Mental Capacity Law Newsletter December 2016: Issue 71

Court of Protection: Health, Welfare and Deprivation of Liberty

Welcome to the December 2016 Newsletters. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Newsletter: DOLS and objections, the scope of s.21A appeals and best interests in treatment withdrawal;

(2) In the Property and Affairs Newsletter: capacity to revoke an LPA, capacity and IVAs, and litigation friends, influence and trusts;

(3) In the Practice and Procedure Newsletter: the Court of Appeal looks at committal, dismissing vs withdrawing proceedings, and the acceptable limits in criticising witnesses;

(4) In the Capacity outside the COP Newsletter: news from the National Mental Capacity Forum, new consent guidelines for anaesthetists, an important Serious Case Review regarding self-neglect, an update on the international protection of vulnerable adults and a Christmas book corner;

(5) In the Scotland Newsletter: delegation by attorneys and getting it backwards as regards capability to stand trial.

And remember, you can now find all our past issues, our case summaries, and much more on our dedicated sub-site here. 'One-pagers' of the cases in these Newsletters of most relevance to social work professionals will also shortly appear on the SCIE website.

We will be back in early February, and wish you all a very happy holidays in the interim.

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Law Commission Deprivation of Liberty project delay

On 1 December, the Law Commission sent the following email to stakeholders:

> *I am writing to inform you that unfortunately the publication of our final report and draft bill will be delayed. We had planned to publish by the end of 2016, but we now expect to publish in March 2017.*
>
> *The reason for the delay is the complexity of the task of drafting legislation on such an important issue. It is vitally important to get the law right here. Badly drafted, over-complicated law is a big part of the problem with the current DoLS, and we do not want to fall into the same trap again.*
>
> *We are very aware that the project deadline was brought forward at the request of the Department of Health and for a good reason: there is an urgent need for the system to be improved. We know too that many stakeholders are waiting for our report and draft Bill and will be disappointed with any delay. For this we apologise.*
>
> *But we are convinced that it is far more important to deliver a fully completed draft Bill that can deliver effective safeguards to those being deprived of liberty. We are also confident that our new publication date will not delay the introduction of legislation into Parliament, should the Government wish to do so. It will be for Government to decide how to take forward the recommendations and draft Bill.*

DOLS, objections and s.21A applications

Re RD & Ors (Duties and powers of RPRS and s.39D IMCAs) [2016] EWCOP 49 (Baker J)

Article 5 – DOLS RPR

Summary

Five test cases involving elderly people (RD, JB, JP, EP and JW) who suffered from a form of dementia were identified to enable the court to consider the question of when an application should be made under section 21A MCA. A brief description of the five cases is as follows:

1. RD had a lifelong presentation of mental and physical disabilities with a historic diagnosis of chronic schizophrenia although her symptoms were more closely akin to learning disabilities and autism. During the initial stages of her stay, she frequently expressed an objection to being at the care home and a desire to leave. Recently, she became inconsistent about her wishes and expressed a fear of moving from the care home;

2. JB had Alzheimer's disease. After moving to the care home, she was frequently agitated, attempted to leave the building and became verbally aggressive when prevented from doing so. At other times she requested to leave and thought she had to pick up her children (all of whom were grown up) from school. In more recent months the episodes of agitation had decreased and she was no longer attempting to leave the property. She was engaged more in activities and enjoyed walking around the grounds;

3. JP had a history of physical medical problems

and suffered from moderate to severe dementia. On arrival at the nursing home, she repeatedly asked to be allowed to return home. She was regularly distressed and agitated, calling out loudly with repetitive sounds. JP moved to a quieter wing in the nursing home but once again became very agitated. When her RPR discussed with her the option of bringing an application to court JP emphatically stated that she would like this to happen;

4. EP had vascular dementia. After an admission to hospital following a fall, EP was discharged to a care home. She clearly objected to being at the care home, saying that it was like a prison, and that she wanted to return to her own home. The RPR concluded that there was a fluctuation in EP's compliance with the care arrangements and her acceptance of the situation;

5. JW suffered a series of strokes. He consistently expressed objections to his placement at a nursing home. He became more settled and willing to engage with staff and activities but whenever questioned about his placement he reiterated his wish to return home. Over time, JW increasingly appeared settled but always maintained his position of wanting to return home.

In the earlier case of *AJ* [2015] EWCOP 5 (which was reported in our February 2015 newsletter), Baker J considered the selection and appointment of RPRs and IMCAs, and the duty on the local authority to ensure that the person who lacks capacity is able to challenge the deprivation of their liberty. In this case, Baker J concentrated on the question of how the relevant person's representatives (RPRs) and s.39D MCA 2005 independent mental capacity advocates (IMCAs) should decide whether to bring an application to the Court of Protection under s.21A MCA 2005. In the end, the local authorities accepted that the section 21A applications had been properly brought in the cases of EP and JW, and the other three cases (RD, JB and JP) were referred back to the RPRs for a decision in light of the court's general guidance.

When to bring proceedings under section 21A MCA

Competing submissions were made on behalf of the Official Solicitor, the RPRs/s39D IMCA, the local authorities and CCG.

The Official Solicitor argued that the court should adopt a broad approach to the general question as summarised by the court at paragraph 46:

> *(a) Given the importance of the availability of a court review in circumstances where a person is detained by administrative action, any evidence of P's wishes to bring the application is sufficient to trigger the duty of the RPR or IMCA to assist P in their application to the court.*
>
> *(b) Evidence of P's wishes may be direct, (arising from conversations between P and the RPR, or IMCA, or comments made by P to others, in which he or she has expressed a wish to challenge the standard authorisation or leave the care home), or indirect, (for example inferences drawn from P's behavior such as attempts to leave the home).*
>
> *(c) In certain circumstances, (for example, if P's wishes appear to fluctuate) it may not be possible for the RPR or IMCA to be satisfied that P does not wish to exercise the right to apply to the court. P's compliance with arrangements and/or a lack of clarify about whether he/she objects and/or any fluctuation in his or her*

> *wishes is not necessarily evidence that he is she does not wish to exercise the right of access to the court. It is the Official Solicitor's submission that in those circumstances it is appropriate for the RPR or IMCA to apply under s. 21A"*

The Official Solicitor characterised the RPR's decision as a best interests' decision which required the RPR to take into account all the relevant circumstances, including P's wishes and feelings, as well as the likely benefit to P of independent judicial scrutiny, and the impact of the proceedings on P, whether positive or negative (para 54).

