Mental Capacity Law Newsletter May 2014: Issue 46

Court of Protection: Health, Welfare and Deprivation of Liberty

Introduction

Welcome to the May issue of the Mental Capacity Law Newsletter family. The newsletters are significantly shorter this month, although we nonetheless have important developments to report upon:

(1) In the Health, Welfare and Deprivation of Liberty Newsletter, we cover the spectrum from refusing blood transfusions (*Re J*) to looking for sexual partners (*Re TZ (No 2)*);

(2) In the Property and Affairs Newsletter, we cover giving to the Mormon Church *(Re P*) and the useful case summarising the principles relating to reconsideration of orders in the context of the revocation of LPAs (*Re MRJ*);

(3) In the Practice and Procedure Newsletter, we cover an important case about the Court of Protection's powers where a person has been found in contempt (*A Local Authority v B, F & G*) as well as a decision of the Court of Appeal which is required reading wherever a party to proceedings is deaf or hearing impaired;

(4) In the Capacity outside the COP newsletter, we note a range of developments both from within England and Wales and further afield including, importantly, the General Comment on Article 12 of the Convention on the Rights of the Persons with Disabilities (about which much more in the June Newsletter). We also include our first ever book review;

(5) Finally, in the Scotland Newsletter, we cover an important case upon powers of attorney, a symposium upon the Assisted Suicide Bill before the Scottish Parliament, and an update on the Scottish *Bournewood* case.

ThirtyNine ESSEX STREET

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Mental capacity – contact – sexual relations

Summary

This is a sequel to a case that we reported in the August newsletter, and has a number of extremely interesting things to say about contact and sex.

In July 2013, Baker J declared that TZ, a 24-year-old man with mild learning disabilities, atypical autism and hyperactivity disorder, who lacked the capacity to litigate, had the capacity to consent to and engage in sexual relations. At that hearing, Baker J adjourned two further issues, namely whether he had the capacity: (1) to make decisions as to his contact with other people, and (2) to make decisions as to his care needs. After further assessments, those issues, and others consequential issues, were listed for a further hearing in early December 2013.

At that point, it was generally known that the question of capacity to consent to sexual relations had been considered by the Court of Appeal in a case in which judgment had been reserved. Baker J therefore decided, with the agreement of the parties' representatives, to adjourn the hearing until after the Court of Appeal judgment was available, and to permit the parties to file addendum written submissions as to the impact of that decision on this case. In the event, the Court of Appeal judgment, *IM v LM and others* [2014] EWCA Civ 37, upheld the interpretation of the law concerning capacity to consent to sexual relations that Baker J had adopted in these proceedings. As a result, the supplemental submissions delivered by the parties were brief.

In the event, the hearing in December took a slightly different course from that anticipated in July because of a refinement of the issues as identified by the parties. The principal focus of the latest assessments was the issues that may arise as TZ endeavoured to meet, and form intimate relations with, other men. TZ was clear that he wished to have the opportunity to have these experiences, and all professionals involved in supporting him agree that he should be given that opportunity. The question was whether he had the capacity in respect of decisions that may have to be made when that opportunity arises.

Baker J summarised the issues as follows:

1. What is the relevant decision in respect of which the question of capacity arises?

2. Does TZ lack capacity in respect of that decision?

3. If yes, what orders should be made in TZ's best interests?

4. Should the court appoint the local authority to act as TZ's welfare deputy?

The relevant decision

The local authority argued initially that the relevant decision in the case was whether TZ had the capacity to make decisions regarding contact with others, either generally or with one or more named individuals. As Baker J noted, the difficulty with this formulation was that it did not focus on what McFarlane LJ described in PC and NC v City of York Council [2013] EWCA Civ 478,as the "specific factual context" arising at this stage,

namely the prospect of future contact of a personal and intimate nature between TZ and an individual or individuals as yet unidentified. Baker J noted that it was not asserted that TZ lacks capacity generally to make decisions as to contact. Equally, there were at present no named individuals who can be identified with whom he may have contact of a personal intimate nature.

The local authority reformulated their position, and ultimately submitted that risk was the live issue in this case, given the current situation in which the court had determined that TZ had capacity to consent to sexual relations and that TZ now wished to have contact with other men which may include intimate sexual relations. The local authority submitted that the key question in this context was whether TZ lacked capacity to assess risks to himself from such contact.

