

The Supreme Court also rejected the suggestion made by the Court of Appeal that the test of the patient's wishes and feelings was an objective one, or what 'the reasonable patient' would think: "*The purpose of the best interests test is to consider matters from the patient's point of view. That is not to say that his wishes must prevail, any more than those of a fully capable patient must prevail. We cannot always have what we want. Nor will it always be possible to ascertain what an incapable patient's wishes are. Even if it is possible to determine what his views were in the past, they might well have changed in the light of the stresses and strains of his current predicament. In this case, the highest it could be put was, as counsel had agreed, that 'It was likely that Mr James would want treatment up to the point where it became hopeless'. But insofar as it is possible to ascertain the patient's wishes and feelings, his beliefs and values or the things which were important to him, it is those which should be taken into account because they are a component in making the choice which is right for him as an individual human being."*

However, having disagreed with the Court of Appeal on its approach to the law, the Supreme Court found that in light of the changed medical position that prevailed by the time that matter had come before the Court of Appeal, it had reached the right conclusion, and so the appeal was dismissed.

Comment

Although Baroness Hale was at pains to make clear that she considered the Supreme Court's judgment did no more than reflect the pre-existing legal framework for decision-making in end of life scenarios, the implications of this judgment are likely to be significant. First, the emphasis on the patient's own views as being a core aspect of the 'objective best interests' test is important – the Supreme Court suggests that decisions should be made through the prism of P's likely or actual wishes, which is not an approach that has always been reflected in the caselaw. Secondly, the judgment suggests that applications to the court in circumstances where P's condition is fluctuating or uncertain may not be appropriate, making it difficult for clinicians to know whether and when to approach the court where there is disagreement about proposed future interventions. Thirdly, the court's approach to the key concepts of 'futility' and 'recovery' is likely to be of great interest to clinicians, who will have to reconcile the court's analysis with the GMC guidance on treatment at the end of life (guidance which Baroness Hale considered to be in accordance with the law as set down in the judgment of the Supreme Court).

We will be discussing the judgment in more detail at a seminar on Monday 4 November at King's College London. The flyer is available here – please email marketing@39essex.com if you would like to attend.

Capacity to consent to sexual relations revisited

A Local Authority v TZ [2013] EWHC 2322 (COP)

Mental Capacity – Sexual relations

Summary

This is the latest decision concerning capacity to consent to sexual relations. In a scenario which will not be unfamiliar to lawyers working in this area, while the local authority and Official Solicitor agreed that TZ did have capacity to consent to sexual relations, the psychiatrist who assessed TZ concluded that he lacked capacity in this regard.

TZ was a 24 year old man with mild learning disabilities, atypical autism and ADHD. He had been in a homosexual relationship for some three years. The independent expert psychiatrist in the proceedings concluded that TZ lacked capacity to consent to sexual relations because he could not use and weigh the relevant information as a result of his cognitive impairments, "*specifically, symptoms associated with his ADHD (including distractibility and impulsivity), and those associated with autism (abstract thinking/imagination difficulties and intense interests) together with his intellectual impairment are still likely to significantly interfere with his ability to use and weigh relevant information. Other psychological factors such as*

early attachment issues, emotional factors related to his traumatic experiences are also likely to contribute." Under cross-examination, the psychiatrist stated that "[t]*he problem lay not so much with his cognitive difficulties but rather with the impulsivity that is a feature of his ADHD, coupled with "his social tendency to trust people in an unexamined way*." However, the psychiatrist's evidence was rejected because he had mistakenly considered the process of weighing up the relevant information to be a complex one:

> "*Most people faced with the decision whether or not to have sex do not embark on a process of weighing up complex, abstract or hypothetical information. I accept the submission on behalf of the Official Solicitor that the weighing up of the relevant information should be seen as a relatively straightforward decision balancing the risks of ill health (and possible pregnancy if the relations are heterosexual) with pleasure, sexual and emotional brought about by intimacy. There is a danger that the imposition of a higher standard for capacity may discriminate against people with a mental impairment*." (paragraph 55)

In any case, the judge heard evidence from TZ himself and was satisfied that TZ did "*have an understanding of the need to weigh up the emotional consequences of having sexual relations.*"

Referring to the apparent conflict within the existing case-law as to whether capacity to consent to sexual relations is act-specific or person/situation-specific, Baker J adopted the act-specific approach of Mostyn J in *D Borough Council v AB* [2011] EWHC 101 (Fam), observing that it was "*more consistent with respect for autonomy in matters of private life, particularly in the context of the statutory provisions of the MCA and specifically the presumption of capacity and the obligation to take all practical steps to enable a person to make a decision. To require the issue of capacity to be considered in respect of every person with whom TZ contemplated sexual relations would not only be impracticable but would also constitute a great intrusion into his private life*" (paragraph 23).

Baker J also held that where it has been clearly established that P is homosexual, "*it is ordinarily unnecessary to establish that the person has an understanding or awareness that sexual activity between a man and a woman may result in pregnancy*" since pregnancy is not a foreseeable consequence of homosexual sex. The judge did however note that where P has been at times attracted to both men and women, "*it will be necessary to establish an understanding and awareness of the fact that sex between a man and a woman may result in pregnancy as part of the assessment of capacity to consent to sexual relations*" (paragraphs 31-3).

Comment

Once again the High Court has taken the act-specific approach to the assessment of capacity to consent to sexual relations – perhaps unsurprisingly in the context of a case where P has been in a longstanding relationship, rather than, as in other cases, the subject of exploitation or sexual abuse. The Court of Appeal is shortly to consider whether the act-specific approach is the right one, which may go some way to resolving the uncertainty that practitioners currently face.