The RPRs and s.39D IMCA argued that in cases other than those in which P expressed a clear and consistent objection to the arrangements for his/her care and treatment, proceedings under s. 21A should be issued where it appears, having regard to all the circumstances, that P wishes, or would wish, to exercise a right of appeal. This required evidence capable of founding a reasonable belief that P would wish to appeal, having regard to P's express wishes, his or her behaviour, and the wider circumstances of his or her deprivation of liberty (para 56).

The local authorities expressed real concern at the practical consequences of the approach advanced on behalf of the applicants which would be significant, particularly in the context of the increased level of DOLS applications following *Cheshire West* in an economic environment where a local authority might be subject to significant cuts.

They argued that proceedings under section 21A should be issued where it appears that P or the RPR wishes to exercise a right of appeal (para 62). There was no need to add the words "would wish" but accepted that in reality there may be little difference (para 65).

The CCG made common cause with the local authorities and argued that what is required is a reasonable belief, considering the totality of the evidence, that it appears that P wishes to apply to court (para 70).

Baker J gave some helpful general guidance as to the approach that should be adopted by RPRs and IMCAs in deciding whether to issue proceedings under s.21A at para 86:

> *(1) The RPR must consider whether P wishes, or would wish, to apply to the Court of Protection. This involves the following steps:*
>
> *(a) Consider whether P has capacity to ask to issue proceedings. This simply requires P to understand that he/she should not be subject to his/her current care arrangements. It is a lower threshold than the capacity to conduct proceedings.*
>
> *(b) If P does not have such capacity, consider whether P is objecting to the arrangements for his/her care, either verbally or by behaviour, or both, in a way that indicates that he would wish to apply to the Court of Protection if he had the capacity to ask.*
>
> *(2) In considering P's stated preferences, regard should be had to:*
>
> *(a) any statements made by P about his/her wishes and feelings in relation to issuing proceedings,*
>
> *(b) any statements made by P about his/her residence in care,*
>
> *(c) P's expressions of his/her emotional state,*
>
> *(d) the frequency with which he/she objects*

to the placement or asks to leave,

(e) the consistency of his/her express wishes or emotional state; and

(f) the potential alternative reasons for his/her express wishes for emotional state.

(3) In considering whether P's behaviour constitutes an objection, regard should be had to:

(a) the possible reasons for P's behaviour,

(b) whether P is being medicated for depression or being sedated,

(c) whether P actively tries to leave the care home,

(d) whether P takes preparatory steps to leave, e.g. packing bags,

(e) P's demeanour and relationship with staff,

(f) any records of challenging behaviour and the triggers for such behaviour.

(g) whether P's behaviour is a response to particular aspects of the care arrangements or to the entirety of those arrangements.

(4) In carrying out this assessment, it should be recognised that there could be reason to think that P would wish to make an application even if P says that he/she does not wish to do so or, conversely, reason to think that P would not wish to make an application even though he/she says that she does wish to, since his/her understanding of the purpose of an application may be very poor.

(5) When P does not express a wish to start proceedings, the RPR, in carrying out his duty to represent and support P in matters relating to or connected with the Schedule, may apply to the Court of Protection to determine any of the four questions identified in s.21A(2) i.e. on the grounds that P does not meet one or more of the qualifying requirements for an authorisation under Schedule A1 ; or that the period of the standard authorisation or the conditions subject to which the standard authorisation is given are contrary to P's best interests; or that the purpose of the standard authorisation could be as effectively achieved in a way that is less restrictive of P's rights and freedom of action.

(6) Consideration of P's circumstances must be holistic and usually based on more than one meeting with P, together with discussions with care staff familiar with P and his/her family and friends. It is likely to be appropriate to visit P on more than one occasion in order to form a view about whether proceedings should be started.

(7) By way of an alternative to proceedings, it may be appropriate to instigate a Part 8 review, or to seek to work collaboratively with the family and the commissioning authority to see whether alternate arrangements can be put in place. Such measures should not, however, prevent an application to the court being made where it appears that P would wish to exercise a right of appeal.

(8) The role of the IMCA appointed under s.39D is to take such steps as are practicable to help P and the RPR understand matters relating to the authorisation set out in s.39D(7)(a) to (e), and the rights to apply the Court of Protection and for a Part 8 review, and how to exercise those rights. Where it appears to the IMCA that P or the RPR wishes to exercise the right, the IMCA must take all practical steps to assist them to do so. In considering P's apparent wishes, the IMCA should follow the guidance set out above so far as relevant."

In his judgment, Baker J emphasised that there is an important distinction between the roles of the RPR and the s.39D IMCA. The RPR has a wide role to represent and support P in matters relating to or connected with Schedule A1. The s.39D IMCA's role is more narrow and confined to the specific duties in s. 39(7), (8) and (9) (para 72).

The role of the RPR

The supervisory body must appoint a relevant person's representative (RPR) for every person to whom they give a standard authorisation for deprivation of liberty. Baker J described the RPR as *"a crucial role in the deprivation of liberty process, providing the relevant person with representation and support that is independent of the commissioners and providers of the services they are receiving"* (para 32)

Under paragraph 140 of Schedule A1, the RPR is obliged to:

- Maintain contact with the relevant person;
- Represent the relevant person in matters relating to or connected with Schedule A1;
- Support the relevant person in matters relating to or connected with Schedule A1

Baker J made clear that this obligation includes:

- Taking all steps to identify whether P wishes to exercise the right to apply to the Court of Protection (or the right to review) and, if so, it is the RPR's duty to ensure that the application is brought (para 73).
- Representing and supporting P in making an application to the Court of Protection where the RPR concludes that P would wish to make the application in circumstances where P is unable to communicate that wish (para 77); and
- In supporting P, the RPR must assess for himself or herself whether an application should be made to the court in P's best interests, independent of any wishes expressed by P, and must therefore assess for himself or herself the matters in s 21A(2) namely:
    - Whether P meets one or more of the qualifying requirements;
    - The period for which the standard authorisation is to be in force;
    - The purpose for which the authorisation is given; and
    - The conditions subject to which the authorisation is given (paragraph 78).

The role of a s.39D IMCA

Baker J made clear that the role of a s.39D IMCA is much more limited. Under the MCA, the IMCA is obliged to:

- Take such steps as are practicable to help P and the RPR to understand the effect, purpose, duration, conditions, and reasons for the DOLS authorisation, and the relevant rights and how to exercise them;
- Take such steps as are practicable to help P or the RPR to apply to court or exercise the right of review.