The Official Solicitor submitted that the key question was whether TZ could decide what support he requires when meeting unfamiliar adults. He also rejected the suggestion that the relevant decision could be characterized simply as a decision about contact in general or with any specific individuals. The Official Solicitor submitted that the better analysis was that the relevant decision at this stage was whether TZ can make a decision about whether or not to receive care and support when meeting unfamiliar adults. He argued that assessment of risk was part of the information relevant to making the decision.

Baker J found himself unable to accept either submission without some qualification. He did not agree with the Official Solicitor:

> *"15.* […] *that the relevant decision can be characterised merely as whether TZ can decide what support he requires when meeting unfamiliar adults. The question of support required when meeting unfamiliar adults only arises if he lacks capacity in making decisions when meeting unfamiliar adults.*
>
> *16. On the other hand, I do not accept Mr. Dooley's* [for the local authority] *formulation. I agree with Mr McKendrick that the assessment of risk is not the decision but rather part of the information relevant to making the decision This is indeed expressly set out in s. 3(4) of the MCA which provides that information relevant to a decision includes information about the reasonably foreseeable consequences of (a) deciding one way or another, or (b) failing to make the decision. It seemed to me that Mr Dooley in fact acknowledged this point himself in the course of his oral submissions when he observed that the decision must include consideration of the benefits and disbenefits arising from that decision. Thus the analysis of risk is part of the decision-making process, not the decision itself.*
>
> *17. That analysis is required in situations when TZ comes into contact with certain types of people, namely those with whom he wishes or may wish to have sexual relations. That is the 'specific factual context' in this case. Thus the relevant decision is not the decision whether to have contact with people generally. That is too broad. It is not a decision whether to have contact with a named individual. Since no individual has been named, that is too narrow. The primary relevant decision is whether or not an individual with whom TZ may wish to have sexual relations is safe. The secondary relevant decision is whether, in those circumstances, he then has the capacity to make a decision as to the support he requires.*
>
> *18. Accordingly, the questions arising here are:*
>
> *(1) whether TZ has the capacity to make a decision whether or not an individual with whom he may wish to have sexual relations is safe, and, if not,*

(2) whether he has the capacity to make a decision as to the support he requires when having contact with an individual with whom he may wish to have sexual relations."

Did TZ have these capacities?

After a close analysis of the evidence, Baker J held that TZ lacked capacity in both domains. In respect of the first domain, he placed particular weight upon the expert evidence that, whilst he "*had the ability to understand and retain information, he lacks the ability to use or weigh up the information, including the ability to assess risk and, in the language of s. 3(4), to understand the reasonably foreseeable consequences of the decision. This is, in my judgment, a good example of the distinction identified in paragraph 4.30 of the Code of Practice between, on the one hand, unwise decisions, which a person has the right to make, and, on the other hand, decisions based on a lack of understanding of risks and the inability to weigh up the information concerning a decision*" (paragraph 37).

Baker J noted in conclusion on this aspect that: "[i]*n reaching these conclusions as to capacity, I have reminded myself, again, of the need to avoid what could be called the vulnerable person's protective imperative – that is to say, the dangers of being drawn towards an outcome that is more protective of the adult and thus fail to carry out an assessment of capacity that is detached and objective. I do not consider that I have fallen into that trap in this case*."

What orders should be made in TZ's best interests

Baker J set out a series of principles and dicta to guide his approach – of note are paragraphs 46-48, where he held:

"46. Mr. McKendrick further submits, rightly, that in applying the principle in s.1(6) and generally, the Court must have regard to TZ's human rights, in particular his rights under article 8 of ECHR to respect for private and family life. As the European Court of Human Rights observed in Niemitz v Germany (1993) 16 EHRR 97 at para 29, 'private life' includes, inter alia, the right to establish relationships with other human beings. This has been reiterated on a number of occasions, see for example Pretty v UK (2002) EHRR 1 at paragraph 61 and in Evans v UK (2008) 46 EHRR 34 at paragraph 71. There is a positive obligation on the state to take measures to ensure that his private life is respected, and the European Court has stated that 'these obligations may involve the adoption of measures designed to secure respect for private life even in the sphere of the relations of individuals between themselves': Botta v Italy (1998) 26 EHRR 241 paragraph 33.

