



Welcome to the April 2025 Mental Capacity Report. Highlights this month include:

- (1) In the Health, Welfare and Deprivation of Liberty Report: a masterclass in determining a particularly complex set of capacity questions;
- (2) In the Property and Affairs Report: statutory will applications and publicity; OPG guidance on family care payments, and the bond provider saga continues;
- (3) In the Practice and Procedure Report: a helpful reminder of elephant traps for the unwary as regards when time runs for purposes of appealing decisions;
- (4) In the Mental Health Matters Report: the Mental Health Bill progresses, and the CQC reports on the MHA 1983 in 2023-24;
- (5) In the Children's Capacity Report: a new BMA toolkit to help with capacity and other issues in relation to those aged 16 and 17, and back to the vexed question of parental consent to confinement;
- (6) In the Wider Context Report: the inherent jurisdiction rebuffed in a personal injury case, recent research of relevance, and strong views from the CRPD Committee on medical assistance in dying and the 2000 Hague Convention.
- (7) In the Scotland Report: what is appealable in the AWI context, and the complexities of the position of those aged 16 and 17 in Scotland.

The progress of the Terminally Ill Adults (End of Life) Bill can be followed on Alex's resources page [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

BMA Toolkit..... 2

Deprivation of liberty statistics October – December 2024..... 2

Parental consent to confinement..... 2

Can the court order blood testing of a baby before it is born?..... 6

### BMA Toolkit

The British Medical Association has published a [toolkit](#) on treating 16 and 17-year-olds in England, Wales, and Northern Ireland.<sup>1</sup>

This toolkit sets out the legal and ethical factors doctors need to consider when providing care and treatment for young people aged 16 and 17 years old in England, Wales, and Northern Ireland, such as consent, refusal of treatment, and confidentiality.

### Deprivation of liberty statistics October – December 2024

The MoJ [quarterly statistics](#) show that there were 321 applications to the High Court for it to exercise its inherent jurisdiction to authorise the deprivation of liberty of a child during October to December 2024, up 13% compared to the same period in 2013, for this purpose, handling the same number of children. Almost all of these children were teenagers; 53% aged between 13 and 15 and 37% aged between 16 and 18 years. In October to December 2024, 294 orders were issued (up 5%), of which, 149 have had a final order made. 30% of the orders which were finalised between October to December 2024 lasted less than 3 months, while 14% lasted more than 12 months.

<sup>1</sup> Full disclosure, Alex has had input into the England Wales sections.

In 2024 there were 1,280 deprivation of liberty applications and 1,151 orders made by the High Court.

### Parental consent to confinement

The vexed question of whether and under what circumstances parents can consent to (or otherwise authorise) the confinement of children under 16 came before HHJ Burrows (sitting as a High Court Judge) in *QX (Parental Consent for Deprivation of liberty: Children under 16)* [2025] EWHC 745 (Fam). As he noted:

*3. The issues I had to determine in this case are almost identical to those before me in [Lancashire County Council v PX \[2022\] EWHC 2379 \(Fam\)](#) ("PX"). There, I had to decide whether a care order should be made where those with parental responsibility had asked the LA to accommodate and look after the child who had serious mental health conditions that made him impossible for them to care for. Furthermore, in the event that I did not make a care order, whether the child's care plan, which inevitably resulted in his objective deprivation of liberty at the behest of the State had to be authorised by the Court?*

*3. I decided that a care order was not appropriate in that case. I reached the same decision in this case.*

4. In PX I decided I would follow the then recent decision of the High Court in Lincolnshire County Council v TGA [2022] 3 WLR 1297 (FD) ("Lincolnshire"), a judgment of Mrs Justice Lieven, meaning that parental consent to the child's arrangements acted to prevent the engagement of Article 5 of the European Convention of Human Rights (ECHR).

5. I reached that conclusion in PX because I decided that unless I was satisfied that Lincolnshire was wrongly decided, I ought to follow it. However, at the earlier hearing in this case, I was mindful that the tide may have turned since then and the approach taken by Lieven, J needed to be reconsidered. This was particularly so because of the recent Court of Appeal decision in which Lieven, J's judgment in Re J: Local Authority Consent to Deprivation of Liberty [2024] EWHC 1690 (Fam) had been reversed. Unfortunately, at both hearings in this case, and at the time this judgment is written, the judgment of the Court of Appeal in J had not been handed down.