This case is yet another example of the Court of Protection rejecting expert psychiatric evidence, which must cast some doubt on whether the approach to capacity that the court takes is being properly disseminated, and whether an overly-high threshold for capacity is being applied generally in decisions that do not come before the court. The description by the psychiatrist in this case of TZ's inability to use and weigh information seems in great contrast with the record of TZ's oral evidence contained in the judgment – but it appears that the psychiatrist's real concern was that because of TZ's tendency to trust people automatically, he would not be able to assess the particular risks and consequences of a sexual encounter. While the judgment notes that this was said to be conflating an unwise decision with an incapacitous one, that is not necessarily correct. If TZ was actually unable to consider the risks of sexual encounters with different people (for example his partner, a carer,

or a stranger) because of his cognitive limitations and mental impairments, then arguably that could mean he lacked capacity to consent to sexual relations, at least in circumstances where risks existed which he could not recognise or weigh up. It may be that the right answer in such cases, from the perspective of the civil law, is to say that capacity should be continue to be presumed as the alternative is a major intrusion into P's daily life – as Baker J said in this case – but, of course, the same applies in respect of contact decisions in light of the Court of Appeal decision in *PC and NC v City of York Council* [2013] EWCA Civ 478. The reality surely is that practitioners will not assess capacity at every turn, but only when specific risks exist which raise a concern about P's capacity to make a particular decision, as is generally the case at present.

It will be of great interest to see future judgments in these proceedings, as the court noted that having established TZ has capacity to consent to sexual relations, it may yet be the case that his ability to engage in sexual relations with his partner might be curtailed if he lacks capacity to make decisions about contact with his partner. What scope does the court have to interfere with freedom of sexual expression through the mechanism of best interests declarations as to contact?

Bringing applications relating to termination to Court

An NHS Trust v P & Anor [2013] EWHC 50 (COP)

Mental Capacity – Medical Treatment

Summary

Although this case was decided back in January, it is included in this issue of the newsletter as the judgment has only just become available. The subject of the proceedings, P, was a young woman who was born with sickle cell disease which caused her to suffer a number of cerebral vascular incidents, or strokes. P's resultant learning disabilities placed her intellectually in the bottom 1% of the population.

P discovered that she was pregnant towards the end of 2012 and the NHS Trust made a serious medical treatment application to the Court of Protection concerning P's capacity to decide whether or not she wished to continue with the pregnancy.

At the time the application first came before Hedley J, there were grounds to believe that P lacked the capacity to make this decision. However, by the time of the hearing in January, there was unanimity between the parties, supported by independent psychiatric evidence, that P had capacity to decide whether or not to continue with or to terminate the pregnancy.

In his review of the law, Hedley J placed particular emphasis upon the principle enshrined in s.1(4) of the MCA 2005 that a person is not to be treated as unable to make a decision merely because he makes an unwise decision. He noted (para 10) that

> "*In the field of personal relationships that is a very important qualification to the powers of the court. The plain fact is that anyone who has sat in the Family jurisdiction for as long as I have, spends the greater part of their life dealing with the consequences of unwise decisions made in personal relationships. The intention of the Act is not to dress an incapacitous person in forensic cotton wool but to allow them as far as possible to make the same mistakes that all other human beings are at liberty to make and not infrequently do.*"

Hedley J reiterated the importance of assessing an individual's capacity to make deeply personal decisions (at para 16):

> "*It is, as I said, very important to bear in mind, particularly in the field of those with significant learning difficulties who may well be unable to function independently in the community in every aspects of their life, that they may very well retain capacity to make deeply personal decisions about how they conduct their lives. One has in mind the question of choice of partners; the extent to which they wish to be sexually active; the extent to which they may wish to*

make permanent relationships by way of marriage or indeed civil partnership; the extent to which they may wish to be able to make decisions about their own medical care, including, as in this case, the continuation or termination of a pregnancy. It cannot be the case that merely because a person has significant difficulties in functioning in the community, it can be presumed that they lack capacity to make profoundly personal decisions. They may in fact do so but that has to be assessed on an individual basis."

Comment

This was Hedley J's last decision as a puisne judge of the High Court sitting in the Court of Protection. The extracts set out above stand as a fitting testament to the humanity and wisdom which he brought to the Bench.

The most important practice point is his endorsement of the pre-MCA 2005 guidance given by Coleridge J at paragraphs 29-38 of *An NHS Trust v D* [2004] 1 FLR 1110 as to when applications concerning termination should be brought to Court. As those passages are not reproduced in the judgment of Hedley J, and in light of their importance, we set out their central points below.

Coleridge J emphasised that "t*he effect upon a mentally incapacitated woman of terminating a pregnancy should not be underestimated. Whilst it may be true that the overall effect of a termination may not be as pronounced as that of a sterilisation procedure, it is nevertheless a drastic and irreversible procedure however commonplace it might now have become. The opportunity for a woman to become pregnant again does not detract from this fact. The issues raised by a proposed termination can be complex and difficult, and they may in the harder cases be finely balanced*" (para. 28). He further emphasised that, although proposed terminations of pregnancies in mentally incapacitated women are not uncommon, and that where the issues of capacity and best interests are clear and beyond doubt, an application to the court is not necessary, where there is any doubt as to either capacity or best interests, an application to the court should be made. He noted that, in particular, that the following circumstances would ordinarily warrant the making of an application:

1. where there is a dispute as to capacity, or where there is a realistic prospect that the patient will regain capacity, following a response to treatment, within the period of her pregnancy or shortly thereafter;

2. where there is a lack of unanimity amongst the medical professionals as to the best interests of the patient;

3. where the procedures under s 1 of the Abortion Act 1967 have not been followed (ie where two medical practitioners have not provided a certificate);

4. where the patient, members of her immediate family, or the foetus' father have opposed, or expressed views inconsistent with, a termination of the pregnancy; or

5. where there are other exceptional circumstances (including where the termination may be the patient's last chance to bear a child).

If any case falls anywhere near the borderline in relation to any one of the criteria, Coleridge J emphasised that for the avoidance of doubt it should be referred to the Court.

Coleridge J also noted that the importance of making necessary applications in good time cannot be overstated, and that "[i]*t is imperative that the medical profession ensures that adequate protocols are put in place for the timely resolution of these issues*" (para 36).

In the circumstances, whilst it is not clear from the judgment what formal assessments of P's capacity were undertaken before the proceedings commenced (and hence whether the need for the proceedings would have been obviated if there had been clear evidence of lack of capacity), it is not surprising that Hedley J was not critical of the NHS Trust for bringing the application.