47. These principles plainly apply when considering what steps should be taken to protect someone, such as TZ, who has the capacity to consent to sexual relations but lacks both the capacity to make a decision whether or not an individual with whom he may wish to have sexual relations is safe and the capacity to make a decision as to the support he requires when having contact with such an individual. In such circumstances, the state through the local authority is under a positive obligation to take steps to ensure that TZ is supported in having a sexual relationship should he wish to do so.

48. In passing, it should be noted that this is consistent with the provisions of the United Nations Convention on the Rights of Persons with Disabilities, (ratified by the UK in 2009 although not yet incorporated into English law) and in particular article 23 which requires states to 'take effective and appropriate measures to eliminate discrimination against persons with in all matters relating to

marriage, family, parenthood and relationships, on an equal basis with others'."

Noting that decision-making for incapacitated adults should, as far as possible, be a collaborative exercise, Baker J set out a series of observations as to the contents of a care plan that was to be drawn up for his approval, divided in (a) basic principles; (b) education and empowerment; (c) support; (d) intervention; (e) decision-making. Under 'basic principles,' he noted that its purpose is "*to identify the support to be provided to assist* [TZ] *in developing a sexual relationship without exposing him to a risk of harm*" (paragraph 56(6)). Under 'education and empowerment,' Baker J noted that "[w]*hen delivering a plan to address TZ's lack of capacity to decide whether someone with whom he may wish to have sexual relations is safe, the principal focus should be on educating and empowering him to make these decisions. Any provisions in the plan directed at protecting him and restricting his contact should be seen as interim measures until the time when he acquires skills to make such decisions for himself.*" Under 'support,' Baker J wanted to see, in practical terms, the support TZ would receive when he went out with a view to meeting individuals with whom he might wish to have sexual relations. Under 'intervention,' Baker J wanted to see a plan that clearly delineate the circumstances in which care workers might intervene to protect TZ and the steps they were entitled to take when intervening.

Finally, under 'decision-making,' Baker J rejected the proposal that immediate decisions under the care plan (for instance example in the event that TZ found himself in a situation that was unsafe) could be made by a welfare deputy in the form of the Director of Adult Social Care and Wellbeing. Baker J noted that he did:

"82. … not consider that this is an appropriate case for the appointment of a welfare deputy. The Code clearly provides that deputies for personal welfare decisions will only be required in the most difficult cases (paragraph 8.38) and that, for most day to day actions or decisions, the decision-maker should be the carer most directly involved with the person at the time (paragraph 5.8). That is simply a matter of common-sense. If a situation arises in which TZ is perceived to be at risk, a decision needs to be taken by the person on the ground who is giving him support. It would be impractical to refer the decision to anyone else, either the Court or a deputy. Any decision that has to be taken arising out of an immediate risk of harm should be taken, so far as possible, collaboratively and informally by TZ's care worker.

83. The question arises as to the course to be followed if the support worker is unable to extract TZ from a situation where he is at immediate risk of harm. The MCA does permit a deputy to restrain P if certain conditions are satisfied: see s.20 (8) to (11). Parliament has expressly provided, however, that a deputy cannot make a decision preventing contact between an incapacitated adult and a named individual. By the time action is needed to remove TZ from a situation where there is a risk of harm, the individual or individuals who are the source of the risk will in all probability be identified or identifiable, so a deputy would be unable lawfully to prevent that contact with or without using restraint. If the situation cannot be resolved by the support worker, consideration must then be given to applying to the court for injunctive relief. In an emergency, the police should be called. To my mind, the appointment of a deputy to be given the power to make decisions for the removal of TZ from such situations, enforceable by acts of restraint under s.20, would be inconsistent with the provisions of the Act and Code.

84. Long-term decisions, such as whether or not TZ should move out of his accommodation and cohabit with another man, are plainly matters more appropriately decided by the Court, given the scheme of the legislation.

85. The appointment of a deputy to take such decisions is therefore both impractical and, in my judgment, inconsistent with the scheme of the Act and Code. It is also arguable that it would run counter to the principal focus of the plan, which should be to educate and empower TZ to make these decisions for himself.

86. Accordingly, I conclude that the care plan should provide that any immediate decisions concerning risk, for example whether TZ is safe in a social setting, should be made by his support worker. Long-term decisions should be referred to the Court of Protection."