By contrast with the RPR, it is not the role of the

IMCA:

- Where P is unable to express a wish, either verbally or through behaviour, to analyse whether P would wish to apply. That is the role of the RPR.

- To consider whether there is any other reason to apply to the court to consider the questions in s 21A(2). That is also a matter for the RPR (para 84).

Comment

This is a very important judgment that makes for essential reading for all RPRs and IMCAs, as well as other practitioners. At the heart of this case is the court's general guidance at paragraph 86 which will no doubt provide a very useful reference point for practitioners when approaching the question of whether to issue s21A proceedings.

There are a number of interesting points arising out of this judgement:

Capacity

The first is the starting point of Baker J's approach, which is for RPRs and IMCAs to consider *"whether P has capacity to ask to issue proceedings"* (para 86(1)(a)). Baker J made clear that this capacity test was different to the test for capacity to conduct proceedings in that it had a lower threshold. It simply *"requires P to understand that the court has the power to decide that he/she should not be subject to his/her current care arrangements."* In the event that P has capacity to ask to issue court proceedings, then plainly those wishes must be followed. It is quite possible that P may have capacity to ask to issue court proceedings but lack capacity to conduct the proceedings (in which case, P will require a litigation friend in the usual way).

Would P wish to apply to court?

In the event that P lacks such capacity, the crucial question to ask is *"whether P is objecting to the arrangements for his/her care, either verbally or by behaviour, or both, in a way that indicates that he would wish to apply to the Court of Protection if he had the capacity to ask"* (para 86(1)(b)).

It is therefore clear that practitioners should take into account verbal and non-verbal behaviour when considering the question of whether P is objecting and would wish to apply to court. It is important that the focus of the question is on whether P wishes to apply to the court and not simply whether he or she objects to the arrangements for his or her care (para 76). However, a note of caution: practitioners should be alert to the fact that P might wish to make an application to court even though P says that he/she does not wish to, and vice-versa (para 86(4)) (AJ might well have been an example of the former[1]). In considering whether P's behaviour constitutes an objection, regard should be had to other possible reasons for P's behaviour such as whether P is on medication (although Baker J does not explicitly accept or reject the local authorities' contention that certain behaviour may be the symptom of a mental health condition) (para 86(3)). This can make it extremely difficult for RPRs and IMCAs to accurately assess whether P really wants to, or

[1] See para 67 of the judgment of Baker J "*In oral evidence, Ms G* [the BIA] *confirmed that she knew from the outset that AJ objected to being in care, but that she was adamant that she didn't want to use her right to appeal. She wanted nothing to do with lawyers, but rather wanted Mr. and Mrs C to do what they could to get her out*."

would want to, apply to court. In cases of doubt, we suggest that RPRs should also apply the best interests test in para 86(5) of Baker J's judgment.

The role of best interests

Baker J rejected the Official Solicitor's contention that an RPR's decision to apply to court is always a best interests' decision. Instead, *"[w]here the RPR concludes that P wishes to apply to the court, it is not the function of the RPR to consider whether such an application would be in P's best interests"* (para 74).

However, when the RPR decides, independent of P's wishes, that an application should be made to court under s. 21A, then he is bound to apply the best interests principle (para 80). So, in short, *"the best interests principle does not apply where the RPR is facilitating P's wish to apply to the court, but it does apply when the RPR himself is deciding whether or not to apply"* (para 81).

It is very important that the second limb of the RPR's duty to make an application to court in P's best interests is not overlooked, even where P is not objecting (verbally or by his behaviour) to his care arrangements or expressing any wish to apply to court. RPRs must assess for themselves whether the conditions of a standard authorisation are met and whether the arrangements are the least restrictive. This is a vital part of the overall protection afforded for P's rights. As Baker J recognised in the judgment, it is the statutory scheme as a whole that guarantees that P's rights under Article 5(4) are adequately protected (para 85).

Flowchart

Tor has produced a flowchart summary of Baker J's judgment, available here.

Section 21A under the microscope[2]

Briggs v Briggs [2016] EWCOP 48 (Charles J)

Article 5 – DOLS Authorisations – Medical treatment – Deprivation of liberty

Summary

In this case, Charles J had to decide whether it was possible for the question of whether it is a person's best interests to continue to be given clinically assisted nutrition and hydration ('CANH') to be determined in proceedings brought under s.21A MCA 2005. The question arose because the applicant – the wife of, and RPR for a man in a minimally conscious state – brought an application under s.21A MCA 2005 challenging the DOLS authorisation in place at the hospital he was in. She did so on the express basis that doing so would allow her to claim legal aid on a non-means-tested basis so as to be able to have legal representation to be able to argue her case that continuation of CANH was not in his best interests. Her position was opposed by the Official Solicitor, the Legal Aid Agency and the Secretary of State (as the Ministry of Justice and Department of Health collectively) on the basis that:

1. On the Official Solicitor's case, non means tested funding is not available to present arguments relating to the care, support or treatment of a P as they related to conditions of detention, and were therefore outside the scope of s.21A (Article 5 not relating to conditions of detention);

2. On the Secretary of State's case, such funding

[2] Note, Tor and Annabel being involved (in different capacities) in this litigation, this note is prepared without their input.

was only available where the issues related to "physical liberty."

Charles J, in an extensive and wide-ranging judgment, came to the very clear conclusion that both of these arguments were wrong, and that it was entirely proper for the Court of Protection on a s.21A application to consider the question of whether CANH was in Mr Briggs' best interests as part and parcel of the discharge of its functions under s.21A MCA 2005. The following conclusions from his judgment are of particular relevance or importance:

1. The clear conclusion that a DOLS authorisation does not authorise the care plan for, or medical treatment of P, or protect those who are providing them from liability for so doing. It is limited to authorising the deprivation of liberty that those acts create (paragraph 48);

2. The determination of whether the deprivation of liberty is in P's best interests, necessary and proportionate "*has to involve consideration of P's circumstances in a hospital or care home and so of the care, support and treatment proposed or provided to meet P's needs in them even if it is limited to a consideration of their effect*" (paragraph 50), and hence "*the determination of the questions posed by the definition of the best interests condition must involve a consideration of: i) the impact of possible and available alternatives and issues of degree, and ii) as far as reasonably ascertainable P's past and present wishes and feelings, beliefs and values and factors that P would be likely to consider if he were able to do so*" (paragraph 52);