The last practice point is masked in diplomatic language, but it is perhaps proper to imply that

Hedley J had seen by the time that he had retired one too many reports from psychiatrists certified as s.12 MHA 1983 doctors who did not entirely grasp the complexities of the MCA 2005 – see paragraph 14, where he commented dryly that: "[e]*xperience has suggested that not everyone familiar with the Mental Health Acts is necessarily in a position to give [the] kind of very precise guidance and assistance under the Mental Capacity Act 2005*" needed to assist the Court in the resolution of questions of capacity.

Judicial despair at costs incurred in COP proceedings

A Local Authority v ED [2013] EWHC 3069 (COP)

COP jurisdiction and powers – Costs

Summary

This case concerned ED, a young woman in her early 30's. Litigation between the responsible local authority and her parents stretched back to 2007. After a 12-month stay, her parents were granted permission to restore the proceedings in late 2011, seeking, amongst other things, a declaration that it was in her best interests to return to live at the family home. The judgment records that the grant of permission proved to be an "open-sesame" for the re-litigation of a great range of issues. In August 2013 the parents changed their case to seek a declaration that it was in ED's best interests to reside at a residential care home closer to the family home. No explanation for this volte face was provided. The matter was listed for a final hearing for ten days in October 2013, but the day before the hearing was due to begin the court was notified that it was more likely than not that the parents would agree to the orders that were ultimately made. In a short judgment Roderic Wood J referred to the "*inordinate*" quantity of paper the case had generated (including 740 pages of witness statements and almost 300 pages of expert evidence) and the "*astonishing*" cost to the public purse since 2011 (approximately £138,000 for the local authority, £82,000 for the parents and £130,000 for the Official Solicitor, who was acting as ED's litigation friend).

Comment

This case underscores the vital importance of conducting and case-managing proceedings in the Court of Protection in accordance with the overriding objective. The very significant costs that were incurred since 2011 represent a portion of the total costs since the litigation began in 2007 and Roderic Wood J noted that the final orders, to which the parents ultimately consented, dismissed any hope of ED coming to live with them and a significant reduction in her contact to them. One point that might be of broader interest to readers is the expert evidence as to the removal of ED's pubic hair, which is an issue that her parents raised in the proceedings and has featured in a number of Court of Protection cases. The parties obtained expert evidence that there was a duty to shave a Muslim woman's pubic hair (both for religious and cultural reasons) but that there is an exemption for those incapacitated, such as ED. This evidence was not challenged by any of the parties.

Testamentary capacity does not require knowledge of foreign law of succession

Re Devillebichot (deceased) [2013] EWHC 2867 (Ch)

Mental capacity – Finance

Summary and comment

We note this probate case for two reasons. The first relates to one of the grounds upon which it was alleged that the testator lacked the capacity to make a will. It was said by his sole next-of-kin that he was familiar with French law, and that an attempt by him to leave the whole of a property in France to a sibling (impossible under French law) was evidence of his incapacity at the material time. Mark Herbert QC, sitting as a Deputy High Court Judge, rejected this submission. He did so in part because he was not satisfied that there was convincing evidence that the testator either had or lacked the knowledge of the legal ramifications of leaving the property away from his heir. Of more general significance was the judge's conclusion that "the requirement to prove testamentary capacity does not… extend to a requirement for knowledge of the comparative law of succession"

(paragraph 58).

The second point of interest is that is – another – case in which the will in question was made after 1 October 2007 but the Court in considering whether the testator had the requisite capacity approached matters solely by reference to Banks v Goodfellow, rather than by reference to ss.2-3 MCA 2005. It does not appear that the Court was addressed on the extent to which the latter represents a reformulation of the former but this does provide an opportunity to note that Barbara Rich has reiterated her doubts about whether this is correct in the most recent issue of the Elder Law Journal [2013] 3 Eld LJ 258. This chimes with Alex's doubts as to whether this is correct (see in this regard both his recent paper and the article he co-wrote with Annabel Lee in the same issue [2013] 3 Eld LJ 272).

Article 5(4) and the incapacitated patient

MH v United Kingdom [2013] ECHR 1008

Mental Health Act 1983 – Interface with MCA

Summary

This decision is the outcome of the challenge to the House of Lords' decision in *R (MH) v Secretary of State for Health* [2006] 1 AC 441. MH was an adult severely disabled by Down's syndrome who lived with her mother. She was removed by execution of a warrant under section 135 of the Mental Health Act 1983 and detained for assessment which she did not challenge within 14 days of admission. As nearest relative, her mother's application for discharge was barred and proceedings to displace her commenced after she objected to a proposed guardianship order. The consequence was to automatically extend the detention period until those proceedings were concluded, with no interim right to an Article 5(4) review. The Health Secretary exercised her discretionary power to refer the case to the tribunal which decided not to discharge the patient. As a result, MH was detained for almost 6 months rather than the maximum 28 days and she argued that Article 5(4) was violated as the right to challenge her detention was ineffective if she lacked the ability to instruct solicitors.

The House of Lords had held that Article 5(4) did not require every case to be considered by a court and that the scheme was "capable of being operated compatibly" (para 28). It required "every sensible effort should be made to enable the patient to exercise that right if there is reason to think that she would wish to do so" (para 24). In relation to the automatic extension of the time limit resulting from displacement proceedings, it held the Secretary of State "would be well advised to make [a tribunal reference] as soon as the position is drawn to her attention" (para 30).

