Mental Capacity Law Newsletter June 2015: Issue 57

Court of Protection: Health, Welfare and Deprivation of Liberty

Editors
Alex Ruck Keene
Victoria Butler-Cole
Neil Allen
Annabel Lee
Simon Edwards (P&A)

Guest contributor
Beverley Taylor

Scottish contributors
Adrian Ward
Jill Stavert

Introduction

Welcome to the June 2015 Newsletters. Highlights this month

(1) In the Health, Welfare and Deprivation of Liberty Newsletter: two more decisions about the vexed interaction between the MHA/MCA, revocation of a health and welfare deputyship and updated SCIE guidance on DOLS;

(2) In the Property and Affairs Newsletter: an important case on complex provisions in LPAs, calibration of risk, and new guidance from the OPG for attorneys;

(3) In the Practice and Procedure Newsletter: Schedule 3 under the spotlight, costs on appeal, and the possibility of damages for breach of the right to autonomy;

(4) In the Capacity outside the COP Newsletter: a very useful perspective from Singapore on undue influence and the MCA, and case-law and legislative developments impacting upon capacity issues;

(5) In the Scotland Newsletter: an important judicial review in the context of compliance with mental health obligations which sheds light on equivalent obligations under the 2000 Act, a useful case upon habitual residence, statistics from the OPG, and an update on relevant legislative developments.

Remember you can now find all our past issues, our case summaries, and much more on our dedicated sub-site here. We are also delighted to announce that, as of later this month, tailored summaries of key cases will be available on the SCIE website to assist front-line professionals access case-law updates.

Table of Contents

For all our mental capacity resources, click here. Transcripts not available at time of writing are likely to be soon at www.mentalhealthlaw.co.uk.

Stop press:

As we went to press, we learnt that:

(1) The *Re X* decision should be handed down on 16 June, and we will send round a newsflash addressing the decision as soon as we can thereafter;

(2) The Law Commission consultation paper on deprivation of liberty will be published on 7 July, and we hope to have an article by Tim Spencer-Lane, the lawyer leading the project at the Commission, in the next issue of the Newsletter.

An unholy mess – s.17 leave and treatment for physical disorder

A Local Health Board v AB [2015] EWCOP 31 (HHJ Isabel Parry (sitting as a judge nominated under s.9(1) Senior Courts Act 1981))

Article 5 ECHR – DOLS ineligibility – interface with MCA

Summary

If there ever had been reason to doubt that Schedule 1A to the MCA 2005 is irredeemably flawed, this case is it. The facts of the case are tragic, the outcome – substantively – is entirely correct, but the hoops through which it was necessary for the parties to go were ludicrous.

AB, a 34 year old woman, had a serious and life threatening cardiac condition, the recommended treatment for which was surgery. She was detained under s.3 MHA 1983 at a low secure private hospital, her diagnoses including mild/borderline learning disability, a working diagnosis of autism, and a schizophrenic illness with prominent persecutory thinking. In consequence, she lacked the capacity to make decisions as to her medical treatment (and to conduct proceedings in relation to her medical treatment).

The local health board made an application to the Court of Protection for declarations and decisions in relation to AB's capacity and best interests as regards heart surgery, as well as (prior) dental surgery to remove her lower teeth. The intention was that AB would be granted leave under s.17 MHA 1983 by her Responsible Clinician to attend at the general hospital for purposes of undergoing both treatments.

The assessment by the court of the evidence before it as to AB's capacity and best interests was scrupulous, as were the attempts made to engage AB in the process (attempts which ultimately did not involve her speaking to the judge because AB's anxiety at the number of professionals who had been to see her led her to decline to see anyone further, even if that was the judge who was to make the decision). It is particularly noteworthy that the judge made entirely clear:

> *"64. The fact that AB suffers with serious psychological difficulties and has been subject to in-patient treatment compulsorily under the MHA so that it may be considered by some that she does not have an equivalent quality of life to a person with capacity and without her difficulties should be excluded from the court's consideration. Otherwise a person in need of a protective decision would be at risk of being treated less favourably than any other person."*

HHJ Parry recognised that "*imposing two unwanted surgical procedures on AB, one of which is serious and accompanied by risks in itself undermines her personal autonomy over her own body and is therefore a very serious step and only to be taken where it is necessary in her own interests. This is not a case in which the proposed course of medical treatment is merely desirable or would make AB's day to day life easier. She is at risk of dying if she does not undergo this particular cardiac surgery and the necessary pre – operation dental extractions*." However, taking all the evidence into account, including the steps that could be taken to reduce and manage identified risk factors, HHJ Parry concluded that it was in AB's best interests to undergo both medical procedures.

