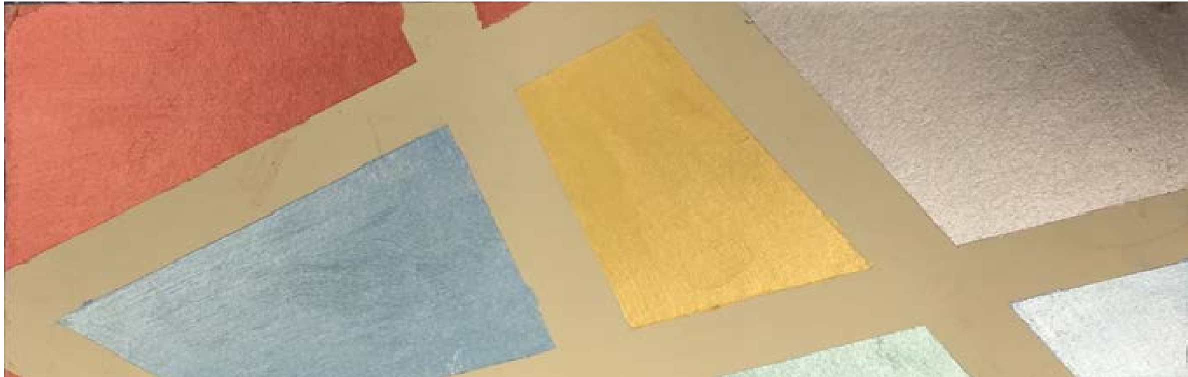

Welcome to the September 2024 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: the Court of Appeal on belief and capacity, and both sexual and medical complexities before the courts;

(2) In the Property and Affairs Report: a guest post updating deputies and attorneys on important responsibilities;

(3) In the Practice and Procedure Report: which decisions are for doctors, and which for the courts; jury-rigging Article 5(4) compliance in community DoL cases, and transparency under the spotlight;

(4) In the Mental Health Matters Report: a Mental Health Bill on the way, the hard edges of the MHA 1983 and the CQC and Valdo Calocane;

(5) In the Wider Context Report: the limits of Article 3 in the context of the inherent jurisdiction, the CQC and covert medication and Lord Falconer's Assisted Dying Bill;

(6) In the Scotland Report: the Scottish Government consults on legislative measures to respond to the Scott Review and a report from the World Congress on Adult Care and Support.

There is one plug this month, for a free digital trial of the newly relaunched Court of Protection Law Reports (now published by Butterworths. For a walkthrough of one of the reports, see here.

You can find our past issues, our case summaries, and more on our dedicated sub-site here, where you can also sign up to the Mental Capacity Report.

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The picture at the top, "*Colourful*," is by Geoffrey Files, a young autistic man. We are very grateful to him and his family for permission to use his artwork.

Contents

A Mental Health Bill on the way? 2
The hard edges of the MHA 1983 2
Valdo Calocane – the CQC, the MHA 1983 and the MCA 2005 7
DHSC guidance on ordinary residence on s.117 MHA 1983 8

A Mental Health Bill on the way?

In the mental health context, the big news is that the King's Speech contained a commitment to bring forward a Mental Health Bill. For more on this, see here.

The hard edges of the MHA 1983

North Tees and Hartlepool NHS Foundation Trust & Anor v KAG & Ors [2024] EWCOP 38 (T3) (Victoria Butler-Cole KC (sitting as a Deputy Tier 3 Judge)

Mental Health Act 1983 – interface with MCA

Summary[1]

North Tees and Hartlepool NHS Foundation Trust & Anor v KAG & Ors [2024] EWCOP 38 (T3) is a case confirming the hard-edged nature of s.63 Mental Health Act 1983. It concerned a woman, KAG, who developed severe depression and in consequence was not eating or drinking. For extremely complicated reasons, including potentially crossed wires as to what the Official Solicitor's position, the case ultimately came before Victoria Butler-Cole KC (sitting as a Deputy Tier 3 judge), who was asked to declare that it was lawful for a PEG to be inserted to provide KAG with clinically assisted nutrition and hydration. She did so, but made clear that:

19. [t]his application was not required. The AMHP rightly determined that the MHA was the correct legal framework to provide treatment to KAG for her mental disorder, including the provision of CANH, and that is the framework that should have been applied. While there will be cases where the scope of s.63 MHA is in question, this was not one of them. The Official Solicitor did not object to the court making a declaration of lawfulness in the exceptional circumstances of this case, but did not expect similar applications to be made in future. This judgment should not be taken as any sort of encouragement to statutory bodies to seek the court's intervention where there is no uncertainty on the part of a treating Trust as to whether treatment can be provided under s.63 and s.145 MHA, even in the face of objection by a patient.

20. As Lieven J explained in in Re JK [2019] EWHC 67 (Fam) at §66:

> *"The MHA gives the power to decide whether to compulsorily treat a patient to the responsible clinician and not to the Court. This is a fundamentally different scheme to that in the MCA where many decisions are given by statute to the court. The difference makes sense because the MHA is a statutory*

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

> *scheme for, inter alia, detention and compulsory treatment in the public interest, where the responsible clinician has a specific role in the statutory scheme. There is no statutory process in the MHA to question the decision of the clinician. However, if the clinician decides to impose treatment, then the individual can judicially review that decision."*

21. The observation by Mrs Justice Lieven in the subsequent case of A Healthcare and B NHS Trust v CC [2020] EWHC 574 (Fam) at paragraph 48 needs to be read carefully. The judge accepted a submission that "considerable care needs to be taken in the use of section 63 [MHA] if it is not to become a way of treating detained mental patients, with or without capacity, without their consent. However, the safeguard that is in place is the requirement set out by Baker J in NHS Trust v A[2013] EWHC 2442 (Fam) at [80] that in cases of uncertainty, the appropriate course is to apply to the Court." Lieven J is there referring to a risk that s.63 MHA is given such a broad interpretation that it can be relied on to treat conditions that are not manifestations or symptoms of a mental disorder – it is self-evident that s.63 MHA permits the treatment of mental disorders without consent. The uncertainty referred to by Baker J (as he then was) is "doubt as to whether the treatment falls within section 145 and section 63 MHA". It is not a reference to cases where the detained patient objects to treatment.

22. The question whether, where a detained patient objects to treatment being imposed on them under the MHA, and lacks capacity to conduct proceedings or to instruct a representative to bring proceedings for judicial review, the treating Trust has any duty to find a litigation friend for the patient or take any other steps to bring the dispute before a court, does not fall to be determined in this case, as the Trusts have in fact brought an application in respect of the lawfulness of the proposed treatment.

Victoria Butler-Cole KC found on the facts of the case before her that it was:

> *24.* [...] *unquestionably in KAG's interests to receive CANH. Equally, it is clear to me that it is now in her interests for CANH to be administered by way of PEG rather than nasogastric tube. As I have previously set out, a PEG will be less risky, more comfortable and more effective. It is reversible, and KAG will be able to eat and drink normally while it is in place should she wish. While the operation to insert the PEG has the potential to be an unpleasant experience, sedating medication will be given, and it will only last for around 10 minutes. Once in place, KAG will be able to move to a suitable therapeutic environment where she can receive the treatment she needs for her mental disorder. Dr A was clear that this was simply not possible in her current hospital which is not a psychiatric hospital. Although KAG is fearful of the procedure, it is the only realistic option to maintain her physical health and to help her to get through this period of depression, as she has in the past.*

Comment

This judgment is delivered at an interesting point, coming as it does as the Government has announced plans to bring forward plans to amend the Mental Health Act 1983. A considerable amount of attention was paid by the independent Review of the Mental Health Act 1983 (to which Alex was the legal adviser) to the question of whether the current procedural safeguards around treatment for mental

disorder complied with Article 8 ECHR. The review concluded (at pages 75-6) that:

> *At the moment, a patient has only very limited ability to question the treatment they are receiving in the first three months of their detention, and most decisions are taken on the basis of the opinion of the patient's Responsible Clinician alone. After three months a second opinion from a SOAD is required if the patient lacks capacity or has capacity and has not consented. Until that point, most treatments can be administered despite a patient's refusal, without any statutory requirement to explain or justify that decision. Criticism of this situation was raised as an issue by service users. Service users' unhappiness with the way they were treated, more even than the detention itself, persisted long after the period of detention or treatment was over. We are clear that the current approach does not go far enough to meet either the ECHR or the CRPD […]*
>
> *At the moment the only way for a patient to challenge the decision of the RC and SOAD is a right to appeal treatment by way of Judicial Review, but we have reached a firm conclusion that it is simply inaccessible. It is both too difficult and too expensive. We believe there should be a route of challenge to a single judge of the Tribunal, supported by non-means tested legal aid. That judge would have the power either to require the Responsible Clinician to reconsider their treatment decision or to order that a specific treatment is not given where they find that it is a disproportionate interference with the patient's rights. The judge would not have the power to order that a specific treatment is provided, but only to prevent treatment (as set out above). We do not think that the judge would, in most cases, need to obtain further clinical evidence, but we think they should have the power to request evidence (for example a medical report) if necessary. Where the patient themselves does not have capacity to bring the application, we think that either their NP or their IMHA should have the power to do so on their behalf, where the patient is unable to do this themselves, and the NP or IMHA believe that the patient would not agree to that treatment (or the NP or IMHA themselves has reason to believe the decision is not in the patient's best interests)*

The draft Mental Health Bill did not include this proposal. The Joint Committee convened to consider the draft Bill noted that:

> *263. We agree with the Independent Review that a slimmed down Mental Health Tribunal should be able to consider whether a patient is entitled to challenge their treatment plans, if requested, following a Second Opinion Authorised Doctor review of their care and treatment plan or a major change in treatment. We recommend that the Government amend the draft Bill to allow for pilots in the first instance, to ensure that the additional workload is manageable and the Tribunal and clinicians' roles are not compromised*

It will be interesting to see what the Bill brought forward says in due course.

One other observation: whilst the application did not need to be brought, this is not the same as saying that Trusts cannot bring applications where they consider that the arguments for and against treatment are finely balanced. There is a steady stream of cases involving patients with disordered eating (usually, but not exclusively patients with anorexia) where Trusts could use s.63 MHA 1983 to treat, but vote with their feet to seek a determination instead from the Court of Protection as to whether (1) the person has

the capacity to make the relevant decisions; and (2) if not, what is in their best interests.

Codes, case-law, restraint and children

An NHS Trust v Mother & Ors [2024] EWHC 2207 (Fam) (Family Division) (Francis J)

Other proceedings – family (public)

Summary

This is a case which throws two issues into stark relief. The first is the problem of government by guidance. The second is what might be thought to be the increasingly urgent need for an appellate level decision on the rights of children in the context of restrictive interventions. The judgment was delivered in slightly curious circumstances, almost a year after a consent order had been endorsed providing for the feeding by naso-gastric tube of a 12 year old girl. The parties (including the girl's parents, and by her Guardian) were able to reach agreement, but Francis J agreed to produce a reserved judgment to address:

> *an apparent tension between, on the one hand, the common law authorities around consent to treatment and restrictions for children and, on the other, the Code* [of Practice to the Mental Health Act 1983].