Eight years later, the European Court of Human Rights held that MH's Article 5(4) rights were violated in relation to the initial 28 days of detention but not thereafter. In so deciding, it summarised the following principles, which in our view are equally applicable to detention under the Mental Capacity Act 2005:

1. An initial period of detention may be authorised by an administrative authority as an emergency measure provided that it is of short duration and the individual is able to bring judicial proceedings "speedily" to challenge the lawfulness of any such detention including, where appropriate, its lawful justification as an emergency measure;

2. Following the expiry of any such initial period of emergency detention, a person thereafter detained for an indefinite or lengthy period is in principle entitled, at any rate where there is no automatic periodic review of a judicial character, to take proceedings "at reasonable intervals" before a court to put in issue the "lawfulness" – within the meaning of the Convention – of his detention;

3. Article 5(4) requires the procedure followed to have a judicial character and to afford the individual concerned guarantees appropriate to the kind of deprivation of liberty in question; in order to determine whether proceedings provide adequate guarantees, regard must be had to the particular nature of the circumstances in which they take place;

4. The judicial proceedings referred to in Article 5(4) need not always be attended by the same guarantees as those required under Article 6(1) for civil or criminal litigation. Nonetheless, it is essential that the person concerned should have access to a court and the opportunity to be heard either in person or, where necessary, through some form of representation;

5. Special procedural safeguards may be called for in order to protect the interests of persons who, on account of their mental disabilities, are not fully capable of acting for themselves.

The Court accepted that for those with "legal capacity", the right to apply to the tribunal within the first 14 days satisfied Article 5(4). However, in this case, she lacked "legal capacity," such that:

> "*81. In the case of Winterwerp, cited above, § 60, the Court held that it was essential for the patient to have access to a court and the opportunity to be heard either in person or, where necessary, through some form of representation; that mental illness could entail restricting or modifying the manner of exercising that right, but could not justify impairing its very essence; and that special procedural safeguards might be called for in order to protect the interests of persons who, on account of their mental disabilities, were not fully capable of acting for themselves.*
>
> *81. As the right set forth in Article 5 § 4 of the Convention is guaranteed to everyone, it is clear that special safeguards are called for in the case of detained mental patients who lack legal capacity to institute proceedings before judicial bodies. However, it is not for this Court to dictate what form those special safeguards should take, provided that they make the right guaranteed by Article 5 § 4 as nearly as possible as practical and effective for this particular category of detainees as it is for other detainees. While automatic judicial review might be one means of providing the requisite safeguard, it is not necessarily the only means.*
>
> *…*
>
> *86 … Neither the applicant nor her mother acting as her nearest relative was able in practice to avail themselves of the normal remedy granted by the 1983 Act to patients detained under section 2 for assessment. That being so, in relation to the initial measure taken by social services depriving her of her liberty, the applicant did not, at the relevant time, before the elucidation of the legal framework by the House of Lords in her case, have the benefit of effective access to a mechanism enabling her to "take proceedings" of the kind guaranteed to her by Article 5 § 4 of the Convention. The special safeguards required under Article 5 § 4 for incompetent mental patients in a position such as hers were lacking in relation to the means available to her to challenge the lawfulness of her "assessment detention" in hospital for a period of up to twenty-eight days.*
>
> *93 … When a mental patient is not fully capable of acting for herself on account of her mental disabilities, by definition the compensatory safeguards to which the State might have recourse in order to remove the legal or practical obstacles barring such a person from being able to benefit from the procedural guarantee afforded by Article 5 § 4 may well include empowering or even requiring some other person or authority to act on the patient's behalf in that regard*." (emphasis added).

MH did not make a claim for any financial compensation.

Comment

This decision is clearly of significance in respect of those detained under both the 1983 and 2005 Acts. It is unfortunate that the Court loosely invokes the term lacking "legal capacity" throughout its judgment. There is a danger of

wrongly equating this with lacking the mental capacity to litigate which may not have been what the Court was intending. Indeed, the Court does appear at para 84 to differentiate "incompetence" from "legal capacity" when it observed: "*An incompetent patient such as the applicant could not make a section 66(2)(a) application to the Tribunal for discharge because she lacked legal capacity*…". The reality is that, as Lady Hale had observed at para 26 of the judgment of the House of Lords, "*the threshold for* [mental] *capacity is not a demanding one" when it comes to applying to the tribunal*.

If ever there were any doubt, this decision makes clear that the internal DoLS review process by the Local Authority would not satisfy the requirements of Article 5(4). It lacks the necessary judicial character and fails to afford detained residents the appropriate guarantees. Indeed, there appears to be very little in the way of procedure governing the undertaking of such reviews. Clearly the principal Article 5(4) guarantee is the availability of the Court of Protection.

Where someone is deprived of their liberty and lacks litigation capacity, whether that be in a hospital, care home, supported living, education residential establishment, or elsewhere, para 93 of the *MH* decision becomes key and is likely to be closely analysed in future Court of Protection cases. Expecting the State to empower or require another person or authority to act on the incapacitated person's behalf to secure the procedural Article 5(4) guarantee is clearly significant. It reinforces Mr Justice Peter Jackson's comment in *Neary* that "*there is an obligation on the State to ensure that a person deprived of liberty is not only entitled but enabled to have the lawfulness of his detention reviewed speedily by a court*." But who will take on that role and who will pay for it regrettably remains to be seen.

Finally, the fact that Article 5(4) does not require an automatic review by a Court is of interest. Must Court of Protection proceedings be initiated where, for example, it is difficult to ascertain the wishes and feelings of someone deprived of their liberty? Should their representative err on the side of caution and make an application? What if the person is vehemently expressing a wish to challenge their detention with utterly hopeless prospects of success? Should their wish suffice in order to protect their Article 5(4) rights? We await a forthcoming Court of Appeal decision which, it is hoped, will address some of these issues. In the meantime, however, *MH* would certainly appear to support erring on the side of caution.

Capacity, immigration detention and the vulnerable adult

R(Muhammad) v SSHD (and two linked cases) [2013] EWHC 3157 (Admin)

Mental capacity – Medical treatment

Summary and comment

These three – linked – applications for interim relief in judicial review proceedings contain an interesting (if glancing) discussion of the width of the category of those falling within the definition of the 'vulnerable adults' identified by Munby J (as he then was) in *Re SA* [2006] 1 FLR 867.