Were it not for the discussion as to deprivation of liberty, we would have noted this case in passing as a Short Note, emphasising the passage at paragraph 64 set out above. However, the judge was required to grapple with the implications of the fact that AB was detained under the Mental Health Act 1983, and her conclusions there are (a) of sufficiently wide ramifications; and (b) (to us) sufficiently concerning, that they require further analysis.

HHJ Parry concluded, on the basis of an agreed statement of the law, that:

1. Both before and during the procedures, AB would be subject to restraints amounting to a deprivation of her liberty. This would be a further deprivation of liberty to that to which she was subjected as a result of her detention under the MNA 1983, for which separate authority was required (applying *Munjaz v United Kingdom* [2012] ECHR 1704);

2. AB was either within Case A or Case B of Schedule 1A to the MCA 2005 because either:

    a. She would be detained at the general hospital 'under the mental health regime' if conditions were attached to the s.17 MHA 1983 leave requiring her to stay at the hospital; or

    b. If no conditions were attached to the s.17 MHA 1983 leave, she would be within Case B.

3. In either case, the Court of Protection could not exercise its powers so as to authorise the deprivation of her liberty (and hence to make an effective welfare order):

    a. If AB was in Case A, this would be so simply by virtue of the operation of Case A (as in *Dr A*'s case [2013] EWHC 2442 (Fam);

    b. If AB was in Case B, this would be because of the wording of paragraph 3(2) of Schedule 1A, which provides that unless the proposed treatment is in accordance which the relevant regime (i.e. here the hospital treatment regime) imposes, she would be ineligible;

4. It was therefore necessary, as in *Dr A's* case, for relief (including declarations and decisions as to AB's best interests as well as authority for the deprivation of liberty that would arise in consequence of the medical procedures) to be granted under the inherent jurisdiction of the High Court (applying, by analogy, the s.4 MCA checklist).

Comment

The substantive outcome of this case is clearly correct, and it represents a textbook analysis of both capacity and best interests in a difficult clinical dilemma.

The case is also important because it represents the first discussion (at least in a reported case) of the Strasbourg court's identification in *Munjaz* of the concept of residual liberty – i.e. the fact that a person is lawfully deprived of their liberty under one statutory regime does not mean that consideration must not be given to whether they are subject to an additional deprivation of their liberty requiring justification. Curiously, whilst this was, in fact, in issue in *Dr A's* case, it appears that the case was not cited to Baker J.

We must, however, with due respect to those involved, register a considerable note of caution as to the correctness of the legal analysis adopted to reach the conclusion that AB would be ineligible to be deprived of her liberty at the general hospital.

If the analysis is correct, it means that where a responsible clinician grants s.17 leave from a psychiatric to a general hospital with conditions that amount to a deprivation of residual liberty, the MCA cannot be used to authorise it because P will be ineligible. Either the conditions must be relaxed so as to avoid the acid test being satisfied or if, as is very likely, this is not possible, an application to the High Court under the inherent jurisdiction will be required (or, possibly, s.17(3) MHA 1983 should be invoked).

The conventional approach, and that reflected in the Code of Practice to the DOLS safeguards, has always been understood to be the following:

Case A

1. This applies where the person is currently subject to and detained under one of the stated sections of the MHA. It is the managers of the psychiatric hospital named in the application/order/direction that are authorised to detain the patient (see MHA ss 34, 6(2)).

2. A person is not subject to Case A if they are given s.17 MHA 1983 leave from a psychiatric hospital to receive treatment for a physical disorder in a general hospital. They continue to be 'liable to be detained' by the psychiatric hospital managers but are not detained under the stated section. See paragraphs 4.41 and 4.51 of the DoLS Code of Practice, in particular the latter, which provides that "[p]eople on leave of absence from detention under the Mental Health Act 1983 […] are, however, eligible for the deprivation of liberty safeguards if they require treatment in hospital for a physical disorder." See also paragraphs 31.8-3.11 of the new Mental Health Act Code of Practice.