G was not, in fact, detained under the MHA 1983, but at paragraph 13, Francis J held that:

> *it would be incorrect to regard this case as being subject to different principles simply because it technically falls outside of the Code. In my judgement, the Trust is correct in contending that it is, in effect, bound by the Code, even though strictly speaking G is not detained pursuant to the Mental Health Act 1983. In my judgement, the Code is properly to be seen as guidance for registered medical practitioners and members of other professions in relation to the medical treatment of patients suffering from mental disorder.*

Francis J set out the relevant passages of the (English) Code of Practice, namely paragraphs 19.40 and 19.41. He identified that:

> *19. Eva Holland's very helpful skeleton argument on behalf of the Guardian correctly identifies that the Code refers to a number of cases in a footnote to section 19.40 and these are also referred to in the Position Statement on behalf of the Trust. The Code came into force in 2015. Ms Holland submits to the court that practitioners must be guided by the developing case law in this area. I agree; it is, it seems to me, clear that the Code must follow case law. Case law will be developed with the basis of legal analysis following expert evidence. Parliament produces statutes. Judges interpret statutes where that is necessary. The Common Law is derived from judicial precedents, to which the long established and understood doctrine of precedent applies. These are basic truisms. It is a fundamental principle of our doctrine of precedent that the Common Law in England and Wales is developed by Judgments of the High Court and above. Of course when delivering a Judgment, judges will always take into account the expert evidence that is placed before them. I am not in any doubt that it is judges, and not those writing the Code, that state the law. Indeed, I cannot see how any student of jurisprudence could suggest that a Code of Practice could be superior to judicial precedent. From time to time the Code will be developed and updated, based upon judicial precedent. I agree with the submission that there should be no tension between the Code and the common law authorities. However, if there is, the matter must be referred to the court for the judge to decide.*

He agreed with the submissions made on behalf of the Trust that:

> *21. […] the authorities establish the following proposition: where a child lacks Gillick competence to make their own decision, and there is agreement between the clinical team and parents as to the best interests of the child, a parent can consent to both medical treatment and any consequent deprivation of liberty. This enables clinicians lawfully to carry out the treatment plan. In those circumstances, no court authorisation is required. NG Tube feeding, even if contrary to the non-Gillick competent child's wishes, does not fall within a special category that requires court authorisation. The primary purpose of the tube feeding is to preserve life. Rather than being a case where it will have long-term physiological consequences, I agree with the submission made on behalf of the Trust that the opposite is in fact true, to the extent that without tube feeding the child might (probably would) die. I agree with the submission made by the Trust that the guidance in the Code that there are limits on the decisions which can be taken by parents in relation to treatment of their children under the age of 16 is erroneous. Where there is consensus of the clinical team and parents, the parents are able to provide their consent.*

He noted that the Code – which had not been updated since 2015 – required updating.

> *22. The Trust, supported by the Guardian, invites the court to conclude that for those in G's situation, a parent can consent to treatment on their behalf, even that which is repeatedly invasive and amounts to a deprivation of liberty, and a court application is not required. It seems to me that the Code has not been updated since 2015 and that updating is now required. It is not, of course, the judicial function to become immersed in the drafting of such guidance; however, of course, the Code will from time to time be amended to reflect judicial decisions.*

He also address the question of restraint and deprivation of liberty, and agreed with Lieven J in *Lincolnshire County Council v TGA* [2022] EWHC 2323 (Fam) that G's parents could consent to what would otherwise be a deprivation of her liberty. Indeed, he went even further than had Lieven J in *TGA*, Lieven J had held that parent could only exercise their parental rights – including (as she put it) consenting to deprivation of liberty – if they were acting in their child's best interests. If they were not, she said, then such a decision would no longer fallen within the zone of parental responsibility. Francis J noted that:

> *25. […] It seems to me that even a decision which was made contrary to the child's best interests could still be a decision made in the exercise of parental responsibility. Every day parents will exercise parental responsibility and will sometimes make decisions that are contrary to their child's best interests. This is still exercising parental responsibility. It is the duty of the State to intervene where a decision is contrary to the best interests of the child, and might cause the child to suffer significant harm. However, where, as in the instant case, the treating medical team and the parents agree, the state's intervention is unnecessary; indeed, in my judgement, it would be inappropriate unless, for example (in what I believe would be a very rare case) a local authority or the Children's Guardian took the view that both the hospital and the parents had "got it seriously wrong". Such cases, as I have said, will be extremely rare.*

Accordingly, Francis J concluded at paragraph 26:

> *that in G's sad and difficult situation, where the parents and the treating medical team are "at one", it is lawful to rely on parental consent, that an application is not only unnecessary, but would make an already almost unbearable situation in respect of G (from her family's perspective) even more difficult, and would also cause huge expense and delay. Accordingly, a declaration that it is in G's best interests to receive the treatment and, if needed, to be restrained in order to receive the NG treatment, is unnecessary.*

Comment

Francis J is undoubtedly right to say that a Code of Practice cannot make the law, as oppose to reflect it (a point also made by reference to the Code of Practice to the MCA 2005 by the Supreme Court in *NHS Trust v Y* [2018] UKSC 46). The Code of Practice to the MHA 1983 undoubtedly needs updating in several respects, including, most relevantly, to address the fact that – as a matter of law – parents cannot consent to the confinement of their children when they turn 16, following the decision of the Supreme Court in *Re D*. However, an appellate level decision is, we would suggest, urgently required to address the position of children below the age of 16. None of the cases determined by Lieven J in recent years (including that of *TGA*), nor that of Francis J, have featured any actual arguments about the scope of parental rights in respect of restrictive interventions in the case of children below the age of 16. And the case of *AB v CD* upon which Francis J placed considerable reliance in suggesting that cases were not required to go to court where there was agreement between parents and clinicians involved a situation where there the course of action was in line with the child's identified wishes and feelings. That may be thought to be feel very different to a situation where the course of action is against their known wishes and feelings – on Francis J's analysis at paragraph 21, that could be said to be irrelevant if the child lacked Gillick competence. It might be thought to be challenging, not only by reference to the UNCRC and UNCRPD, but also by reference to Articles 8 and 14 ECHR, that a body of case-law is developing which could be characterised as replacing the voice of the child with that of the parent without a clear requirement to identify whether the two are identical. We have a very extensive body of case-law now making clear that incapacity is not an off-switch for a person's rights and freedoms when they are being looked at under the MCA 2005. It is not immediately obvious, one might think, that a lack of Gillick competence means that a child's wishes, feelings, beliefs and values should not be put into the mix.

Valdo Calocane – the CQC, the MHA 1983 and the MCA 2005

Following the conviction of Valdo Calocane ('VC') in January 2024 for the killings of Ian Coates, Grace O'Malley-Kumar and Barnaby Webber, the CQC was commissioned carry out a rapid review of Nottinghamshire Healthcare NHS Foundation Trust ('NHFT'). The review has been delivered in three parts. The first two, an assessment of patient safety and quality of care provided by the trust and assessment of progress made at Rampton Hospital since the most recent CQC inspection, were published in March 2024. The final part, published in August 2024, was a rapid review of the available evidence related to the care of VC during the period he was under the care of NHFT, alongside a small number of other cases for benchmarking purposes, to determine whether this evidence indicates wider patient safety concerns or systemic issues with the provision of mental health services in Nottinghamshire. The conclusions

include a recommendation that NHS England, together with the Royal College of Psychiatrists:

- *reviews and strengthens the guidance to clinicians relating to medicines management in a community setting, for example depot vs oral medication.*
- *reviews how legislation is used in the community to deliver medication for those patients who have a serious mental illness and where it is known they are non-compliant with medication regimes.*

The Mental Capacity Act 2005 features significantly throughout the rapid review, although it is not always entirely obvious how the authors of the review consider it to be relevant vis-à-vis the MHA 1983. The latter is not a capacity-based regime. But in circumstances where (as appears to have been the case) there were serious question-marks about VC's capacity to make decisions about his care and treatment, there was potentially an entirely separate decision-making structure which could have been in play overseen by the Court of Protection, providing a framework for treatment even in the face of non-engagement. It may be that the review provided for above will address this.

DHSC guidance on ordinary residence on s.117 MHA 1983

DHSC has again updated its guidance following the *Worcestershire* s.117 ordinary residence decision. As previously reported, DHSC has lifted the stay on ordinary residence decisions involving similar issues to those in *Worcestershire*, but appears not yet to have published any determinations on them. New referrals continue to be accepted.