New SCIE report on deprivation of liberty practice

The recently published SCIE report, 'Deprivation of Liberty Safeguards: putting them into practice' is an essential read for anyone working within the realms of DoLS. It identifies the framework that should be used by hospitals and care homes to promote the effective use of the safeguards and gives examples of good practice. Crucially, in our view, it states at page 29 that "Care plans should explain how a resident's liberty is being promoted". The late great John Leighton was very much in favour of incorporating a liberty-enhancing section into a person's care plan and it is great to see the idea finding the light of day in good practice guidance. Also, throughout the report are benchmarks of what makes a good assessment or a good supervisory body, for example, which are particularly useful.

The three Claimants were all in immigration detention; they were challenging the lawfulness of that detention, but sought their immediate release from detention on an interim basis pending the final determination of their claims. The basis upon which they did so was on the basis that their mental health was such that they were not fit for detention; specifically, they relied upon the fact that they were refusing food and drink. Their precise circumstances varied; in considering the position of two of the Claimants, Stewart J noted that it was common ground that that they both had capacity to litigate and to make decisions about refusing food and/or treatment. It was, further, common ground, that "[t]*he Court's inherent jurisdiction to act to protect a vulnerable adult who is incapacitated for reasons not covered by the Mental Capacity Act 2005 cannot be exercised. The Court has no jurisdiction in relation to an adult who has capacity and is not a 'vulnerable adult'. In the case of Re: SA (Vulnerable Adult with Capacity: Marriage) (2006) 1 FLR 867 at 82 Munby J (as he then was) gave a description of a 'vulnerable adult'. I appreciate that it was only a description and not a definition. That description was adopted by the Court of Appeal in Re L (Vulnerable Adults: Court Jurisdiction) (No 2) (2012) 3 WLR 1439. The Claimants in the present case do not, it seems to me, come within the definition of a 'vulnerable adult'. Nor did either party contend that they did*." (paragraph 35(iii)).

In refusing to grant them interim relief, Stewart J placed particular emphasis upon the fact that, whilst their continued detention in a detention centre would be unlawful, it would not be unlawful to detain them in hospital (as the Secretary of State was fully prepared to bring about). He further considered that the Claimants' refusals to accept hospitalisation were made with capacity to do so; they therefore bore the responsibility for their own actions, and could not rely upon the consequences to establish that they should be discharged immediately.

On the facts of these cases, it is perhaps not entirely surprising that the court did not engage in a detailed discussion of the scope of the class of vulnerable adults. It would, though, appear from Stewart J's comments that his approach to the class did not encompass those whose need for protection arose from their own actions (as opposed to those of third parties). If this is correct – and Alex for one would have some reservations as to whether it is – this might suggest that the 'great safety net' of the inherent jurisdiction upon which the Government places such reliance would not extend to secure adults against the consequences of self-neglect and self-harm.

Capacity and self-neglect

R (Greenough) v Ministry of Justice [2013] EWHC 3112 (Admin)

Mental capacity – Residence

Summary

This case bears short note as an acute example of the dilemma that faces professionals confronted with a truly unwise decision. The Claimant's brother, a Mr Shovelton, suffered from a history of alcohol and substance abuse, and poor health generally, having suffered from heart attacks, strokes and depression at various stages in his life. He had a history of self-harm and self-neglect as well. Between November 2011 and February 2012 there was a repeated pattern of discharge from hospital and some social work support, followed by further examples of self-harm and self-neglect which resulted in further admissions to hospital. The Claimant attended the hospital where the deceased was a patient. She asked for help in relation to the management of the deceased given the history of admissions to hospital following self-neglect and she was assured that the deceased would be noted as a vulnerable person. The local authority Housing Association informed the claimant that an emergency care package would be delivered. However, before that care package had commenced, Mr Shovelton discharged himself from hospital, against the advice of medical and nursing staff. As at that point, it appears from the witness statement prepared by the Coroner for purposes of the judicial review proceedings, the local authority considered that he had "*mental capacity to decide where he should live and the local authority had no legal powers to prevent him from returning home. Furthermore, there has been a psychiatric assessment and the deceased had been assessed as not having a mental illness. The Wigan Council People*

Directorate also indicates that it was recognised the deceased was vulnerable and therefore considerable efforts were made to offer him appropriate support but the local authority was unable to exercise any legal powers." The Claimant sought funding for representation on the basis that because it was likely to be necessary to enable the Coroner to carry out an effective investigation into the death as required by Article 2 of the European Convention of Human Rights. She was refused this funding, and sought permission to challenge the decision by way of judicial review.

In refusing the application for permission, HHJ Pelling QC noted that:

> "*28. There is no evidence that the deceased died or died earlier than he might otherwise have done as a result of any failings on the part of the local authority to provide the care package. Indeed, there is no evidence as to what care package it was intended should be provided, so it becomes extremely difficult to analyse that issue with any degree of precision. The fact remains however, that the post mortem report on the deceased, as summarised by the Coroner, describes in fairly clear detail that the deceased was a chronically ill man, with severe heart disease, which had compromised his lungs and that his death was the result of that chronic ill-health.*
>
> *29. In the absence of any material which suggests that potentially his death occurred earlier than it would have as a result of the failure by the local authority to provide the relevant care package (whatever that was) it is difficult to see how the Lord Chancellor can be criticised for failing to provide discretionary legal funding for representation at an inquest, and particularly when there is a decision yet to be taken as to whether or not the inquest should be in the more wide-ranging Article 2 compliant format.*
>
> *30. I then return to the analysis of Smith LJ in Humberstone* [R (Humberstone v The Legal Services Commission [2010] EWCA Civ 1479] *at paragraph 58 and remind myself of the limited circumstances that can trigger the Article 2 duty. The deceased was not in the custody of the local authority or any other emanation of the State. The deceased was not a detained patient, or a voluntary patient in a mental hospital. He was a patient in a hospital who had fully [sic] mental capacity who discharged himself as he was entitled to. In summary most of not all the critical indicia of an Article 2 claim are not made out in the circumstances of this case. The deceased was not under the care or control of the emanation of the state concerned at the time of his death, and there is no evidence that what is alleged to have constituted the breach of duty (the failure to provide a care package or alternative accommodation more suited to his needs) was is any way causative of the deceased's death, either directly or indirectly*."