Comment

The decision is a careful one, loyally following the guidance of the Court of Appeal in PC, and taking particular pains to ensure that the questions asked were neither too narrow nor too broad. Moreover, the assessment of where TZ's best interests lay was one that sought to take into account the (commendably shared) desire of all concerned to produce an outcome that allowed TZ to develop and explore his desires to form sexual relationships with other men in such a way that would at the same time (insofar as possible) not bring him into harm.

However, it might be said that the decision sheds light, in particular, upon the mismatch between the test for capacity to consent to sexual relations, which is act-specific, (*IM*, until and unless the Supreme Court revisits this issue), and questions of capacity to consent to contact, which is person specific. The approach adopted in this case could be said to bring in, by the back door, a person-specific approach to the actual exercise of capacity to consent to sexual relations – the order made anticipating that the local authority will assess the risk of sexual assault from prospective partners on an individual basis.

One might also, potentially, question whether a test for capacity to decide whether a potential sexual partner is 'safe' is one that would withstand detailed analytical scrutiny. Whilst one can quite understand how it was arrived it for purposes of resolving the difficult issue before the court, it is one that we suspect may well be examined carefully in any future case in which the same issue arises.

Further, whilst the decision could be said in many ways (at least in its outcome) to be a case study in the exercise of the balance between protection and autonomy enshrined in the MCA 2005, whether it would be consistent with the approach mandated by the CRPD is a rather different question to which the answer is, we suspect, not that Baker J would have anticipated. We will have much more upon the CRPD and its implications for the MCA 2005 in our June issue.

One final point that should perhaps be noted that, whilst it is difficult to fault Baker J's decision not to appoint a welfare deputy on the facts of the case, it did not take into account the decision of Roderic Wood J in *SBC v PBA and Others* [2011] EWHC 2580 (Fam); [2011] COPLR Con Vol 1095, in which Roderic Wood J had held that the test to be applied when determining whether to appoint a deputy (whether to manage a person's property and affairs or take decisions regarding their health and welfare), was to be derived from the unvarnished words of the MCA 2005, and that there was no additional requirement to be derived from the Code of Practice that in order for a deputy to be appointed it was necessary that the case before the court be one of the

'most difficult' categories of case (the language used in the Code). For our part, the editors would prefer the approach adopted by Baker J at paragraph 82 (not least as Alex was arguing for it in SBC!) but we now have two directly inconsistent judgments upon the relevance of paragraph 8.38 of the Code in this regard.

Advance directives and s.63 MHA 1983

Nottinghamshire Healthcare NHS Trust v J [2014] EWHC 1136 (COP) (Holman J)

Mental Health Act 1983 – interface with the MCA 2005

Summary

In this case the judge was asked to consider an urgent without notice application in a medical treatment case.

The case concerned J, a young man aged 23 who was in prison but detained under the Mental Health Act 1983. He suffered from what was described as a serious personality disorder, a symptom of which was that he had engaged in significant self-harm on a number of occasions which resulted in profuse bleeding (he was on anticoagulant drugs because of a history of thrombosis). He was a Jehovah's Witness and had made what purported to be an advance decision to refuse specified medical treatment, namely blood transfusions.

The first limb of the application asked for a declaration that a written advance decision was valid and was applicable to the treatment described in the advance decision. The judge considered sections 24 – 26 of the MCA 2005 and declared on an interim basis that the written advance decision was valid and applicable to that treatment notwithstanding that (a) the young man's life may be at risk from the refusal of treatment and (b) that he was a patient detained under the Mental Health Act.

The second limb of the application brought by the NHS Trust related to the interrelation of the provisions of the MCA 2005 in relation to advance decisions to refuse treatment and the applicability in this case of section 63 of the Mental Health Act 1983 which provides: "*the consent of a patient shall not be required for any medical treatment given to him for the mental disorder from which he is suffering…if the treatment is given by or under the direction of the approved clinician in charge of the treatment*."