3. That generally the COP should take control of all aspects of the case when proceedings are brought under s.21A MCA (even if an authorisation should remain in place to allow non-means-tested legal aid to continue to be justified: paragraphs 29-34). This was particularly the case in the proceedings before him given the nature of the CANH best interests issue (paragraph 70), in which the determinative or central issue was whether CANH is in Mr Briggs' best interests and the conclusion on it should found an order under s. 16(2) MCA 2005. The determination of that issue by the COP would found and so was directly relevant to its consideration of its exercise of its functions under s.21A (which it can exercise whether or not proceedings have been issued under s.21A) (paragraph 76);

4. Whatever the precise requirements of Article 5 ECHR, a literal construction of DOLS shows that they went beyond that required to meet Article 5 and effectively include the best interests test that is applied whenever a decision has to be made pursuant to the MCA for a person who lacks capacity to make that decision himself (paragraph 87). This showed that:

> *91.* […] *in a case such as this when the purpose of the placement in the hospital is obviously for care and treatment the "all or nothing approach" advanced effectively on the basis that P will continue to be deprived of his liberty whatever regime of treatment is put in place (and so whether or not CANH is in Mr Briggs' best interests) runs contrary to a best interests consideration of the circumstances P (Mr Briggs) is in on the ground as it seeks to exclude a consideration of P's views etc. under s. 4(6) and whether the conditions can be improved or made less restrictive under s. 1(6) of the MCA.*

> *92. Alternatively, if it is said that the views of P on (life sustaining or other) treatment can be taken into account in considering whether he should be deprived of his liberty (or his personal liberty should be removed) this takes one back to the central issue in this case namely the impact of Mr Briggs' views etc. under s. 4(6) on whether treatment should be withheld with the consequence that he should be allowed to die. It would be very artificial and in my view callous to say that this was irrelevant to the issues relating to his physical liberty, or the termination of the exiting DOLS authorisation, because during the period after the cessation of the CANH leading up to his death his physical liberty would not change even if (as is at least likely) he moves from the hospital to a hospice.*

5. The acknowledgement that the best interests assessor will not be able to carry out the intense scrutiny that the COP can and would have practical difficulties in challenging the medical decisions that found protection from liability under s. 5 MCA. Charles J noted, however, that the assessor could reach his best interests assessment on the basis of the views of the treating team leaving it to P or his RPR to challenge the authorisation or put a condition on the authorisation or limit its duration to enable any dispute to be put before the COP (paragraph 94);

6. Further, even if the best interests requirement under DOLS was limited in the way that the Official Solicitor and the Secretary of State argued, the best interests test as then applied by the Court of Protection in determining whether CANH should be continued was related to matters arising under s.21A(2)(a)-(d), because (1) it was related to the best interests condition of the best interests requirement; (2) and provided the answers or information relevant to the answers to the questions of: (a) the period of the standard authorisation (e.g. until a move to a hospice or a rehabilitation unit); (b) the purpose of the standard authorisation, namely whether the treatment should or should not include CANH; and (c) conditions of the standard authorisation (e.g. about preparations to be made for a move). These answers informed – Charles J held – what the COP can order under s.21A(3) by way of variation or termination of the standard authority itself or by direction to the supervisory body (paragraphs 96-99). Charles J noted in this regard that:

> *102. This view of the width of what the COP can properly do under s. 21A is confirmed when other types of case are considered. For example, when P is in a care home the best interests issues can encompass changes in the care plan (incorporated into or on which the standard authorisation is based) involving less restrictive options, the giving of medication covertly or in particular circumstances, the use of restraint, more visits to the community and contact. Even if they are outside the factors to be considered under the qualifying requirements (and so the best interests condition) they:*
>
> *i) inform and so relate to the matters referred to in s. 21A (2)(b) to (d), and*
>
> *ii) inform the order or orders to be made under s.21A(3), (6) and (7) in respect of the DOLS authorisation that has been granted (and if necessary extended by the COP applying the approach in Re UF).*

7. Finally, Charles J noted that, on a purposive intention of the legislation, Parliament would not have intended the COP to be concerned with the distinctions advanced in this case by the Secretary of State, the LAA and the Official Solicitor:

> *108. Absent the issue relating to the availability of non means test legal aid, which it is common ground is irrelevant, these distinctions are not agreed between them, give rise to fine, difficult and potentially emotionally draining issues (e.g. whether a decision that leaves out of account the views etc. of P on whether he should be detained at place A or place B relates to his personal liberty or a deprivation of his liberty within Article 5 having regard to its subjective element) and are irrelevant because the COP can deal with all issues in this case in an application brought in reliance on s. 21A or an application brought seeking orders under ss. 15 and 16 of the MCA.* […]

Charles J therefore held that Mrs Briggs could properly raise the issue of whether CANH should be continued as part of her s.21A challenge as RPR for her husband. We address the substantive decision in relation to her husband's treatment in the separate case comment below.

Comment

On one view, it would appear odd that a s.21A application could be used as a vehicle to challenge decisions about CANH, and it is undoubtedly the case that Mrs Briggs was "lucky" that there happened to be in place a DOLS authorisation at the hospital to allow her to do so (note that Charles J expressly did not decide whether or not in fact Mr Briggs was deprived of his liberty, as this was assumed to be the case for purposes of the preliminary issue decided here).

However, once one steps away from the specific place that CANH has as a type of serious medical treatment ('SMT') and the mindset of SMT cases, Charles J's logic would seem impeccable. DOLS may have been designed to plug the Bournewood gap, and to that end could have been limited solely to a determining whether or not the deprivation of liberty was necessary and proportionate (the test for Article 5 purposes). However, the scheme undoubtedly went further to include a specific best interests requirement which, in turn, requires the application of the best interests test under s.4 MCA 2005. Once the best interests genie was let out of the bottle, that must carry with it the connotation that those concerned with considering the requirement (and the court on a s.21A application) must have a wide view of the nature and purpose of the authorisation and – in turn – asking whether the care and treatment which gives rise to the need for it is, in fact, in the person's best interests.

It is, perhaps, not surprising – given the implications for legal aid in s.21A applications – that the Secretary of State/Legal Aid Agency are seeking permission to appeal to put the best interests genie back in its bottle.