Comment

The inquest (it appears) has yet to take place, so it is not clear the extent to which the Coroner will scrutinise the steps taken to assess Mr Shovelton's capacity to decide as to his residence and care arrangements. Whilst we are acutely aware of the dangers of succumbing to the protective impulse identified by Baker J in *PH v A Local Authority* [2011] EHWC 1704 (COP), the (relatively) limited information provided in the transcript of this judgment would suggest – at least to us – that this will (or should be) a case in which the Coroner expects to see an extremely detailed assessment both of the capacity and of the steps taken to consider the legal options open to Wigan to secure a vulnerable adult against the consequences of his own actions.

DOLS and CQC authorisation

Oluku v Care Quality Commission [2012] UKFTT 275

Article 5 – DOLS authorisation

Summary and comment

With thanks to Lucy Series for bringing this case

to our attention, we note briefly this appeal against the cancellation of the registration of a manager of a care home which was determined last year.

A carer's secretly recorded video footage of widespread abuse in a residential care home led to the successful conviction of two members of staff under MCA s.44 and the removal of a number of residents. The case is of particular interest because the Tribunal acknowledged that a failure to have all the necessary DoLS paperwork could breach regulation 11(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because it would mean that a care home manager did not have suitable arrangements in place to protect service users against the risk of such control or restraint being unlawful or otherwise excessive.

Aside from this decision, there is a real concern that the Care Quality Commission is not being adequately notified of DoLS applications. Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 requires hospitals and care homes to notify them of DoLS applications. Although there has been an increase in reporting, the CQC is not notified of a substantial number, as highlighted in chapter 3 of their report, *Monitoring the use of the Mental Capacity Act Deprivation of Liberty Safeguards in 2011/12*.

Costs in the Court of Protection – important practice points

Two very important practice points have arisen concerning costs before the Court of Protection, both (for different reasons) relating to changes coming into effect on 1 April 2013.

The first is of general application (and was highlighted by District Judge Marin at the recent Jordans' Court of Protection conference), and concerns the fact that rule 160(1) COPR 2007 appears, on their face, simply to import the costs provisions of the CPR 1998 as they are in force from time to time – i.e., now, as they stand post the substantial Jackson reforms brought in as of 1 April 2013. There are good arguments to suggest that this cannot be the proper construction of the legislation, but pending clarification by way of amendment to the Rules and/or a new Practice Direction, it is suggested that any final order makes clear which rules are to apply (i.e. the CPR as they stood as at 31 March 2013, or the CPR as now amended). This will avoid doubt, for instance, as to whether in assessing costs the new definition of proportionality in CPR r44 is to apply.

The second is limited to s.21A MCA 2005 applications (i.e. in respect of authorisations made under Schedule A1), and concerns the implications of the change in the legal We attach to this newsletter a paper on the subject by the Law Society's Mental Health and Disability Committee, but, in short, there is now a real danger that if the route adopted by Charles J in *Re HA* is adopted (i.e. that the Court on a s.21A application 'holds the ring' by authorising any deprivation of liberty itself by way of orders/declarations) then P will cease to be considered eligible for legal aid by the LAA.

Advocates Gateway

Those who appear before the Court of Protection may well have cause to examine/cross-examine witnesses with varying degrees of vulnerability. May we heartily recommend the Advocates Gateway as a resource in such situations. Hosted by the Advocacy Training Council, the gateway provides invaluable (free) evidence-based guidance on the proper approach to take to the questioning of vulnerable witnesses. Whilst aimed, in the first instance, at those appearing in criminal trials, it is of wider application, and is particularly helpful because it breaks down the guidance as to as to address such specific categories of witnesses as those with learning disabilities or those with autism spectrum disorder.

Attempt to include power of entry in Care Bill defeated

As is well known, the Care Bill making its way through Parliament at present imposes a statutory duty upon local authorities to make enquiries where they have safeguarding concerns, the duty currently being contained in Clause 42 and reading thus:

42 Enquiry by local authority.

(1) This section applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)—

(a) has needs for care and support (whether or not the authority is meeting any of those needs),

(b) is experiencing, or is at risk of, abuse or neglect, and.

(c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it..

(2) The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case (whether under this Part or otherwise) and, if so, what and by whom.

(3) "Abuse" includes financial abuse; and for that purpose "financial abuse" includes—

(a) having money or other property stolen,

(b) being defrauded,

(c) being put under pressure in relation to money or other property, and

(d) having money or other property misused.

As part of the consultation upon the draft Bill, the Department of Health consulted upon whether or not there should be a new power to support this duty. The Department of Health suggested that this could take the form of a power of entry, enabling the local authority to speak to someone with mental capacity who they think could be at risk of abuse and neglect, in order to ascertain that they are making their decisions freely. The Department of Health did not consult upon any equivalent to the other suite of orders within the ASP and made clear that it was not proposing to introduce any new power of removal or

Transforming the services of the OPG consultation

On 15 October the Ministry of Justice opened a consultation on "Transforming the services of the Office of the Public Guardian - enabling digital by default".

The consultation paper is said to consider the next phase of the OPG transformation, following recent changes. Part 1 considers changes that may be made by April 2014, including proposals for improving the design of the paper forms for creating an LPA (including the potential for a new combined form), revisions to fees, access to the OPG Registers and changes to the supervision of Court appointed deputies. The aspect of this consultation that has caused the most press reaction is the proposal to amend the health and welfare LPA form so as to remove the requirement for the grant of power to refuse life-sustaining treatment to be signed and witnessed separately. This was the subject of some alarmist commentary in certain national newspapers, but we would commend a proper reading of the consultation document before a rush to judgment in this regard.

Part 2 considers "the bigger picture", including initial proposals for the delivery of a fully digital method of creating and registering Lasting Powers of Attorney (e-LPAs). On 1 July 2013 the OPG launched digital tool that enables the majority of the LPA process to be completed online.

detention.