3. A residence condition imposed by an RC under s.17 is not, itself, sufficient to give rise to a deprivation of liberty, confinement for these purposes requiring both continuous supervision and control and a lack of freedom to leave. See, by analogy, the UT decision in *NL v Hampshire County Council* [2014] UKUT 475 (AAC) in relation to guardianship.

Case B

4. In the case of an individual who is subject to the hospital treatment regime (i.e. here, s.3 MHA 1983) but not detained under that regime, Case B applies and the MHA and

the MCA can operate in parallel. Here, the patient continues to be 'liable to be detained' in the psychiatric hospital whilst on leave to the general hospital but is not detained under the hospital treatment regime.

5. The effect of paragraph 3(2) of Schedule 1A is to ensure that decisions taken under the MHA (including residence conditions under s.17 MHA 1983 – see paragraph 3(3)) take primacy. In other words, one could not have a standard authorisation authorising the deprivation of an individual's liberty at hospital A if the patient's RC had imposed a residence condition under s.17 requiring them to be at hospital B.

6. In a case such as that of AB, decisions as to treatment for physical disorder could not be taken under the MHA 1983. The MHA 1983 only gives authority – under Part IV – for decisions to be taken in respect of treatment for mental disorder. Decisions as to physical treatment could either be taken on the basis that the clinicians were able to rely upon the defence in s.5 MCA 2005 or – as in AB's case – on the basis that authority was required by way of an order from a court. A decision as to purely physical treatment could therefore never be a "*requirement imposed by the mental health regime*" for the purposes of paragraph 3(2) of Schedule 1A;

7. As a matter of logic, therefore, in the context of the delivery of treatment for physical disorder, assuming that any s.17 leave granted was to the hospital at which the proposed treatment was to be given, it is difficult to envisage there being a conflict between the course of action that would be authorised by an order of the Court of Protection under s.16(2)(a) MCA and "*a requirement imposed by the mental health regime*."

We should note, finally, that s.17(3) MHA 1983 (which was not discussed by HHJ Parry) enables patients to be kept in the custody of staff or person authorised by the hospital managers, including the staff of another hospital. We do not understand it routinely to be used in the 'transfer treatment' cases of the kind considered in AB, its function (as identified by Richard Jones) being primarily to confirm that immediate powers of restraint can be used in the event of an attempt to abscond by a high risk patient (see also s.137(1) and (2) MHA 1983). Precisely how it is intended to fit into the operation of Schedule 1A is not clear. We note that the definition of 'hospital treatment regime' in Schedule 1A is exhaustive and does not include s.17, such that even if the individual is deprived of their liberty pursuant to the operation of s.17(3) MHA 1983, they are not 'detained in a hospital under [the hospital treatment] regime' (emphasis added). It would therefore appear that, even if s.17(3) MHA 1983 is invoked, it would not give rise to a Case A situation, but a situation where either (1) there is no need to invoke the MCA at all because it provides the necessary authority for the additional deprivation of liberty attendant upon the arrangements made for the treatment for the physical disorder (which does not appear to have been in the contemplation of DH when drawing up either Code of Practice, and which we would doubt); or (2) a Case B situation, requiring authorisation to be sought under the MCA.

Whilst the issues relating to the operation of s.17 leave set out above were not addressed in terms in *NHS Trust v FG* [2014] EWCOP 30, we would note that Keehan J appears (rightly) to have been

entirely content to exercise the jurisdiction of the Court of Protection so as to provide for the lawful deprivation of liberty of a woman detained under s.3 MHA 1983 who was to be granted leave under s.17 MHA 1983 to a general hospital for purposes of undergoing a Caesarian section.[1] Indeed, the tenor of the guidance given by Keehan J was to the effect that, where an application to the Court of Protection was not required (because the procedure would not amount to serious medical treatment), the key consideration was that there was proper coordination between the two hospitals so as to ensure that any necessary standard authorisation was in place prior to the woman being transferred to the maternity unit at the general hospital (see paragraph 101).