Holman J noted that there was clear authority to the effect that the words "*medical treatment given to him for the mental disorder from which he is suffering*" were wide enough to extend to medical treatment for physical conditions caused or arising as a result of the underlying mental disorder (*B v Croydon Health Authority* [1995] Fam 133). It followed that if a detained patient cut himself as a result of a self-harming mental disorder, then it may be lawful under that section to treat and stitch up the cuts. The judge held that it was little or no extension of that approach that if, as a result of the mental disorder from which he is suffering, a patient cuts himself and bleeds so profusely that he needs a blood transfusion, that transfusion would be covered by s.63. Hence this case squarely raised the issue of the interrelation between the provisions of the MCA 2005 in relation to advance decisions and the power under s.63 MHA 1983 to give medical treatment notwithstanding the absence of consent.

The man's responsible clinician described having 'some ethical difficulty' in using the MHA 1983 to override a capacitous patient's wishes based on

religious wishes and stated that she "*would not chose to use* [her] *Mental Health Act powers to override his advance decision*." Holman J stressed (at paragraph 15) that it was not the business of a court to make any kind of ethical decision: "*all the court can do is state the applicable law and, where appropriate, apply it in the form of a legal, though not necessarily an ethical, decision*."

The second limb of the application asked the judge to make an interim declaration that "*it is lawful for those responsible for the medical care of the respondent to act in accordance with his written advance decision and withhold treatment by blood transfusion or with blood products in accordance with his expressed wishes notwithstanding the existence of powers under section 63 of the Mental Health Act 1983*."

Holman J held that he did not feel equipped or willing to make the declaration as he had only heard representations from one side without notice to the patient or any other person. He listed a hearing for the next day having made a preliminary inquiry of the Official Solicitor. He also directed that the NHS Trust use its best endeavours to facilitate and promote that the patient himself be represented at the hearing and to ensure that the patient's father be informed of the hearing and encouraged to attend.

Comment

As the judge stated, this case raises a 'terrible dilemma', namely the interrelationship between a capacitous advance decision which has the effect of endangering life and the power under the MHA 1983 to override consent where treatment is for a mental disorder.

Given the NHS Trust's position that those treating the man would not exercise their s63 MHA 1983 powers in the face of a clear advance decision based on religious views, the position at the hearing was that if physical restraints were removed from the patient and he was able to cause profuse bleeding he might die, whether he intended to bring about his death or not.

At a subsequent hearing, of which only press coverage is available, Mostyn J upheld the validity of the advance decision and the lawfulness of J's responsible clinician under s.63 MHA 1983 not to administer a blood transfusion.

Personality and capacity

Wandsworth CCG v IA and TA [2014] EWHC 990 (COP) (Cobb J)

Mental capacity – finance – medical treatment – residence

Summary

This case is a model of the approach to the assessment of the capacity to decide as to (1) ongoing medical treatment; (2) future residence and care; and (2) management of property and affairs.

IA was a 59 year old man suffering from Type 2 diabetes mellitus, who partially blind (due to diabetic retinopathy) and had limited mobility. He also had a serious kidney disease for which he required regular dialysis, and suffered from anaemia, as well as a number of serious complications as a result of his diabetes from which he was constantly at risk of severe infection.

In June 2007, IA was the subject of a violent criminal assault, being repeatedly kicked to the head; he sustained a serious head injury, involving skull fractures, brain haemorrhage and contusions to the right frontal area of the brain.

As a result he suffered a degree of cognitive impairment for which he was treated at a specialist rehabilitation centre. The injury was said to have left IA with problems of memory, inflexibility of thought, impulsivity, and mood control. He had consequently exhibited deficits in executive functioning with reduced capacity to organise, judge and show control over decision-making.

IA had been an in-patient at a major London teaching hospital since November 2013, having been admitted as an emergency following an episode of diabetes-related hypoglycaemia. He was ready for discharge from hospital, and decisions were required as to his future care. The court had to determine whether IA had the capacity to make or contribute to the relevant decisions. There was before a care plan which provided proposals for post-discharge care which would either be delivered under the CCG's ordinary statutory duties (IA had been assessed as eligible for NHS continuing healthcare in part due to non-compliance with care interventions and challenging behaviour), or as being as a plan representing his best interests under s.4 MCA 2005.

In directing himself as to the law, Cobb J made specific reference to (1) the need not to set the threshold in relation to capacity to understand unduly high; (2) the need that the person only understand the salient factors in relation to the respective options; and (3) the 'clear guidance' of the Court of Appeal in *PC and NC v City of York* in relation to the causative nexus (which Cobb J slightly curiously described as the 'diagnostic test').