Best interests and life-sustaining treatment[3]

Briggs v Briggs (No 2) [2016] EWCOP 53 (Charles J)

Best interests - Medical treatment

[3] Note, Tor and Annabel being involved (in different capacities) in this litigation, this note is prepared without their input.

Summary

On 3 July 2015, Paul Briggs was the victim of a road traffic accident when he was travelling to work on his motorcycle. As a result of that accident he suffered serious brain and other multiple injuries and was rendered unconscious. He was minimally conscious state (MCS) and does not have the capacity to make decisions relating to his care and treatment or to communicate his wishes and feelings to others. His survival depended on the package of the care and treatment he was receiving in hospital. That care and treatment included clinically assisted nutrition and hydration (CANH). If that treatment was no longer given he would die.

In circumstances described in our case note on the earlier decision in this case ([2016] EWCOP 48), his wife brought proceedings on their face to challenge the DOLS authorisation in place at the hospital where he was being cared for, but in reality to seek a determination as to whether it was in her husband's best interests to continue to be given CANH or to be moved to a hospice where he would receive palliative care but no further CANH, and would, as a result, die.

His family and a police colleague of Mr Briggs described – in oral evidence the force of which Charles J described as not being easy to convey to those who had not heard it – a picture which convinced Charles J:

> *in the sense that I am sure (and so have no reasonable doubt) that if Mr Briggs had heard the evidence and argument that I have, including the evidence about his best case scenario and the possible distress, pain and difficulties he and his family may face if his CANH treatment is not continued he would have would have decided not to give consent to the continuation of his CANH treatment. I add that he would have been supported in this decision by his family and they would have faced the tragic consequences of his accident together* (paragraph 98).

There was therefore, in light of the approach taken by the treating NHS Trust and CCG, a profound clash of principles identified by Charles J at paragraph (28) of his overview between:

> *a. The sanctity of life and so the preservation and prolongation of Mr Briggs' life. Understandably this lies at the heart of the strongly held and consistent view of Mr Briggs' treating consultant that it would be unethical to withdraw his treatment by CANH and so deprive him of the opportunity of leading a life of value.*
>
> *b. Autonomy and so self-determination which enables a person with capacity to do so to refuse life-sustaining treatment and so as a consequence to choose the side-effect of death. That decision can be made for any reason including that in existing or defined future circumstances that person considers that his or her life is or would be intolerable or has or would have no value and so not worth living. Understandably, the family want to achieve the result that they are convinced Mr Briggs would have wanted and decided on.*

The Official Solicitor, as litigation friend for Mr Briggs, contended that the court should adjourn the matter for reconsideration after 6 months of treatment and rehabilitation which would allow a better informed neurological diagnosis and prognosis. The most realistic best case scenario, it was said, would be that, ultimately, Mr Briggs would:

> *a. Not regain mental capacity to make complex decisions*
> *b. Be happy*
> *c. Be able to make simple choices such as*

what colour t-shirt to wear

d. *Have some pleasurable experiences*
e. *Have some painful experiences*
f. *Be unlikely to be depressed given his lack of insight, including lack of insight as to his pre-injury life, and pre-injury expressed wishes and feelings*
g. *Not have any improvement in his physical abilities*
h. *Be severely physically impaired*
i. *Need 24 hour care and be dependent on others for all activities of daily living*
j. *Have some improvement in his medical symptoms with the optimal treatment that would be available, including PSH, dystonia, groaning and contractures.*

Because of the way in which the case was put by the NHS bodies (and the Official Solicitor), Charles J was required to go back to first principles as regards the construction and application of the MCA 2005, and also to conduct a detailed review of the case-law. This required him to consider, inter alia:

1. The background law and principles (paras 8-42), including – importantly – an analysis of the significance of Advance Decisions to Refuse Treatment and powers of attorney. As Charles J noted (at para 28), the sections of the MCA relating to these provisions "*are directed to enabling people with the relevant capacity to make choices refusing a wide range of future treatment (including life-sustaining treatment), or to giving donee(s) of a lasting power of attorney power to give or refuse consent to refuse any such treatment, at a time when the donors lack capacity and when, because of brain or other injuries, they may be very different and have very different perspectives on a whole range of issues including the quality of their life.*" This therefore carried with it the conclusion that "*the right to self-determination can dictate future decisions or steps to be taken in future*" (para 30);

2. The making of best interests decisions (including by the court) in respect of life-sustaining treatment (paras 43-75), including in particular, an identification of the "holistic" approach to the application of the MCA identified by the Supreme Court in *Aintree* and its implications. Whilst Charles J emphasised that the test to be applied by the court is not – in general – a "*what P would have done test*," but a test requiring weighing and balancing, he expressly endorsed, "*as showing that P is at the very heart of the decision-making process*," the approach originally set down by HHJ Marshall QC in *S and S (Protected Persons)* [2010] 1 WLR 1082, namely that:

> *55. In my judgment it is the inescapable conclusion from the stress laid on these matters in the 2005 Act that the views and wishes of P in regard to decisions made on his behalf are to carry great weight. What, after all, is the point of taking great trouble to ascertain or deduce P's views, and to encourage P to be involved in the decision-making process, unless the objective is to try to achieve the outcome which P wants or prefers, even if he does not have the capacity to achieve it for himself.*
>
> *56. The 2005 Act does not, of course, say that P's wishes are to be paramount, nor does it lay down any express presumption in favour of implementing them if they can be ascertained. Indeed the paramount objective is that of P's "best interests". However, by giving such prominence to the above matters, the Act does, in my*

> *judgment, recognise that having his views and wishes taken into account and respected is a very significant aspect of P's best interests. Due regard should therefore be paid to this recognition when doing the weighing exercise of determining what is in P's best interest in all the relevant circumstances, including those wishes.*

3. At para 53, Charles J further emphasised that, whilst there is a strong presumption – which set the default position – that it is in a person's best interests to stay alive, it is a starting point but does not dictate what the relevant person's attitude (wishes and feelings) are now or were in the past. At para 62(ii) made clear that "*if the decision that P would have made, and so their wishes on such an intensely personal issue can be ascertained with sufficient certainty it should generally prevail over the very strong presumption in favour of preserving life*." Perhaps the core of his decision is to be found at paragraphs 69 to 74 thus:

> *69.* […] *the MCA requires a holistic and enabling approach and in my view this means that the court can and should take a realistic approach to the way in which people conduct their lives and make their decisions and so:*
>
> *(i) firstly make findings on the evidence relating to the matters set out in s. 4(6) on the attitude and approach of the relevant individual when he or she had capacity to the fundamental and deeply personal principles now at stake relating to the giving or continuance of life-sustaining treatment, and then*
>
> *(ii) apply those findings to the relevant circumstances in which the best interests decision now has to be made on whether life-sustaining treatment should be given or continue to be given to that person, to determine what decision he or she would have made if they now had capacity and so, in exercise of their right of self-determination was able to make the decision.*
>
> *70. At step (ii), the court will address points that the evidence shows that the relevant person (P) did not specifically consider aspects of the present situation (e.g. being in MCS, the detail of his or her present position and best case scenario, difficulties and consequences of withdrawing CANH) and take them into account in a holistic way with all other factors, including the strong presumption in favour of preserving life and so the powerful instinct for survival, in determining how they would affect the attitude and choice of that particular P.*
>
> *71. I acknowledge and urge that the evidence and reasoning relied on to reach a conclusion that P would not have given consent to the relevant life-sustaining treatment, and then to rely on it as a weighty or determinative factor to depart from the default position that P's best interests are promoted by preserving his or her life, require close and detailed analysis which founds a compelling and cogent case that this is what the particular P would have wanted and decided and so considered to be in his or her best interests.*
>
> *72. It is also obvious that the existence*

of a relevant written statement (referred to in s. 4(6)(a)) would be helpful and so of particular relevance in the way that an advance directive or living will was before the MCA was enacted. But it is also obvious that in real life many if not most relevant expressions of wishes and feelings will not be in writing.

73 This approach promotes the protection and preservation of life of severely disabled people who lack capacity and whose survival is dependent on life-sustaining treatment because it requires that the factors assessed on a past and present basis are sufficiently compelling to outweigh the very strong presumption that underlies the default position (see for example and by analogy the citation from and the decision in In re AK (Medical Treatment: Consent) [2001] 1 FLR 129 at paragraph 83 of Baker J's judgment in Re M). As I have said, that intense analysis will address points that the evidence shows that P did not specifically consider aspects of the present situation.

74. I have deliberately not tried to set out how convinced the court has to be about what P would have decided if he or she was able to do so because, in my view, the weighing exercise is so case and issue sensitive and is not a linear or binary exercise, and because here I am sure (in the sense that I have no reasonable doubt) on the decision that Mr Briggs would have made if he was able to do so.

4. Earlier cases (paras 76-82), in which Charles J analysed previous case-law, and found made clear that he preferred the (post-*Aintree*) approach taken by Pauffley J in *United Lincolnshire Hospitals NHS Trust v N* [2014] COPLR 60 and that of Hayden J in *Re N* [2016] COPLR 88, to that taken (pre-*Aintree*) by Baker J in *W v M* [2012] 1 WLR 1653;

5. The effect of s.4(5) MCA 2005 (paras 83 to 94), Charles J having little difficulty dispensing with the argument that s.4(5) MCA precluded him from making a welfare order/declarations which would have the effect of bringing about Mr Briggs' death.

At the end of his judgment (which also included a careful rehearsal both of the medical evidence and the powerful evidence as to Mr Briggs as a person), Charles J concluded that:

128. In my view, on an in all the relevant circumstances approach to the very difficult issue in this case the weighing exercise comes down to whether Mr Briggs' best interests are best promoted by giving more weight to:

(i) the very strong presumption in favour of preserving life, or

(ii) the great weight to be attached to what Mr Briggs as an individual would have decided himself if he had the capacity and so was able to do so.

129. I have concluded that as I am sure that if Mr Briggs had been sitting in my chair and heard all the evidence and argument he would, in exercise of his right of self-determination, not have consented to further CANH treatment that his best interests are best promoted by the court not giving that consent on his behalf.

130. This means that the court is doing on behalf of Mr Briggs what he would have wanted and done for himself in what he thought was his own best interests if he was able to do so.

Charles J therefore granted the order sought by Mrs Briggs. As we went to press, the Official Solicitor was seeking permission to appeal, the order of Charles J being stayed in the interim. Whilst we understand that the basis of this application is the direction that Charles J gave himself as to the weight to be afforded to the presumption in favour of life, it is also clear that Charles J was concerned by the approach taken by the Official Solicitor to the family's evidence:

> *97. The Official Solicitor, or his lawyers, rejected the warning given by Hayden J in Sheffield Teaching Hospitals NHS Foundation Trust v TH [2014] EWCOP 4 where the judge said that his lawyers had not absorbed the force of the emphasis placed on a holistic evaluation by the Supreme Court. Worryingly, as in the case before Hayden J, the Official Solicitor, through his lawyers, sought to rely on the ways in which Mr Briggs' mother and one of his brothers had expressed themselves as a basis for weakening the force of their evidence. It would be surprising if loving family members did not express themselves in terms that differed in some respects and arrived at their conclusions for reasons that differed in some respects and over different periods of time. Complete consistency of approach and expression would give rise to more concern. I express the hope that the Official Solicitor will in future not seek to test family evidence in such a pedantic and so unsympathetic and unhelpful a way.*[4]

Comment

This judgment represents – we suggest – the paradigmatic application of the principles at the heart of the MCA 2005 governing best interests decision-making, as interpreted (or, more properly perhaps, confirmed) by Lady Hale in *Aintree*. Charles J sought carefully – and with due caution given the potential impact of his decision – to make the decision that was right for Mr Briggs as an individual human being.

Running through the judgment as an unspoken (and possibly unrecognised) undercurrent is Article 12(4) of the Convention in the Rights of Persons with Disabilities, as the various parts of the Act that Charles J explored and analysed seek to provide in different ways for the upholding, insofar as possible, of an individual's legal capacity notwithstanding their present inability to make their own decisions.