We hesitate to raise the difficulties outlined above because, on one view, they could be characterised as lawyerly dancing on the heads of a pin. However, if *AB* is correct, then this suggests that very many more applications in relation to psychiatric patients requiring procedures for physical disorders will be required to the High Court (not the Court of Protection) in cases where the sole reason for so doing is to obtain authority for deprivation of liberty.

Given that – albeit in stellarly badly drafted form – Parliament has provided a mechanism for the MHA and the MCA to operate in parallel without recourse to the courts, we look with interest to whether this issue is revisited in due course.

[1] There is a glancing reference in the relief sought by the Trust (at paragraph 17) to the inherent jurisdiction as an alternative basis for authority for the deprivation of FG's liberty, but Keehan J approached matters squarely on the basis that he was exercising his jurisdiction as a Court of Protection judge to make the substantive declarations and decisions: see paragraph 33. Applying the logic of *Dr A's* case and *AB*'s case, he would not have been entitled to do so if he considered that FG was ineligible to be deprived of her liberty under the MCA 2005.

Guardianship and DOLS – the role of the FTT

KD v Walsall MBC & Ors [2015] UKUT 0251 (AAC) (Upper Tribunal (AAC) (Charles J))

Article 5 ECHR – DOLS ineligibility – interface with MCA

Summary

KD had Korsakov's Syndrome and, following his detention under the Mental Health Act 1983, had been subject to guardianship since 2012. He was required to reside in a care home with 24 hour supervision and support where he was not free to leave and not permitted to go out unless accompanied by a member of the care staff, with access to the community is limited by their non-availability. He sought to be discharged from the guardianship order on the basis that it was not necessary because DoLS was less restrictive and guardianship could not authorise his deprivation of liberty.

This is a significant decision for those involved in guardianships cases that this mere summary cannot do justice to. But some of the passages apply to DoLS cases, irrespective of whether the person is under guardianship. The following points are particularly noteworthy:

1. The concept of "deprivation of liberty" in breach of Article 5 is wider or arguably wider that that of "detention" under the MHA (para 29).

2. The guardian's power to return the person to his place of residence has the effect of a requirement or an injunction preventing him from leaving (para 30). And such a power is a

more readily available, effective and sensible means of enforcing the result that the person lives there than an injunction against that person from the Court of Protection (para 31).

3. A deprivation of liberty during guardianship should be authorised under the MCA (where applicable).

4. A standard authorisation under DoLS can provide for it to come into force at a time after the time at which it is given. And the Court of Protection can authorise any deprivation from a date in the future (para 43).

5. The reasoning in *C v Blackburn and Darwen Borough Council* [2011] EWHC 3321 (COP) was developed in terms of what should happen where there is a dispute over residence with a guardian (paras 45-54).

6. A useful checklist was designed for tribunals to approach similar guardianship / Mental Capacity Act 2005 cases.

Comment

This decision illustrates how investigatory the role of the First-Tier Tribunal (Mental Health) can be with regards to the interface with the 2005 Act. The inference that the effect of guardianship powers is to prevent the person from leaving their place of residence is of particular interest as the issue has been the subject of much debate over recent years.

SCIE DOLS Resources

SCIE has recently updated its DOLS resources. Available here are:

1. *At a glance – The Deprivation of Liberty Safeguards*. This updated document includes guidance on what deprivation of liberty is and how it is authorised under the DoL safeguards. It also discusses urgent authorisations, the safeguards for people who may be deprived of their liberty and when DoLS cannot be used.

2. *Report: Deprivation of Liberty Safeguards: putting them into practice*: This resource describes good practice in the management and implementation of the Deprivation of Liberty Safeguards. It includes the roles of clinical commissioning groups (CCGs) and wider local authority governance.

3. *Guide – IMCA and paid relevant person's representative roles in the Mental Capacity Act Deprivation of Liberty Safeguards*: This practice guidance describes the role of IMCAs and paid representatives in DOLS.

Also available is a video (featuring Alex in a cameo appearance) discussing DOLS in light of *Cheshire West*.

Discharging the errant health and welfare deputy

AY v (1) Hertfordshire Partnership NHS Foundation Trust & Ors [2015] EWCOP 36 (DJ Hilder)

Deputies – Welfare matters

Summary

This case concerned the best interests of X in relation to his diet/treatment and a welfare deputyship. The application was brought by his mother, AY.