Cobb J noted that IA's capacity to take the material decisions had been 'repetitively' assessed over the course of 2 ½ years by a range of experts, a number of whom had not assessed IA personally because of his refusal to cooperate with appointments or assessments. As Dr Grace (a consultant neuro-psychiatrist instructed) noted, "*assessment of capacity based on case notes is of necessity a relatively inadequate substitution for the complex assessments that occurs in a clinical interview.*" A strong body of opinion had built up over that period that IA lacked the material decision-making capacity, but this was not entirely consistent.

Cobb J set out in detail the conclusions of those who had assessed IA's capacity before continuing (at paragraph 52) that: "[g]*iven that discrepancy of professional opinion, it was sensibly agreed, at court on 15 July 2013, that the parties be given permission jointly to instruct a further consultant neuro-psychiatrist to obtain a report on IA's capacity to make the relevant decisions. There was a problem in actioning this instruction (IA did agree in principle to meet with a consultant psychiatrist, however of the fifteen experts suggested, only two were acceptable to IA; those two could not report in the prescribed time). At a subsequent hearing on 11 November 2013, TA agreed to identify two experts who would be acceptable to him, to assess IA's capacity. This led to the joint instruction of Dr Anjum Bashir, Consultant Neuro-Psychiatrist, whose written evidence has been before the Court and tested orally at this hearing. Notably, IA has cooperated fully with Dr Bashir's assessment*."

Dr Bashir concluded that IA *had* capacity in the material domains, giving a number of reports (individually and jointly with IA's treating clinicians). His oral evidence was that IA had indeed suffered a serious brain injury in the 2007 assault, but did not accept that this is necessarily a static condition. He told Cobb J that he had direct experience of victims of such assaults improving in their decision-making capacity over a period of time.

"63. [Dr Bashir] indicated in terms (when cross-examined by Ms Scott [for the Official Solicitor on behalf of IA]) that IA is able to make a fully capacitous decision about choice of his future accommodation. He nonetheless emphasised the importance of a fully effective plan: he indicated that if IA was left on his own to do everything himself, he would be at risk of neglect. That is why he needs a carefully constructed care regime. Dr. Bashir confirmed that IA knows what his needs are ('I asked him to specify his needs, and he did so. He does exhibit an understanding of his impairments')."

Cobb J's discussion of whether IA had the capacity in the relevant domains ran to 23 paragraphs of close analysis. In summary, however, he concluded:

*"66. **Summary**: On the evidence reviewed above, and for the reasons fully set out below, I find that the assumption of capacity (section 1(2) MCA 2005) has not been displaced in respect of any of the three issues on which I am invited to adjudicate (§4(i)-(iii) above).*
67. I am of the view that IA does have the capacity to make decisions about his medical treatment, future residential care, and property and financial affairs, and I shall so declare.

68. It seems to me that it has been of considerable benefit to IA that practical steps have been taken (including careful explanation by a trusted professional, Dr. Bashir) to assist him to reach these decisions, weighing up the information relevant to that decision; I trust that such assistance will be available to him in the future.

69. Although I am of the view that IA has made a number of unwise decisions in the past about his medical treatment and home living conditions, these

i) are not demonstrative of lack of capacity;

ii) are more reflective of his somewhat challenging personality; and

iii) in some respects in any event ante-date his acute brain injury and could not therefore be attributable to acquired cognitive deficit (see §46 above).

Moreover, there is reason to believe that his resistance to social work intervention is probably founded in a long-standing grievance about the compulsory purchase of his home, exacerbated by his suspicions about the plans of the authority for his future care.

70 There is a risk that he will make further unwise decisions in the future – hence the importance of effective support for him in the community, and a closely monitored care plan."

Perhaps unsurprisingly, Cobb J noted that "[t]he plan for IA's medical and other care will require very careful formulation and supervision. Appropriately trained care staff with experience of working with patients with brain injury will need to be engaged, with a proper level of expectation about IA's personality. It would be of considerable assistance in my view if Dr. Bashir – a professional whom IA trusts and with whom he has co-operated well – can be directly involved in the transition plans for IA, so as to maximise the prospects that they will be accepted" (paragraph 95).