HHJ Burrows continued:

7. Having read and heard focused argument on this issue and having considered the relevant authorities relied upon, I have come to the same conclusion as I did in PX and I have followed Lieven, J. I do, however, have some misgivings, which were the basis of my interactions with counsel. It seems right for me to outline them here.

Helpfully, HHJ Burrows undertook an exercise which is not always done in this context, namely separating out the individual elements of deprivation of liberty:

36. There are three components to a deprivation of liberty: see e.g. Storck v Germany (2005) 43 EHRR 96).

37. The first is objective confinement which, following Cheshire West means for a person to be confined in a particular restricted place for a not negligible period of time, and being under continuous supervision and control and not free to leave that place (See [2014] UKSC 19).

38. The second component is the absence of consent to that confinement either because the person does not consent (like a prisoner) or is unable to consent (in the case of an adult who lacks capacity, or a child who is not competent to consent).

39. The third component is that the state is responsible.

40. I am not concerned with either the first or the third component in this case. In particular, no one seeks to argue that QX comes within another decision of Lieven, J., namely Peterborough City Council v a Mother and a Father [2024] EWHC 493 (Fam) ("Peterborough") or the more recent decision of Rochdale Borough Council v V [2025] EWHC 200 (Fam) a decision of HHJ Middleton-Roy sitting as a High Court Judge. In those cases, such was the mental and physical disability of the child, that it deprived them of their liberty and not any "restrictions" that were put in place by the State or parents to keep them safe. As Lieven, J put it at [38] of the Peterborough case:

*On a conceptual level it is difficult to see how one can be deprived of something that one is incapable of doing. Equally, how can one be deprived of a right that one is incapable of exercising, not through the actions of the State or*

any third party, but by reason of ones own insuperable inabilities.

41. Had this case rested wholly or in part on this argument, I would have struggled to follow those authorities that appear to be plainly wrong. Wrong conceptually, because they fail to distinguish between "negative" liberty, the freedom from being prevented from doing something, and "positive liberty", the freedom to be enabled to do something. There are many people who are incapable of doing things without the help of others and are enabled to do those things by carers/family etc, often funded or provided for by the State, or following assessments under the Care Act. Where a carer for a profoundly physically, but not mentally disabled person, decides not to assist that person to move from a place where they do not want to be, no one would surely argue that the disabled person was not deprived of their liberty. Unless, it seems, they are mentally incapable, too. But in that case, the universality of human rights, for abled and disabled people alike, as in Cheshire West must be recognised. In which case both are deprived of their liberty.

42. Wrong also because these decisions seem to conflict with the Cheshire West decision as distilled through the Court of Appeal's judgment in Rochdale MBC v. KW [2015] EWCA Civ 1054. In that case, Lord Dyson, MR rejected an earlier iteration of the Peterborough argument, by Mostyn, J. That argument was summarised by the Court of Appeal at [4]:

"Mostyn J purported to apply the test required by Cheshire West, although it is clear from para 19 of the first judgment that he did not agree with it. He said at para 17 that it was impossible to see how the protective measures in place for KW could linguistically be

characterised as a "deprivation of liberty". Quoting from JS Mill, he said that the protected person was "merely in a state to require being taken care of by others, [and] must be protected against their own actions as well as external injury". At para 25, he said that he found that KW was not "in any realistic way being constrained from exercising the freedom to leave, in the required sense, for the essential reason that she does not have the physical or mental ability to exercise that freedom".

43. The Court of Appeal overturned Mostyn, J.

44. Consequently, a person, subject to a care plan that requires them to reside in a particular place and be under constant supervision and control and are not free to leave, whether or not their physical or mental capabilities prevent them from leaving, is deprived of his/her liberty, absent their consent.

45. Mr Jones suggests that the Court needs to apply a modified comparator in this case. In other words, whether a child is subject to confinement that may amount to a deprivation of liberty, one has to ask whether those restrictions are "well in excess" of what a child of his age would have imposed upon them in "normal circumstances".