X was a young man of 25 years old who lived in a care home. He suffered from autistic spectrum disorder and had moderate to severe learning disabilities. He was fully dependent on carers to meet all his personal care needs, food and fluid intake and lacked capacity to make decisions about where to live, how he is cared for and the treatment he received.

AY considered that X's autism had been acquired after birth and related to his receiving the MMR vaccination. AY's view was that X's behavioral challenges were reflective of a bowel condition which often left him "impacted" and in pain which he could not otherwise express. She believed that this bowel condition could and should be treated by means of excluding certain food types (gluten, casein and lactose) from his diet, and by giving him nutritional supplements.

AY also considered that she was best placed to make decisions about the welfare of X and as his mother she understood him best and had always acted in his best interests. Accordingly, AY contended that her authority as welfare deputy, which had been temporarily suspended, should be reinstated.

The local authority contended that AY took an unconventional approach to X's care and treatment, and sought to impose her own views to the detriment of X's wellbeing. Instead, the local authority maintained that X should have an unrestricted diet and medical treatment as advised by the responsible clinicians. The local authority sought revocation of AY's welfare deputyship as it was it placing strain on those responsible for X's day to day care. The OS was broadly supportive of the local authority's position.

The Court made extensive findings of fact in order to reach decisions as to X's best interests. Ultimately, the court found that when X's diet was restricted and he was taking supplements, he remained autistic. When he had access to previously restricted foodstuffs and an unrestricted diet, there was no noted deterioration in his behaviour or the condition of his bowels. The Court held that restriction of X's diet was an infringement of his freedoms and the requirement to take nutritional supplements was an imposition, neither of which were in X's best interests.

The Court also held that AY's views ran counter to the generally accepted approach in respect of treatment for autism. AY would continue to seek testing and administration of nutritional supplements. The Court was satisfied that it would not be in X's best interests for AY alone to have authority to make such decisions for X.

Comment

This decision makes an interesting counterpart to that in *A Local Authority v M & Ors* [2014] EWCOP 33, in which Baker J was faced with a mother who was a health and welfare deputy and held equally fixed views in relation to the role played by the MMR vaccine in the development of her son's autism. In that case, Baker J did not – at least at the reported stage – go as far as removing the mother as her son's deputy, but indicated that such a course was very much on the cards in the event that she was unable to demonstrate a fundamental change in attitude.

In the instant case, the Court had no doubt that AY was devoted to X and dedicated to promoting his wellbeing as she saw it. However, the Court was struck by the rigidity of her views and her refusal to accept professional medical advice.

Rather, AY continued to pursue her views which worked against X's best interests and therefore her appointment as welfare deputy was revoked.

The revocation of AY's welfare deputyship meant that she alone would not have authority to make these decisions for AY. However, the Court emphasised that AY was not excluded from the decision making process. The revocation of the deputyship merely restored AY to the usual position for the parent of an incapacitated (adult) child where her views would be taken into account in making any decision in X's best interests. The Court championed the usual approach of collaborative decision making and in the circumstances agreed with the OS that there was no need to appoint anyone else as replacement welfare deputy.

We would emphasise that there will be very many cases in which the appointment of a parent as the health and welfare deputy for a child with profound disabilities is entirely appropriate and correct so as to secure a privileged voice in decision-making. It often comes as a huge – and very unwelcome – shock to parents in such a position to discover that they cease to have any formal role at all in such circumstances when their child turns 18, and appointment as a health and welfare deputy can be very important. This case, though (as with *A Local Authority v M*) demonstrates the boundaries of the authority that a parent deputy can exercise.

Deprivation of Liberty Statistics

The Health and Social Care Information Centre has now released the DOLS statistics from 1 January to 31 March 2015, updated figures for the preceding three quarters. We therefore have the figures for the entire year since the Cheshire West decision for the 116 out of 152 councils (76%) which have submitted figures for all 4 quarters. Those show that those councils received 113,300 DOLS applications in the period compared to 10,900 in previous year. In a dramatic change to the position prior to the Supreme Court decision, a majority (54%) of applications had not been signed off (or had been withdrawn – presumably because the person had been discharged or died), compared to 3% previously. 36% of applications were granted, and 10% rejected.