Whilst not strictly relevant (on one view) for his analysis, Charles J's exegesis of the role of LPAs and ADRTs make clear how such are designed to operate as important – empowering – tools to secure the right of self-determination even in the face of subsequent (mental) incapacity. In this regard, of particular importance are:

1. His clarification (at para 20) as to the precise requirements of ADRTs concerning life-sustaining treatment, noting that to call them "stringent" (as did Baker J in *W v M*) is to overstate the case, because they do not require that the person making it has any particular knowledge or have had any particular advice. Indeed, as Charles J noted at para 22, "*what is provided is less stringent that what the common law requires for the signing of a bank guarantee*;"

2. The confirmation that whilst there are "safety nets" in the form of s.25(2)(c) and 25(3) MCA, setting a low threshold for rendering an ADRT

[4] It also appears from the 'Storify' – the curated collection of Tweets from the hearing and supporting materials gathered by Celia and Jenny Kitzinger – relating to the case that Charles J may have had concerns about the approach of the clinicians, but these do not appear to feature in the judgment.

invalid – whether on the basis of the sanctity of life or otherwise – "*would run counter to the enabling intention of ss.24 to 26 MCA 2005*" (para 22). As he noted, further, even if the provisions did show that the ADRT was invalid or inapplicable, such that the best interests test became determinative, the court would nonetheless have to take into account the impact of the removal of the person's right to self-determination that they have sought to exercise by making the advance decision (para 22);

3. The clear statement (at para 31) in determining what is to happen to, or in respect of them in future (whether by making an ADRT: "*In making that decision individuals will not know what they will actually feel or want and so have to predict it. To make that prediction they will take into account a range of factors relating to their beliefs, values, lifestyle, wishes and feelings. That is not an easy task for them and their personal history, character, wishes, feelings, belief and values will be central to their performance of it*;"

4. Confirmation that where an individual does not make the future decision themselves but gives a donor of an LPA the power to make it, the donor(s) will be making the decision for themselves "*in light of the circumstances that exist at the time and with their knowledge of what the donor would have wanted them to do*" (para 32, emphasis added).

It is a matter of some regret that Charles J did not confirm expressly what follows as a logical consequence of these propositions (and we suggest clearly flows from the wording of the Act itself), namely that where there is in place a valid and applicable ADRT and/or an attorney with the requisite authority there is no need for application to court before treatment is either withdrawn or withheld, there being no "space" for the court to make any best interests decision on the person's behalf. Charles J certainly recognised that there would be no such space (see para (10) of his overview and his agreement that if Mr Briggs had made a relevant ADRT "such an advance decision it would have been decisive and so no decision would have had to have been made under the MCA best interests test"), and we suggest that this provides a strong – obiter – pointer that an application is not required.

Similarly, where a person has not provided formally for the future exercise of their right of self-determination, the approach adopted by Charles J prioritises, at least in the specific case of determining whether consent should be given or refused to life-sustaining treatment, the identification and then the formal adoption of the decision that P would have made.

Importantly, however, Charles J – correctly – made clear that the best interests test is not a simple "substituted judgment" test. To that extent, and as discussed in the EAP Reports on the compatibility of the MCA with the CRPD, the test is not compatible with Article 12 as interpreted by the UN Committed on the Rights of Persons with Disabilities. However, the list of situations he gives at para 60 of where the court is not enabling P to do what he could or would want do for him or herself if of full capacity is instructive:

> *(i) P's history may show that he or she has made a series of damaging investment or lifestyle decisions and so although if they had capacity they would be likely to do so again the court (or other decision maker) can conclude that it would not be in their best interests for such a decision to be made on their behalf,*

(ii) it is not uncommon that what P would have wanted and would now want is not an available option,

(iii) it is not uncommon that very understandable expressions of present wishes and feelings "I want to go home" would not be made if P was able to weigh the existing competing factors by reference to P's beliefs and values, and in any event are not in P's best interests, although current expressions of wish can inform which of available alternatives has the best chance of being successfully implemented,

(iv) the point that an individual and a court cannot compel a doctor to give certain types of treatment is a factor in cases relating to life-sustaining and other treatment (as an individual can only exercise his or her right of self-determination between available choices), and

(v) the existence of clinical conditions, physical illness and the types of life-sustaining treatment (e.g. resuscitation or treatment in intensive care) and the pain or loss of dignity they cause can be highly relevant factors in reaching a conclusion contrary to the evidence of P's family that P would have wished treatment to continue (see for example NHS Trust v VT [2014] COPLR 44, a decision of Hayden J).

Two of these situations (ii) and (iv) in particular are ones where (on a proper analysis) P's lack of capacity is irrelevant – they could not get what they would or do now appear to want whether or not they were said to have the mental capacity to make the decision. The third of the situations represents one where it might properly be said that there might well be a clash between P's present wishes and feelings and their pre-existing beliefs and values: or, framed in CRPD terms, that there is a clash between their will – if such is intended to capture a more 'essential' aspect of the person – and their (more immediate) preferences. The first and last of the situations (in particular the first) represent an approach to best interests which would appear to prioritise a more "objective" view of what would best serve the person. But in none of them, and crucially, does Charles J suggest that it is not important to seek to ascertain P's wishes and feelings in relation to the matter. Further, in each situation it is arguable that what the court is seeking to do is to find a way to weigh and balance those wishes and feelings against other factors: in other (CRPD) words to find a way to "*respect the rights, will and preferences*" of the person. It is in teasing out precisely what "respect" means in this context that the real demands of Article 12(4) CRPD will make themselves clear.

Interestingly, Charles J notes at a different part of the judgment (para 49) that his approach to resolving the potential for an inconsistency between past and present wishes and feelings is to place less weight on present wishes, as "*what the relevant person says, does, demonstrates or communicates about the matters referred to in s.4(6) has to be assessed against the background that he or she does not have capacity to make the relevant decision and so to weigh those matters with the relevant factors*." This may be a matter which falls for further consideration in a case where such a mismatch is in fact in issue (as was not the case here). We also note a rather different way in which a mismatch was approached in the case of *SAD v SED* discussed in the Property and Affairs section of this Newsletter.

We note, finally, that whilst paragraph 48 might

be read as suggesting that doctors are entitled to place a higher weight upon "medical" or "ethical" (for which we read "a belief in the sanctity of life") matters than upon what P might have wanted, this must be read in its context of a dispute between the family and the treating team as to where P's best interests lie which is before the court to be resolved. Further, we certainly do not read this paragraph as suggesting that all disputes as to medical treatment require resolution by the court, as the very essence of decision-making under the MCA should be collaborative (see *G v E (Deputyship and Litigation Friend)* [2010] EWCOP 2512 at para 57:

> *The Act and Code are therefore constructed on the basis that the vast majority of decisions concerning incapacitated adults are taken informally and collaboratively by individuals or groups of people consulting and working together. It is emphatically not part of the scheme underpinning the Act that there should be one individual who as a matter of course is given a special legal status to make decisions about incapacitated persons. Experience has shown that working together is the best policy to ensure that incapacitated adults such as E receive the highest quality of care),*

There are, further, a host of mechanisms to enable disputes to be resolved without recourse to the court (see, in particular, in this regard, the work of the Medical Mediation Foundation).