The precise scope of the proposed power of entry was left undefined in the consultation, although the Department of Health suggested a possible procedural route to ensure adequate safeguards were in place, namely applying for a warrant from a Circuit Judge (e.g. a nominated judge of the COP) upon evidence of need for the warrant, and ensuring that there was a "process by which the occupiers of the premises understand that they can complain about the way in which a power has been used. The local authority would have to verbally inform the affected persons how they might access that process" (p.5 of the consultation document).

The government, however, rejected a power of access in May, following a consultation that found health and social care professionals were largely in favour of the change, and most members of the public who responded were opposed. An attempt to insert into the Bill at the report stage in the House of Lords by Baroness Greengross was defeated by 143 votes to 72 on 14 October 2013. Responding on behalf of the Government to the proposal, Earl Howe, the Parliamentary Under-Secretary of State at Department of Health, stated he considered that:

> *"There exists no legislative vacuum preventing care or other professionals accessing those in urgent need of assistance. Under the Police and Criminal Evidence Act 1984, the police have the power to enter premises if harm has occurred or, indeed, is likely to occur. The Domestic Violence, Crime and Victims Act 2004, the Fraud Act 2006 and, for those lacking capacity to make decisions, the Mental Capacity Act 2005, provide a wealth of powers for use at the front line, and the inherent jurisdiction of the courts to intervene provides a secure safety net. Therefore, it is not the lack of legislation; rather, as safeguarding lead directors at ADASS have put it, it is a question of a "lack of legal literacy" within the social care and other professions. What is needed is greater knowledge of existing legislative options. If they have that, professionals will be fully equipped to support people to be safe. The core role of an adult social worker is to support people. Further legislation for a new power of access risks undermining this approach, sending the message that legal intervention takes primacy over negotiations and consensus. I stress that legal intervention, on those rare occasions when it is needed, is already possible under the law. For those reasons, I cannot accept this amendment."*

Law Society of Scotland guidance on powers of attorney and vulnerable clients

In our July 2013 issue, we covered the Practice Note issued by the Law Society of England on financial abuse. Its Practice Note on lasting powers of attorney is somewhat older (dating from December 2011). The Law Society of Scotland has also recently issued guidance both upon powers of attorney and on advising and acting for vulnerable clients. Both repay reading by private client practitioners in South Britain because, whilst the statutory context is different, the underlying dilemmas and problems are the same. Indeed, it is perhaps worth noting that the new guidance on taking instructions in respect of the preparation of powers of attorney was drafted as a result of a case concerning (inter alia) a failure by a solicitor and a GP to conduct proper examination of the circumstances under which a powers of attorney had purportedly been made by two mildly leaning disabled adults at the instigation of a relative, a case which could – one suspects – equally have arisen in England and Wales. This case, the so-called *D* case, was the subject of a highly critical report by the Scottish Mental Welfare Commission published in February 2012.

Perhaps the most useful aspect of the new guidance for those outside Scotland is the list of indicators contained in the vulnerable adult guidance as to the type of situations in which particular caution must be exercised so as to ensure that the client is giving instructions which are both capacitous and are not the result of undue influence.

CQC Report – A fresh start for the regulation and inspection of adult social care

The Care Quality Commission has published a new report entitled "A fresh start for the regulation and inspection of adult social care: Working together to change how we inspect and regulate adult social care services". This follows the publication of CQC's strategy for 2013-2016, "*Raising standards, putting people first*" and its recent consultation, "*A new start*". The newly appointed Chief Inspector of Adult Social Care will oversee the regulation of:

- Care home services with nursing;
- Care home services without nursing;
- Specialist college services;
- Domiciliary care services;
- Extra Care housing services;
- Shared Lives;
- Supported living services;
- Hospice services; and
- Hospice services at home.

The report outlines CQC's plans for addressing five priority areas:

6. Developing the new regulatory approach (including in relation to regulation of supported living) with particular focus on registration, inspection and enforcement action. The Department of Health has recently consulted on proposals for a new fitness test for all registered providers and proposals to allow the CQC to insist on the removal of directors that failed this fitness test. The consultation also proposed that the CQC would be able to consider any failure of providers to provide safe, effective care, and to prosecute in cases of serious failure. The CQC report proposes that the CQC may issue penalty notices in relation to breaches of the quality of care (including failure to ensure a registered manager is in place over long periods of time) and in cases where services fail to provide notification of relevant events to the CQC. The CQC report sets out the timetable for the planned changes, with all changes due to take effect by October 2014. The Department of Health will consult on legislation to underpin the registration requirements this autumn.

7. Developing and applying a four-point ratings scale. Subject to receiving Royal Assent in 2014, the Care Bill will allow for regulations to be laid for rating care providers. It is currently proposed that the available ratings will be outstanding, good, requires improvement and inadequate. It is intended that many of the CQC's inspections will lead to a rating and the frequency of future inspections will depend, in part, on the rating given. Consideration is being given to offering providers the opportunity to pay for an inspection to obtain a new rating earlier than the CQC's inspection schedule allows. The CQC anticipates that all adult social care services will be rated by March 2016.

8. Developing the approach to monitoring the finances of some providers. Subject to the Care Bill receiving Royal Assent, from April 2015 the CQC expects to play a role in monitoring the finances of an estimated 50 to 60 care providers that would be difficult to replace if they were to go out of business. The CQC will require regular financial and performance information, provide early warning of a provider's failure and seek to ensure a managed and orderly closure of a provider's business if it cannot continue to provide services.

New safeguarding policy for the OPG

In a development that we should have picked up earlier in the summer, the OPG has published a new policy setting out its approach to safeguarding, and, in particular highlighting what steps it will take where it has reason to suspect that an adult is at risk (including, importantly, what it will and will not investigate, and, where it will not investigate, to whom it will refer matters).

9. Supporting CQC's staff to deliver, including by ensuring inspectors receive more in-depth training on dementia, the Mental Capacity Act and safeguarding.

10. Building confidence in the CQC.

Article 12 of the UN CRPD – draft comment by the Committee on the Rights of Persons with Disabilities

Our readers will, we hope, require no reminding of the importance of the UN Convention on the Rights of Persons with Disabilities. However, from our perspective, the cause of promoting the Convention has not been helped by the draft general comment recently adopted on Article 12 of the Convention by the Committee on the Rights of Persons with Disabilities at its tenth session on 2-13 September 2013. This comment is open for submissions until 31 January 2014 (as is a draft general comment upon Article 9 of the Convention).