Comment

As noted at the outset, we would suggest that this decision is a model of careful capacity assessment, in particular in its careful delineation of the role played by IA's "*eccentric*" personality in his decision-making – a factor clearly falling outside the scope of the MCA 2005. An unusual feature of the decision is that IA (despite being judged to lack litigation capacity) was given a role in the selection of the independent psychiatric expert – with whom it is then clear he was able to form a trusting and co-operative relationship. This is perhaps a slightly unconventional approach, but is one that sits very comfortably with perhaps the most ignored principle of the MCA (albeit the one that is most important for purposes of compliance with the CRPD), namely that it is only if all reasonable steps have been taken to help a person to take a decision, but without success, that a person can be treated as lacking capacity. The decision is also of note for its – entirely proper – recognition that the fact that IA had decision-making capacity in the relevant domains (or, to be precise, that those asserting that he did not had not established their case) did not mean that he should therefore be left without support; whilst applauding the decision of Cobb J on the facts, we also equally clear that taking decisions in relation to IA's future care will be no easy task for any of those involved.

Cheshire West guidance

Alex has pulled together on his website official guidance published to date on the implications of the *Cheshire West* guidance (including from CQC and ADASS), together with the most useful of the extensive commentary and notes written to date by both members of Chambers and others.

We should note in this regard that we understand that guidance is to be issued in short order by the Court of Protection as to the procedure to be followed for making applications in relation to authorise deprivations of liberty falling outside the scope of the DOLS regime (most obviously in relation to supported living placements). We will circulate this guidance by the usual channels as soon as we get our hands on it!

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Conferences at which editors/contributors are speaking

Hot topics in adult incapacity law

Adrian will be speaking on hot topics in the incapacity field at the Solicitors' Group Wills, Trust & Tax conference in Edinburgh on 7 May 2014. Full details are available here.

Bonnar Accident Law Conference

Adrian is speaking at the Bonnar Accident Law residential conference on 15 and 16 May 2014 on incapacity matters relevant to court practitioners; for details, email Adrian.

Annual private law conference convened by the Royal Faculty of Procurators

Adrian will be speaking at the annual private law conference convened by the Royal Faculty of Procurators in Glasgow on 29 May 2014. Full details are available here.

The Hague Convention on the International Protection of Adults – a quiet revolution?

Alex will be presenting a progress report upon his work on the cross-border protection of adults at a free seminar at the Centre for Medical Law and Ethics at Kings College London Strand Campus (Moot Court Ante Room, Somerset House East Wing) on 27 May from 16:00-17:30. To register, please email Isra Black.

The Deprivation of Liberty Procedures: Safeguards for Whom?

Neil is speaking at the day-long conference arranged on 13 June by Cardiff University Centre for Health and Social Care Law and the Law Society's Mental Health and Disability Committee, to discuss the extent to which the DOL procedures comply with international human rights standards, and whether they offer adequate protection for the rights of service users and their carers. The Conference will focus on the implications of the ruling of the Supreme Court *Cheshire West* as well as the likely impact of the Report of the House of Lords Committee on the Mental Capacity Act. Other speakers include Richard Jones, Phil Fennell,

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.

Lucy Series, Professor Peter Bartlett, Sophy Miles and Mark Neary. Full details are available here.

Other conferences of interest

Withholding and Withdrawing Treatment from Patients in a Vegetative or Minimally Conscious State

This day-long conference, arranged jointly by the University of York's Chronic Disorders of Consciousness Research Centre and the Court of Protection Practitioners Association, feature Baker J as keynote speaker, reflecting upon the decision in W v M and Ors [2011] EWHC 2443 (Fam). There will also be talks from a range of experts covering the ethical, clinical, philosophical, economic, and sociological perspectives of withdrawing treatment from vegetative and minimally conscious patients. For full details, please click here.

BABICM Summer Conference

The British Association of Brain Injury Care Managers is holding its summer conference on 25 and 26 June 2014 at the Hilton Birmingham Metropole. Entitled "Nobody Does It Better! Current Practical Issues in Brain Injury," the conference will examine issues facing brain injury case managers: (1) sex, capacity and the law; (2) what constitutes privileged documentation; and (3) the implications of the judgment in *Loughlin v Singh*. For more details and to register, please click here.

Chambers Details

Our next Newsletter will be out in early June. 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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