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Conferences at which editors/contributors are speaking

Update Seminar: "Wills and Trusts"

Adrian will be speaking at this seminar on 11th June in Glasgow on "Incapacity Act: Development or Abolition"

Safeguarding Adults with Learning Disabilities – Capacity to Consent to Sexual Relations and Forced Marriage

Jill will be speaking at this Legal Services Agency Conference on 15th June 2015 in Glasgow on 'Recognition of Rights to Sexual Relationships for People with Intellectual Disabilities.'

Social Work Scotland Annual Conference 2015

Jill will be speaking on 'Deprivation of Liberty' at this conference in Crieff on 17th June.

'In Whose Best Interests?' Determining best interests in health and social care

Alex will be giving the keynote speech at this inaugural conference on 2 July, arranged by the University of Worcester in association with the Worcester Medico-Legal Society. For full details, including as to how to submit papers, see here.

Mental Health Lawyers Association Court of Protection Conference

Alex will be discussing the Court of Protection rule changes at the MHLA's Second Annual conference (keynote speaker, Sir James Munby P) on 3 July in London. For full details, including as to how to submit papers, 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 July. 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.

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

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

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

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

London 39 Essex Street, London WC2R 3AT
Tel: +44 (0)20 7832 1111
Fax: +44 (0)20 7353 3978

Manchester 82 King Street, Manchester M2 4WQ
Tel: +44 (0)161 870 0333
Fax: +44 (0)20 7353 3978

Singapore Maxwell Chambers, 32 Maxwell Road, #02-16,
Singapore 069115
Tel: +(65) 6634 1336

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THE QUEEN'S AWARDS FOR ENTERPRISE INTERNATIONAL TRADE 2013

Alex Ruck Keene
alex.ruckkeene@39essex.com

Alex been recommended as a leading expert in the field of mental capacity law for several years, appearing in cases involving the MCA 2005 at all levels up to and including the Supreme Court. He also writes extensively about mental capacity law and policy, works to which he has contributed including 'The Court of Protection Handbook' (2014, LAG); 'The International Protection of Adults' (2015, Oxford University Press) and Jordan's 'Court of Protection Practice.' He is the general editor of the fourth edition of 'Assessment of Mental Capacity' (Law Society/BMA, forthcoming). He is an Honorary Research Lecturer at the University of Manchester, and the creator of the website www.mentalcapacitylawandpolicy.org.uk. To view full CV click here.

Victoria Butler-Cole
vb@39essex.com

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

Neil Allen
neil.allen@39essex.com

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

Annabel Lee
annabel.lee@39essex.com

Annabel appears frequently in the Court of Protection. Recently, she appeared in a High Court medical treatment case representing the family of a young man in a coma with a rare brain condition. She has also been instructed by local authorities, care homes and individuals in COP proceedings concerning a range of personal welfare and financial matters. Annabel also practices in the related field of human rights. To view full CV click here.

Simon Edwards
simon.edwards@39essex.com

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

Contributors: Scotland

Adrian Ward
adw@tcyoung.co.uk

Adrian is a practising Scottish solicitor, a partner of T C Young LLP, who has specialised in and developed adult incapacity law in Scotland over more than three decades. Described in a court judgment as: "*the acknowledged master of this subject, and the person who has done more than any other practitioner in Scotland to advance this area of law*," he is author of *Adult Incapacity*, *Adults with Incapacity Legislation* and several other books on the subject. To view full CV click here.

Jill Stavert
J.Stavert@napier.ac.uk

Dr Jill Stavert is Reader in Law within the School of Accounting, Financial Services and Law at Edinburgh Napier University and Director of its Centre for Mental Health and Incapacity Law Rights and Policy. Jill is also a member of the Law Society for Scotland's Mental Health and Disability Sub-Committee, Alzheimer Scotland's Human Rights and Public Policy Committee, the South East Scotland Research Ethics Committee 1, and the Scottish Human Rights Commission Research Advisory Group. She has undertaken work for the Mental Welfare Commission for Scotland (including its 2013 updated guidance on Deprivation of Liberty) and is a voluntary legal officer for the Scottish Association for Mental Health. To view full CV click here.