46. It is important to note that the comparator is a normal child and not one with QX's disabilities.

47. I agree with Mr Jones.

HHJ Burrows then went on to consider whether a person holding parental responsibility give consent for that child to be placed in a regime

that leads otherwise to his deprivation of liberty. He noted that:

*54. In Re D (a child) [2019] UKSC 42 the Supreme Court considered the issue of parental consent and deprivation of liberty in respect of children who have reached the age of 16. The answer is that they cannot. That is primarily because the Mental Capacity Act 2005 places people who have reached the age of 16 on a different jurisdiction footing when it comes to the issue of consent, than those under the age of 16.*

*55. For that reason, the tensions between the Justices of the Supreme Court in Re D, as to the proper application of Cheshire West to children under 16 result in observations that are only obiter. These are outlined and analysed by Mr Jones in his Skeleton, and I need not repeat what he says there in this judgment.*

*56. One issue that occurred to me that left me uncertain as to the approach of Lieven, J and Keehan, J, concerned the relevance of disability to the exercise of PR. As Keehan, J stated in Trust A v X [2015] EWHC 922 (Fam) at [54]-[57]:*

*[54] I wish to pay tribute to D's parents who have throughout acted in what they considered to be in the best interests of their elder son. They have, at all times, paid the closest interest in his care at the hospital and they have worked in co-operation with the clinicians, staff and carers at the unit. They have attended, or at least one of them has attended, the periodic reviews held at the hospital.*

*[55] When considering the exercise of parental responsibility in this case and whether a decision falls within the zone of parental responsibility, it is inevitable and necessary that I take into account D's autism and his other*

*diagnosed conditions. I do so because they are important and fundamental factors to take into account when considering his maturity and his ability to make decisions about his day to day life.*

*[56] An appropriate exercise of parental responsibility in respect of a 5 year old child will differ very considerably from what is or is not an appropriate exercise of parental responsibility in respect of a 15 year old young person.*

*[57] The decisions which might be said to come within the zone of parental responsibility for a 15 year old who did not suffer from the conditions with which D has been diagnosed will be of a wholly different order from those decisions which have to be taken by parents whose 15 year old son suffers with D's disabilities. Thus a decision to keep such a 15 year old boy under constant supervision and control would undoubtedly be considered an inappropriate exercise of parental responsibility and would probably amount to ill treatment. The decision to keep an autistic 15 year old boy who has erratic, challenging and potentially harmful behaviours under constant supervision and control is a quite different matter; to do otherwise would be neglectful. In such a case I consider the decision to keep this young person under constant supervision and control is the proper exercise of parental responsibility.*

*57. As I suggested to Mr Jones in argument (an argument conducted exclusively with me!), although Keehan, J's reasoning is clear and very compassionate, it comes close to breaching the anti-discriminatory purpose behind the majority in Cheshire West. If a child of 15 with autism and severe learning disability can be*

*deprived of his liberty on the consent of his parents, but one without autism and severe learning disability cannot, is that not discriminatory against the former child? Does it not deprive the more vulnerable from the protections of Article 5 which are designed to protect the most vulnerable?*

*58. However, I am persuaded that the line of authority, of which Keehan J and Lieven, J's decisions are an essential part, is clearly stated in the judgments and based upon a careful consideration of the law, both domestic and ECtHR. They clearly state that parental responsibility can be deployed to consent to an objective deprivation of liberty. To summarise their views, provided the exercise of parental responsibility is for the interest of the child, then it is within the zone of parental responsibility; if it is not, then it is without that zone.*

## Comment

It is unfortunate that the judgment of the Court of Appeal in *Re J* has yet to be published. That having been said, all parties before the court were unanimous (although not for the same reasons) in submitting to the court that it should not pronounce upon the question that came before HHJ Burrows in *QX*. It is, however, fair to note that some of the parties were submitting (and, it appeared, to a favourable response) that the Court of Appeal should not by such a non-pronouncement suggest that it was endorsing the line of authority including, in particular, the *Lincolnshire* case (a case where there was agreement between all the parties before the

court). An appellate level decision on this point is badly needed.