In the updating guidance, DHSC has confirmed that it does not intend to amend paragraphs 19.62-19.68 of the Care and Support Statutory Guidance in light of the decision. DHSC states that *'[t]hese paragraphs reflect the current legal position and so do not need to be amended.'* These paragraphs relate to which local authority holds responsibility for a person's mental health aftercare. These set out both the pre-*Worcestershire* position and the current position (which is effectively unchanged). Notably, the substance of these paragraphs were also not amended during the pendency of the *Worcestershire* litigation, though DHSC's official position had changed during this period.

The updating guidance further states that "*DHSC does not intend to amend the Care and support statutory guidance to address paragraph 58 of the Worcestershire judgement at this time.*" Paragraph 58 of the Worcestershire judgment states:

> *The test articulated in Shah requires adaptation where the person concerned is someone such as JG who lacks the mental capacity to decide where to live for herself. It seems to us that in principle in such a case the mental aspects of the test must be supplied by considering the state of mind of whoever has the power to make relevant decisions on behalf of the person concerned. Under the Mental Capacity Act 2005 that power will lie with any person who has a lasting power of attorney or with a deputy appointed by the Court of Protection or with the court itself. Applying this approach, JG's residence in the area of Swindon was adopted voluntarily in the relevant sense, as it was the result of a choice made on her behalf to live in the accommodation that Worcestershire provided for her following the first discharge. Manifestly, her residence in that place was also adopted for settled purposes as part of the regular order of her life for the time being. Thus, if the term "ordinarily resident" is given its usual meaning, it is clear that immediately before the second*

> *detention JG was ordinarily resident in the area of Swindon. Indeed in these proceedings the Secretary of State has not sought to argue otherwise.*

The current Statutory Guidance on determining the ordinary residence of people lacking capacity is based on the test as articulated in the *Cornwall* Supreme Court decision, rather than the paragraph above (a paragraph which, it should perhaps be noted, did not represent an issue about which the Supreme Court heard any argument).

Finally, DHSC sets out its view that the *Worcestershire* judgment does not impact on s.117 funding responsibility for ICBs, and is to be determined by reference to the National Health Service (Integrated Care Boards: Responsibilities) Regulations 2022 and the NHS Who Pays? Guidance.

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Adrian is a recognised national and international expert in adult incapacity law. He has been continuously involved in law reform processes. His books include the current standard Scottish texts on the subject. His awards include an MBE for services to the mentally handicapped in Scotland; honorary membership of the Law Society of Scotland; national awards for legal journalism, legal charitable work and legal scholarship; and the lifetime achievement award at the 2014 Scottish Legal Awards.

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Conferences

Members of the Court of Protection team regularly present at seminars and webinars arranged both by Chambers and by others.

Alex is also doing a regular series of 'shedinars,' including capacity fundamentals and 'in conversation with' those who can bring light to bear upon capacity in practice. They can be found on his website.

Adrian will be speaking at the European Law Institute Annual Conference in Dublin (10 October, details here).

Peter Edwards Law have announced their autumn online courses, including, Becoming a Mental Health Act Administrator – The Basics; Introduction to the Mental Health Act, Code and Tribunals; Introduction – MCA and Deprivation of Liberty; Introduction to using Court of Protection including s. 21A Appeals; Masterclass for Mental Health Act Administrators; Mental Health Act Masterclass; and Court of Protection / MCA Masterclass. For more details and to book, see here.

Advertising conferences and training events

If you would like your conference or training event to be included in this section in a subsequent issue, please contact one of the editors. Save for those conferences or training events that are run by non-profit bodies, we would invite a donation of £200 to be made to the dementia charity My Life Films in return for postings for English and Welsh events. For Scottish events, we are inviting donations to Alzheimer Scotland Action on Dementia.

Our next edition will be out in October. Please email us with any judgments or other news items which you think should be included. If you do not wish to receive this Report in the future please contact: marketing@39essex.com.

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