At paragraphs 21 ff, the Committee states as follows:

> *"21. This Committee has repeatedly stated in its Concluding Observations on Article 12 that States Parties must "review the laws allowing for guardianship and trusteeship, and take action to develop laws and policies to replace regimes of substitute decision-making by supported decision-making, which respects the person's autonomy, will and preferences.*
>
> *22. Regimes of substitute decision-making can take many different forms, including plenary guardianship, judicial interdiction, and partial guardianship. However, these regimes have some common characteristics. Substitute decision-making regimes can be defined as systems where 1) legal capacity is removed from the individual, even if this is just in respect of a single decision, 2) a substituted decision-maker can be appointed by someone other than the individual, and this can be done against the person's will, and 3) any decision made by a substitute decision-maker is bound by what is believed to be in the objective 'best interests' of the individual – as opposed to the individual's own will and preferences.*
>
> *23. The obligation to replace regimes of substitute decision-making by supported decision-making requires both the abolishment of substitute decision-making regimes, and the development of supported decision-making alternatives. The development of supported decision-making systems in parallel with the retention of substitute decision-making regimes is not sufficient to comply with Article 12.*

Prima facie, therefore, this suggests that any regime which includes any element of substituted decision-making (including, clearly, the MCA 2005) is incompatible with Article 12 of the Convention. It can undoubtedly be said that the MCA 2005 signally lacks the clear and express mechanisms for supported decision-making that (for instance) the Irish bill does. However, it remains in our (perhaps unduly simplistic minds) impossible to see how a regime can sensibly operate which does not provide for decisions to be made on behalf of an adult who is entirely unable to express their own wishes and feelings (especially where that inability has been life-long and/or where the adult is in a coma/PVS following an accident and made no relevant pre-accident indications of their wishes regarding their treatment).

For a detailed critique both of this General Comment and of the recent European Union Agency for Fundamental Rights report on the "Legal Capacity of Persons with Intellectual Disabilities and Persons with Mental Health Problems" we would respectfully refer our readers to the paper by Adrian Ward (a leading light in Scottish incapacity law) available here.

We should perhaps also note that Article 14 of the Convention was squarely before the Supreme Court in oral argument on the *Cheshire West* and *P and Q* appeals and, in particular, whether it was

Court of Protection Conferences

Shameless plugs for:

(1) Jonathan Auburn, the co-editor of the Community Care Newsletter, who is chairing the Butterworths Deprivation of Safeguards Conference on 20 November.

(2) Tor, who will be speaking a seminar convened by Irwin Mitchell aimed at financial deputies and case managers on 10 December (further details to follow next month).

possible to square the apparent prohibition in the Article on deprivation of liberty upon the basis of disability with Article 5(1)(e) which provides for the deprivation of liberty upon the basis of mental disorder.

Law Society Mental Health and Disability Committee vacancy

The Law Society is recruiting for a vacancy on its Mental Health and Disability Committee. Details and the application form can be found here, and the deadline is 9:00 am on 12 November 2013.

Our next Newsletter 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 Newsletter in the future please contact marketing@39essex.com.

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David Barnes Chief Executive and Director of Clerking
david.barnes@39essex.com

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

Alastair Davidson Senior Clerk
alastair.davidson@39essex.com

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

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London	39 Essex Street, London WC2R 3AT	Tel: +44 (0)20 7832 1111	Fax: +44 (0)20 7353 3978
Manchester	82 King Street, Manchester M2 4WQ	Tel: +44 (0)161 870 0333	Fax: +44 (0)20 7353 3978
Singapore	Maxwell Chambers, 32 Maxwell Road, #02-16, Singapore 069115	Tel: +(65) 6634 1336	

CONTRIBUTORS

Alex Ruck Keene
alex.ruckkeene@39essex.com

Alex is recommended as a leading practitioner in Court of Protection work by Chambers and Partners. He appears on behalf of individuals and public bodies in applications across the spectrum of the Court's jurisdiction. He has particular, and unrivalled, expertise in cross-border incapacity cases. Alex's publications including contributions to Jordan's annual Court of Protection Practice; the Assessment of Mental Capacity (Law Society/BMA 2009); The Court of Protection: A User's Guide (forthcoming, Legal Action Group); and a work on the International Protection of Adults (forthcoming, OUP). Alex is on sabbatical for the academic year 2013-4 at the Institute for Advanced Legal Studies. **To view full CV click here.**

Victoria Butler-Cole
vb@39essex.com

Victoria regularly appears in the Court of Protection, instructed by the Official Solicitor, family members, and statutory bodies, in welfare, financial and medical cases. She previously lectured in Medical Ethics at King's College London and was Assistant Director of the Nuffield Council on Bioethics. Together with Alex, she co-edits the Court of Protection Law Reports for Jordans. She is a contributing editor to Clayton and Tomlinson 'The Law of Human Rights', a contributor to 'Assessment of Mental Capacity' (Law Society/BMA 2009), and a contributor to Heywood and Massey Court of Protection Practice (Sweet and Maxwell). **To view full CV click here.**

Neil Allen
neil.allen@39essex.com

Neil has particular interests in human rights, mental health and incapacity law and mainly practises in the Court of Protection. Also a lecturer at Manchester University, he teaches students in these fields, trains health, social care and legal professionals, and regularly publishes in academic books and journals. Neil is the Deputy Director of the University's Legal Advice Centre and a Trustee for a mental health charity. **To view full CV click here.**

Michelle Pratley
michelle.pratley@39essex.com

Michelle's broad range of experience in the Court of Protection encompasses deprivation of liberty, residence and contact, forced marriage, serious medical treatment, capacity to consent to marriage and capacity to consent to sexual relations as well as applications for financial deputyship. She is recommended as "responsive and approachable" and a "formidable presence" in the Court of Protection in Chambers and Partners 2013. **To view full CV click here.**