It is also relatively rare for a more 'junior' judge<sup>2</sup> to express so baldly the view that the judgment of a more 'senior' judge is "plainly wrong." With respect, in the instant case, we entirely agree with HHJ Burrows that it is very difficult to square the decision in the *Peterborough* case with the authorities. Again, however, an appellate level decision on this point is badly needed so as to be able to resolve this issue one way or another.

## Can the court order blood testing of a baby before it is born?

*Manchester University NHS Foundation Trust v PP* [2025] EWHC 783 (Fam) (High Court (Family Division)) (McKendrick J)

*Other proceedings – family (public law)*

## Summary<sup>3</sup>

In this case, the newly elevated High Court Judge, McKendrick J, had to grapple with a very urgent situation. It is clear that he was concerned as to why the application was brought so late, but did not have the time to investigate in where a pregnant woman did not consent to screening for screening for blood borne viruses (BBVs), namely HIV, hepatitis B (HBV) and syphilis. She had presented at hospital with Kikuchi Lymphadenitis which McKendrick accepted (at paragraph 10) "*may indicate that she has HIV or even AIDS. The applicant considers that there is a real risk that she is infected with HIV.*" He continued:

<sup>2</sup> Although, as HHJ Burrows was sitting as a High Court judge in *QX*, his observations were technically made by a judge of so-called coordinate jurisdiction.

<sup>3</sup> Katie having been involved in the case, she has not contributed to this note.

11. [...] I am told that it is imperative that when the baby is born, it is investigated for these BBVs.

12. The results from both the new born baby's blood and the cord blood, tests maternal antibodies to the BBVs not the child's. Therefore, if the result is positive it does not mean that the child is infected. If the cord blood tests positive for HIV it will reveal the mother's infection status. If the mother has HIV, then there is a risk that the baby does. There is a 4 hour window to get antiretroviral treatment into the baby to give the baby the best chance of avoiding developing HIV. The treatment is most effective within 24 hours. It has no effect after 72 hours.

In the note of the ex tempore (i.e. oral) judgment given, which he perfected afterwards, McKendrick J identified that:

39. This is a difficult case which requires much greater time and thought and care than I can provide for in an urgent application. It raises profound ethical issues including the rights of mothers, the rights of an unborn foetus and matters of women's reproductive health. It also raises issues of human rights both for the mother and the child, when s/he is born. As I have set out, and this is not in doubt as established in *In Re F (In Utero)*, an unborn child does not have a legal personality. It is part of the mother's body and does not have independent rights. That has been the settled status of the law for a long time, and no one says that is wrong. It is also established in a Court of Appeal judgment that I am bound by.

40. I am in essence being asked to provide the Court's consent to the treatment plan on the basis that it is in the best interests of the baby to be tested for BBV and treated within 4 hours of birth if HIV is indicated. I am

being asked to make a welfare decision. I can only consent if the treatment plan is in the child's best interest. This is clear from established case law such as *Aintree v James* [2013] UKSC 67 (which although concerned with adults, also applies to children). The law is also set out most recently and clearly by Harrison J in the case of *C (A child) (Life sustaining treatment)* [2025] EWHC 413 (Fam).

41. The Trust are alive to the difficulties with this application, which is why Ms Scott says in her elegant submissions that I am not being asked to make a welfare decision about the foetus. Rather I am being asked to make anticipatory declarations that the care plan is lawful.

42. However in my view, what I am being asked to make in substance is a welfare decision. I am being asked to determine, whilst the child remains a foetus, the welfare of the baby when born. Munby J in the case of *Re D*, when he set out his anticipatory declarations, made it clear that the jurisdiction did not include the welfare of the child. His declaration is about withholding information from the mother. Ms Scott is asking the court to make a welfare decision about a foetus who has no legal personality. The foetus is not a party to this application.