Of course, the question of whether cases of this nature have to come to court even where there is no dispute is a currently a very hot topic (see inter alia Alex's post and article on the topic, and the article by Lynne Turner-Stokes in the Journal of Medical Ethics), but that is not a matter upon which Charles J touched in his judgment.

When enough is enough

Abertawe Bro Morgannwg University LHB v RY and CP [2016] EWHC 3256 (Fam) (Hayden J)

Best interests – medical treatment

Summary

In this case, Hayden J returned to a theme that has been exercising him increasingly. As he noted during exchanges with Counsel for a family member in an application for withdrawal of life-sustaining treatment from a person said to be in a PVS following severe hypoxic damage:

> *6.* […] *I have been concerned in a number of cases now by the apparent readiness of the profession involved in Court of Protection cases to adjourn these difficult applications for a wide and ever-varying variety of enquiry. This is all entirely well-motivated and there is no doubt that the proper instinct to preserve the sanctity of life must always remain in clear focus when evaluating a course that may lead to the death of a patient. However, it is well established that this important principle does not exist in a vacuum.*

In support of the principle that the sanctity of life is not the sole governing principle, he cited passages from *Re N* [2015] EWCOP 76, *Pretty v United Kingdom* [2002] 35 EHRR 1, and *Airedale NHS Trust v Bland* [1993] AC 789, before noting that:

> 11. *As a Judge sitting in the Court of Protection, I have experience of litigants seeking very extensive assessments and re-assessments, in a way that occurred in the Family Division in Children Act 1989 proceedings, most particularly in public law care proceedings. The reasons for both strike me as similar, namely that the decisions the*

Court is asked to make are of such great importance and carry such profound consequences that there is, I think, a forensic instinct to leave no stone unturned. I am bound to say however, that I sometimes feel that I am being asked to authorise a petrological survey on the upturned stone. Just as the Family Justice reforms have re-emphasised the real dangers to vulnerable children caused by avoidable delay, so to, it seems to me, practitioners in this field must recognise that delay which is not, on a true analysis, either constructive or purposeful is almost certainly damaging and thus inimical to P's welfare.

He continued that:

12. Though avoidance of delay is not a statutory imperative in the Mental Capacity Act 2005 the principle is now so deeply embedded in the law of England and Wales and across every jurisdiction of law that it should be read into Court of Protection proceedings as a facet of Article 6 and 8 ECHR. It requires to be restated that the Court of Protection Rules provide for the Court to restrict expert evidence and assessment…

He noted that he had revisited the core principles because:

13. I have real misgivings whether the proposals for further assessment and inevitably further expert opinion can properly be said to be in RY's best interests. RY, I have been told, is a deeply religious man. His family are similarly committed to their faith. Mr Sachdeva agrees that their position can be stated starkly and without nuance. They would wish RY to have life no matter how fragile or vestigial. Though others might regard their father's life as entirely compromised or even debased they would prefer that to his death. This is a fundamental tenet of their beliefs which resonates throughout the Judeo-Christian and Islamic faiths.

14. Having watched the clinicians from the Health Board in the courtroom this afternoon I had a very strong sense that they were unconvinced as to whether this proposed course was consistent with their ethical obligations to their patient. Their unease was almost palpable, even before Mr Chisholm informed me that the clinicians shared many of the concerns that I articulated during the course of exchanges with counsel.

However, in light of video evidence that had come to light which revealed a level of consciousness that was not consistent with the rest of the available clinical information, Newton J acceded with reluctance to a delay for further assessments, noting that:

20. Given the scale of the hypoxic damage, the preponderant evidence suggests that any significant improvement may be rather a forlorn hope. I think RY's family should be under no delusion as to the prospects. That 'flicker of hope', says the Official Solicitor, is one that should be pursued on RY's behalf. Ultimately, I have acceded to that submission but I do so on a very particular basis and that is that the assessment process, which has been outlined in framework this afternoon, is carefully monitored and that the SMART assessment, is commenced no later than 6th December. If, at any point between today and the end of January when I anticipate this case will return to me, those treating RY feel that this delicately poised decision has shifted, so that ongoing treatment and/or assessment does not continue to be in his best interests, I spell out in clear and unambivalent terms that I regard it as the duty of the Health Board to return the case to Court expeditiously. Sympathetic though I am to the views of RY's family and the complete integrity with which they seek to convey RY's views to the Court, their own views and feelings must always

remain subordinate to RY's best interests, objectively assessed.

21. The care plan requires to be specific, focused, choate and detailed, bearing in mind, as I have emphasised that prolongation of the investigation may be contrary here to the patient's best interests. On this basis, and for these reasons, I am prepared to make the declarations that the parties seek today, including the necessary step of a tracheostomy which I understand, all being well, will be completed within the next twenty-four to forty-eight hours.

Comment

This case reveals a real tension between the – understandable – desire of family members (and other parties) before the Court of Protection to examine every possible avenue which might support their case, and the need both (1) to ensure that cases are determined without undue delay; and (2) not to inflict assessments on P which may not merely give rise to a delay but actively to harm their interests. Although serious medical treatment cases such as that before Hayden J fall outside the Case Management Pilot, these issues arise – albeit perhaps on a less dramatic scale – in many welfare cases, highlighting, above all, the need for robust judicial management of cases to ensure that, at each stage, a proper answer can be given as to why any particular step or assessment is being undertaken.

Hayden J's comments about the place of sanctity of life in the making of best interests decisions in this arena also chime with the considerably more detailed analysis by Charles J in *Briggs v Briggs (No 2)* case that we cover above.

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Conferences at which editors/contributors are speaking

Royal Faculty of Procurators in Glasgow

Adrian will be speaking on adults with incapacity at the RFPG Spring Private Law Conference on 1 March 2017. For more details, and to book, see here.

Scottish Paralegal Association Conference

Adrian will be speaking on adults with incapacity this conference in Glasgow on 20 April 2017. 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 Mind in return for postings for English and Welsh events. For Scottish events, we are inviting donations to Alzheimer Scotland Action on Dementia.

Chambers Details

Our next Newsletter will be out in early 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 Newsletter in the future please contact marketing@39essex.com.

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