43. PP's Article 8 ECHR rights are fully engaged. Testing will reveal the status of her health. Such testing plainly amounts to an interference in her respect of a private life. This interference may amount to a violation. That depends on whether the interference is necessary, proportionate and in accordance with the law. I therefore cannot balance the rights of the foetus against the rights of the mother to justify an interference with the mother's rights. The potential 'rights' engaged are those of the foetus, but I

am bound by *Re F* and as such the foetus has no legal personality and no rights. It is therefore very difficult to balance the rights to justify an interference with the mother's rights. Re-framing the question to consider anticipatory declarations does not, in my judgement, resolve this difficulty.

44. There is also a difficulty with the best interests welfare jurisdiction as the child is not a party, but the declaration would bind the child. The child does not have a Guardian (CAFCAS will not accept an invitation to act for a foetus) and as the foetus is not a party it could not appeal the decision.

If I conclude that I can make a declaration about a foetus that goes to the welfare of the child when born, I may, if I can put it this way at this late hour, be opening a can of worms. What other declarations would be sought by others in the future? Accepting jurisdiction to make welfare decisions for a foetus is fraught with some danger. In as much as I have digested the learning of *Re F* such a step would be for Parliament to decide not the courts. Care is necessary before determining such a jurisdiction exists, other than the circumstances that pertained before *Munby J* in *Re D*. It has the potential to undermine women's reproductive rights.

45. Ms Scott seeks to bolster her argument by reference to the anticipatory declarations made in the Court of Protection. That does not assist me however, as *P* in the Court of Protection has rights which are protected both when capacitous and when incapacitous. There is not a read across from a capacitous *P* to a foetus.

46. Therefore, with some regret, I conclude, there is no jurisdiction to make a welfare decision for this foetus when s/he is born. I am not prepared to circumvent long established common

law principles by dressing up a welfare decision to consent to medical treatment by re-framing the issues as an anticipatory declaration.

47. I conclude I have no jurisdiction to determine what should happen to the foetus when born.

McKendrick J did, however, go on to say "a little" about the welfare issues involved:

49. Notwithstanding my lack of jurisdiction, and given the urgency, I should say a little about the welfare issues involved. From the information provided to me, the welfare analysis is relatively straightforward. Prof CC's evidence is clear – there is a risk that the mother has a BBV. The Trust cannot say definitely if this is so, but even if I assess that risk as being small or medium, it is a risk of very significant harm to the baby due to the effects of BBV on a newborn child. There would be almost no impact or risk to the child of checking the blood cord or even the blood of the baby. There will be no psychological or physical risks, but very many downsides if a blood test does not take place and essential treatment cannot be provided, giving the child risks of developing HIV, HBV or syphilis. The magnitude of that risk is set out in submissions and it is drawn from academic literature. At present I am clear this innocuous blood test is essential to the baby when born, to protect the baby from the symptoms of any serious illness.

50. The best interests analysis incorporates the article 8 rights, which would require me to balance the mother's rights against that of the baby. However the mother has not put forward a good reason for the tests not to take place. If I have to carry out the balance the rights would come down on the side of the child. However, I am not persuaded I have a jurisdiction to make

*welfare decisions, even anticipatory declarations. Therefore I will not decide today what is in the best interest of the unborn baby, but will do so when the baby has been born and has a legal personality. It is highly likely my provisional welfare analysis will not evolve from what I have said today, but of course I have reached no concluded view. I encourage PP to reflect carefully on what she has heard and consider consenting to a test and treatment for her baby when born.*

McKendrick J adjourned the application, in effect to seek to reconstitute it as speedily as possible after the baby was born, and to enable the baby's representation by CAFCASS. In a postscript to the judgment, McKendrick J explained:

*On 27 March 2025 PP was delivered of her baby. A hearing took place before me within an hour of the baby's birth. The baby's guardian was able to attend the hearing and instruct a solicitor to represent the baby's interests. Consent to test was provided as being overwhelmingly in the baby's best interests.*

### Comment

We anticipate that having the necessary people around to be able to reconstitute the proceedings so speedily after the baby's birth was not cost-free. However, that may have been the price necessary to ensure that in reaching a route to a decision which (on its face) was blindingly obvious McKendrick J did not inadvertently open the door to a route to be used in very different circumstances to much more challenging outcomes.

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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 also does 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](#).

### **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.

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Our next edition will be out in May. 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](mailto:marketing@39essex.com).

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